The Dueling Obligations of Opioid Stewardship

The United States leads the developed world in drug poisonings, a title earned through vastly increased opioid analgesic use (1). Overdoses involving opioid analgesics killed almost 17 000 persons in 2010—nearly as many as car accidents—and the number of people with opioid analgesic use disorders has increased to nearly 2 million. As a medical community, we have an ethical obligation to use our resources not only to reduce the incidence of opioid use disorders but also to provide optimum care to patients who have developed disorders due, at least in part, to our prescribing practices. Equally important, medical organizations have an imperative to advocate for changes in policy and practice that are cautious but sufficient to stave off the punitive policies emerging across the nation.

The American College of Physicians (ACP) position paper that appears in this issue (2) provides a thorough historical review of increased opioid prescribing, including the adoption of pain as the "5th vital sign" and the advent of novel opioid formulations. Other factors, most notably welfare and health care reform in the 1990s, also played into overreliance on opioids. Welfare restrictions are believed to have fueled disability claims for persons unable to find work, frequently because of difficulties with chronic pain. Managed care organizations, recognizing that opioids were less expensive than the comprehensive pain management clinics that once existed at many medical centers, stopped reimbursement for those services (3). In fact, many public insurers, whose clients include many at risk for adverse opioid-related events, no longer reimburse for nonmedication services, such as physical therapy. Thus, primary care providers who were instructed to treat pain were seeing more chronic pain complaints, increasingly available opioid medications, and payers unwilling to cover nonpharmacologic interventions, leaving opioids as one of the few therapeutic options, if not the only one.

We have since moved through 3 stages of thinking about opioid medications, from the early hypothesis that treating pain with opioids resulted in addiction among fewer than 3% of patients (4), to the hope that opioid medication problems were due to "bad apples" who could be weeded out through screening, to a recent recognition that the problem is due to "risky drugs, not risky patients" (5). The era of "bad apples" has an unfortunate legacy apparent in the literature and many policy statements. First, "doctor shoppers" make up only 0.7% of persons receiving opioid prescriptions and receive only 1.9% of prescriptions (6), suggesting that these patients represent a small piece of the overall problem. Second, recognizing that many people suffer from iatrogenic opioid use disorders, we must also recognize that many patients who would not have met risk criteria when opioid therapy was initiated subsequently developed use disorders. Thus, these screening criteria may miss patients that will be harmed by opioids. Finally, we should rarely have to "screen out" patients if we are prescribing opioids only when necessary and for proper indications.

While we rein in our use of opioids for less appropriate indications like chronic lower back pain (an approach to reforming prescribing practices not specifically addressed in the ACP policy paper), we must care for patients directly or indirectly harmed by opioid prescribing and diversion. Data indicate some users of opioid analgesics will transition to heroin or other illicitly obtained opioids, and we have witnessed increased overdose death coincident with prescribing restrictions (7). In addition, as we know from opioid maintenance treatment, even dose reductions motivated by practice or policy changes may be hazardous, possibly increasing mortality even among patients who don't seek illicit opioids (8). At the same time, if we fail to act decisively and promote substantial changes, we risk stewardship and legislative efforts that could drive physicians back to the era of "opiophobia" and result in serious morbidity and even mortality among our patients currently receiving opioids.

The dual goals of reducing iatrogenic opioid use disorders and protecting our ability to care for existing patients lead us to suggest several adjustments to opioid prescribing practice. First, we should limit the *reasons* we prescribe opioid medications. Long-term opioids for chronic nonmalignant pain may not improve and may in fact worsen functional status (9). Patients should be aware that medications are rarely the best option for many types of pain. Even acute pain may not warrant opioids. Second, clinicians should rely on functional status, rather than reported pain, as the metric of success for management of chronic, nonmalignant pain. Third, we need to rebuild the infrastructure of nonopioid pain management. Services, such as geographically and financially accessible physical and occupational therapy, would go a long way toward improving management of many pain syndromes. Unfortunately, building infrastructure takes time and payers may balk at upfront costs. However, in the context of medical homes and total cost containment, such approaches may again become plausible economically. Fourth, we should consider buprenorphine for chronic pain in certain circumstances. Notwithstanding some well-publicized risks for diversion, buprenorphine has a "ceiling effect," very low risk of overdose, and early evidence of efficacy for pain control in patients transitioned from other opioids (10). The cost is lower now that generics are available, and the even less expensive monoformulated product may be sufficient for patients with no history of injection.

Finally, we propose that clinicians prescribe the short-acting opioid antagonist naloxone to all patients receiving chronic opioids. Naloxone has been given to tens of thousands of patients for lay overdose reversal with no reported

adverse medical events and is associated with a relative risk for opioid overdose death of 0.53 (11). The U.S. Army's Fort Bragg gave naloxone to pain patients receiving opioid analgesics and witnessed a decrease from 8 overdoses each month to none. Naloxone prescribed to patients may not only be used to reverse overdose but may also be a powerful opportunity to show patients that the opioids they are taking carry serious risks.

The ethical imperative to safely treat patients harmed by our opioid prescribing practices rises to that which a surgeon has for operative complications. This also means taking a proactive role in policy development that satisfies the perceived need to reduce opioid prescribing while protecting our ability to treat those patients already using opioids. The ACP statement includes many important recommendations, yet we remain concerned that those supporting burdensome and punitive policies may not be swayed.

Phillip Coffin, MD, MIA
San Francisco Department of Public Health
San Francisco, California

Caleb Banta-Green, PhD
University of Washington
Seattle, Washington

Disclaimer: The authors are solely responsible for the content of this article, which does not necessarily represent the official views of the San Francisco Department of Public Health.

Potential Conflicts of Interest: None disclosed. Forms can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M13-2781.

Requests for Single Reprints: Phillip Coffin, MD, San Francisco Department of Public Health, 25 Van Ness Avenue, Suite 500, San Francisco, CA 94102; e-mail, pcoffin@gmail.com.

Current author addresses are available at www.annals.org.

This article was published online first at www.annals.org on 10 December 2013.

Ann Intern Med. 2014;160:207-208.

References

1. **US Burden of Disease Collaborators.** The state of US health, 1990-2010: burden of diseases, injuries, and risk factors. JAMA. 2013;310:591-608. [PMID: 23842577]
2. **Kirschner N, Ginsburg J, Snyder Sulmasy L.** Prescription drug abuse: executive summary of a policy position paper from the American College of Physicians. Ann Intern Med. 2014;160:198-200.
3. **Institute of Medicine (US) Committee on Advancing Pain Research Care and Education.** Care of People with Pain. In: Institute of Medicine (US) Committee on Advancing Pain Research Care and Education. Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research. Washington, DC: National Academies Pr; 2011.
4. **Fishbain DA, Rosomoff HL, Rosomoff RS.** Drug abuse, dependence, and addiction in chronic pain patients. Clin J Pain. 1992;8:77-85. [PMID: 1633386]
5. **Dowell D, Kunins HV, Farley TA.** Opioid analgesics—risky drugs, not risky patients. JAMA. 2013;309:2219-20. [PMID: 23700072]
6. **McDonald DC, Carlson KE.** Estimating the prevalence of opioid diversion by "doctor shoppers" in the United States. PLoS One. 2013;8:e69241. [PMID: 23874923]
7. **Unick GJ, Rosenblum D, Mars S, Ciccarone D.** Intertwined epidemics: national demographic trends in hospitalizations for heroin- and opioid-related overdoses, 1993-2009. PLoS One. 2013;8:e54496. [PMID: 23405084]
8. **Hickman M, Kimber J, Cornish R, Davoli M, Strang J, Vickerman P, et al.** Preventing drug related OD/mortality: Key findings from mortality studies in Europe (UK/Italy). Presented at the College on Problems of Drug Dependence Annual Meeting, 9–14 June 2012, Palm Springs, CA.
9. **Chaparro LE, Furlan AD, Deshpande A, Mailis-Gagnon A, Atlas S, Turk DC.** Opioids compared to placebo or other treatments for chronic low-back pain. Cochrane Database Syst Rev. 2013;8:CD004959. [PMID: 23983011]
10. **Roux P, Sullivan MA, Cohen J, Fugon L, Jones JD, Vosburg SK, et al.** Buprenorphine/naloxone as a promising therapeutic option for opioid abusing patients with chronic pain: reduction of pain, opioid withdrawal symptoms, and abuse liability of oral oxycodone. Pain. 2013;154:1442-8. [PMID: 23707283]
11. **Walley AY, Xuan Z, Hackman HH, Quinn E, Doe-Simkins M, Sorensen-Alawad A, et al.** Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. BMJ. 2013;346:f174. [PMID: 23372174]

Current Author Addresses: Dr. Coffin: San Francisco Department of Public Health, 25 Van Ness Avenue, Suite 500, San Francisco, CA 94102.

Dr. Banta-Green: Alcohol and Drug Abuse Institute, University of Washington, 1107 Northeast 45th Street, Suite 120, Box 354805, Seattle, WA 98105-4631.