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CASE AND COMMENTARY

Do Physicians Have Collective, Not Just Individual, Obligations to Respond to the Opioid Crisis?

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Abstract

Evidence-based clinical guidelines could mitigate variations in care for some patients. However, patient and clinician distress can arise when guidelines are misapplied or mandated by processes that are not evidence based, fail to integrate physician expertise and patient preference, or fail to motivate informed, shared decision making. Physicians can choose to collectively advocate at national, state, and local levels for policy changes.

Case

Dr O is an orthopedic surgeon in private practice trying to adapt to a recently passed law restricting opioid prescribing. This law restricts how long physicians may prescribe opioids for acute pain (ie, pain expected to last 3 months or less), prohibiting prescription of more than 5 days' worth of opioids after an initial consultation for acute pain unless the prescription is for postoperative pain relief, which has a 7-day limit.

Dr O is deeply concerned about physicians' roles in the state's opioid problem. Specifically, he is concerned about colleagues who underprescribe clinically indicated opioids, and he is equally concerned about other colleagues who overprescribe opioids and do not manage patients' pain care skillfully or responsibly. Dr O's patients typically require opioid pain relief for more than 7 days after a surgery, so he and other physicians resent being legally required to offer inadequate pain care to many patients.

Dr O and many of his physician colleagues realize, however, that questioning the appropriateness of this new law as public health policy is not enough. He and fellow physicians wonder whether and when they should try to become engaged as a socially and culturally influential group to shape and influence policy decisions that affect their practices and patients.

Commentary

This case raises the following questions: What are physicians' ethical obligations to improve public health and how should they do so? Specifically, what role do physicians have as a profession to address the epidemic of deaths due to opioids? Not specified, but also important, is the question: How should physicians balance their obligations to

individual patients with their obligations to improve the health of the public? One role of professional societies is to improve quality of care by having its members develop clinical practice guidelines, as we discuss below.

Misapplied Guidelines

State laws and regulations for prescribing and reporting that do not allow for the informed and flexible exercise of evidence-based practice and person-centered care might contribute to moral distress among physicians. While few would question the principles of respect for patients' autonomy, beneficence, nonmaleficence, and justice, the question of how these principles apply in individual instances is often open to debate within the medical profession. For example, Dr O believes his patients typically require opioid pain relief for more than 7 days after surgery but is concerned that he is legally required to prescribe opioids for no more than 7 days initially. His conundrum is that, while ethically obligated to act compassionately and in the best interests of his patient, he will be breaking the law if he prescribes what he believes to be adequate pain relief. In North Carolina, which has a 7-day opioid or narcotic initial supply limit for acute postoperative pain, the law specifies: "Upon subsequent consultation for the same pain, practitioners may issue any appropriate renewal, refill, or new prescription for a targeted controlled substance."[1] Nevertheless, several states have passed laws limiting opioid prescriptions for acute pain in opioid-naïve patients.[2] The content of these laws, including permitted duration of opioid therapy and maximum daily morphine milli-equivalents one may prescribe, varies from state to state.[2] The Centers for Disease Control and Prevention (CDC) guideline for opioid prescribing may help mitigate this variation, although the guideline was developed for the treatment of chronic—not acute—pain, as in this case.[3]

Well-intentioned and well-constructed evidence-based guidelines can have unintended consequences, however. Following the issuance of guidelines by the American Pain Society in 1995,[4] the inclusion of assessment of pain as "the fifth vital sign" was linked to reimbursement as a quality metric by the Centers for Medicare and Medicaid Services.[5] Tragically, this step may have contributed to marked increases in opioid prescribing.[5] At the other end of the prescribing spectrum, the opioid guideline that the CDC issued in 2016, which recommended, among other things, optimizing "other therapies and work[ing] with patients to taper opioids to lower dosages or to taper and discontinue opioids" if benefits do not outweigh the harms,[3] may have been applied inflexibly and misapplied to populations outside the scope of the guidelines.[6] Although outpatient opioid prescribing had been declining before the issuance of this guideline, after its publication, prescribers, concerned about their role in the opioid epidemic, began to nonconsensually taper or discontinue patients' opioids.[6]

As a profession, physicians have an obligation to review available evidence and to contribute to the creation of clinical guidelines. Evidence-based practice requires the integration of best available evidence, clinical expertise, and patient preferences.[7] This practice should guide physicians' recommendations and prescribing decisions in pain management and when treating patients who suffer from substance use disorders to help them attain or sustain sobriety. Physicians should advocate for time and reimbursement with employers and payers to have these important, complex conversations. Physicians may also choose to collectively advocate for changes in regulations, policies, and laws in such circumstances.

Physicians' Obligation to Advocate for Public Health

Physicians have an individual and collective obligation to understand the influence of marketing campaigns conducted by pharmaceutical and other companies that benefit financially from physicians' prescriptions and use of their products. But this obligation goes deeper than awareness of such campaigns. US physicians have an obligation to scrutinize their own behaviors. Acceptance of even small gifts from industry, researchers have shown, can add up to large sums of money both over time and from multiple sources. These gifts create powerful incentives to prescribe specific products with sometimes devastating consequences.[8] Aggressive marketing of oxycodone by one major drug company has been implicated in contributing to the opioid epidemic.[9] A recent report noted that this company intentionally marketed more heavily in states with less stringent prescription drug monitoring programs, resulting in significantly more drug overdose deaths in those states even after accounting for regional differences in socioeconomic factors and in supply and demand—an impact that has persisted for 2 decades.[10]

As stated in the American Medical Association's Principles of Medical Ethics, "A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health."[11] This responsibility can be extrapolated to include an individual and collective obligation to keep abreast of changes in knowledge and other relevant information as they occur during the opioid epidemic and to participate in emergency planning and harm mitigation.

The United States is now in the third wave of deaths from opioids. The first wave began in the 1990s, as physicians began to increase opioid prescribing. The second wave began in 2010 with increasing numbers of deaths due to heroin, as patients with substance use disorders turned to illicit drugs. The third wave began in 2013, as illicitly manufactured synthetic opioids flowed into the United States, especially fentanyl sold alone and in combination with other drugs.[12] We may witness a fourth wave of overdose deaths from drugs for which there are currently no antagonists or evidence-based guidelines for treatment; this is a good reason for physicians to advocate for the acceleration of research in this field.

The magnitude of this crisis obliges physicians to advocate for expanded public education and access to medication-assisted treatment (MAT), naloxone, and harm-reduction strategies. When health care expenses, lost earnings, premature deaths, lost productivity, and addiction treatment are considered, the full cost of the opioid crisis was estimated to be $2.5 trillion dollars between 2015 and 2019.[13] Meanwhile, the death toll remains high (69 029 opioid-related deaths between February 2018 and February 2019).[14]

National, State, and Local Options for Action

What are the range of strategies available for physicians to act collectively to improve public health during the epidemic of drug overdoses due to substance use disorders? Nationally, physicians can act collectively in several ways to influence practice and improve public health. They can act through their associations, professional societies, and academies to advocate and lobby for policies that are based on available evidence and consistent with ethical and professional practice and that they believe will improve the health and well-being of the population. For example, health care policies could

address prescribing, access to treatment, and provider reimbursement. Regulatory policies could incentivize treatment over incarceration for substance use disorders.

The American Medical Association convened national, state, specialty, and other organizations to form a broad-based opioid task force to formulate policy recommendations.[15] These recommendations include terminating all payer and pharmacy benefit management requirements for prior authorization to initiate MAT for opioid use disorder and ensuring that MAT is available at the lowest-cost tier to make it accessible and affordable.[15] The task force has also called for access to MAT for incarcerated persons and for their continued care upon their release. Similarly, the task force recommends expanded access to naloxone and funding for research to expand options for evidence-based treatments.[15] In addition, the task force calls on insurers to comply with the 2008 federal Mental Health Parity and Addiction Equity Act[16] to improve access to mental and behavioral health treatment and advocates for patient and public education, particularly for vulnerable populations such as children and pregnant women.[15]

At the state level, physicians can lobby their state medical societies to influence policy. A recent audit of state oversight and opioid prescription monitoring for Medicaid beneficiaries conducted by the US Department of Health and Human Services Office of Inspector General showed that states have implemented a variety of initiatives. These initiatives include state laws, regulations, guidance, and state-specific Medicaid policies for patients with substance use disorders who have been disproportionately affected by the opioid epidemic.[17] Some of the initiatives reported included using data analytics to identify high-prescribing clinicians and users; limits on opioid drug coverage and prior authorization requirements; education, training and feedback for clinicians about their prescribing practices; community outreach and messaging campaigns; and expanded opioid use disorder treatment programs.[17] Other organizations are beginning to identify promising practices, including those aimed at preventing misapplication of the CDC guideline.[18]

Locally, physicians can advocate for policies that will improve pain management, risk assessment, and treatment in their communities by educating themselves, colleagues, and learners and by participating in hospital credentialing and privileging committees that establish and monitor adherence to standards for professional practice.

Physicians can act collectively by advocating for and participating in the establishment of standards for education and practice across the continuum of learning. Organizations that accredit educational institutions and training programs influence professional and practice norms, as do medical education associations and academies. The Association of American Medical Colleges (AAMC) is working with its member institutions to enhance and expand training in the management of pain and substance use disorders.[19] Excellent resources are available to clinician educators from the US Department of Health and Human Services and elsewhere to inform curricula, research, and policy.[20,21] The AAMC is also promoting awareness of the Opioid Workforce Act of 2019, introduced to expand graduate medical education slots for qualifying hospitals with approved residency programs in addiction medicine, addiction psychiatry, and pain medicine.[22] The Accreditation Council on Graduate Medical Education has joined the National Academy of Medicine's newly formed Action Collaborative on Countering the US Opioid Epidemic, a private-public partnership aimed at coordinating and accelerating efforts to stem the tide of the opioid epidemic.[23]

Summary

In summary, physicians have obligations to individual patients and to the public's health, and they have many opportunities to contribute to the enhancement of both. The obligations include contributing to or keeping abreast of evidence and best practice guidelines as they evolve; demonstrating compassion, respect, and clinical judgment when prescribing and tapering opioids; and acknowledging and addressing conflicts of interest when they influence individual and collective professional behavior. Physicians can also contribute collectively to the improvement of public health at the national, state, and local levels through their professional and educational organizations.

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Editor's Note

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The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

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