

It is 7 p.m. on a Friday evening and you are hitting the home stretch of your noon to 9 p.m. swing shift in the emergency department (ED). So far it has been a reasonably good day, but it has been busy and you are looking forward to calling it a night. You pick up the “next to be seen” chart and see the chief complaint of “back pain.” You feel a little uneasy. You scan the chart for more information and see the patient is a 41-year-old male, brought in by ambulance for “severe right lower back pain.” However, the nurse’s note clarifies that the medics saw him walk briskly to the ambulance after they arrived at his house. He had an IV placed and received 8 mg of morphine before arriving at the ED. You look up his electronic record and see that he has a history of chronic back pain and is prescribed OxyContin and Percocet.

You find him on the bed in some discomfort though still

able to text on his phone. You introduce yourself and ask what you can do to help. He explains that he was helping a friend move three days ago and exacerbated his back pain. He says he tried to “tough it out” until he could get into his regular clinic but could not wait any longer. He called his clinic at 5 p.m. and they told him to come to the ED. He assures you that he would not normally have come to the ED because he “does not like hospitals” or “taking medications” (though review of his electronic record might indicate otherwise). He

Dying from prescription heroin

A perspective on the opiate epidemic

By Chris Johnson, MD

explains that his regular medications “aren’t working” and his current pain level is a “14 out of 10!” While you are summoning up your energy reserves for what could be a challenging encounter, you are aware of another thought—this patient is at very high risk of joining the many thousands of Americans who die each year from prescription opiate overdose.

This vignette is an amalgamation of many patient encounters. It combines multiple elements that are all too commonplace for those of us in emergency medicine. Especially common are the mathematical impossibilities reported when the patient is asked to rate their pain from 0 to 10. This type of encounter, more often than the unresponsive patient who is overdosing, represents the most commonly observed face of the prescription opiate epidemic in the ED. And while this scenario has its frustrations and absurdities, the end result for these patients is often far more devastating—dependence, addiction, overdose, and death. This combination of frustration and tragedy is playing out with ever-increasing frequency in Minnesota and across the nation. But for all the stresses these interactions can bring to physicians, nurses, and other providers, the reason we are seeing so many of these patients in our EDs and clinics is simple: We did it to ourselves.

The problem

Since the late 1990s there has been an explosion in the prescribing of opiate pain medication. As a result of advocacy programs such as treating pain as the “Fifth Vital Sign” and aggressive marketing

by the pharmaceutical industry, the number of prescriptions has tripled from 76 million in 1991 to 219 million in 2011 (Vector One National). According to CDC data, the United States now contains 5 percent of the world’s population but we consume 80 percent of the world’s opiates, including 99 percent of the world’s hydrocodone. Led by academics in the leading pain societies and supported by pharmaceutical companies eager to enter new markets, it was argued that opiate pain medicines should be used for chronic pain conditions such as back pain or headaches, conditions that historically were not treated with opiates. This broadening of prescribing indications was also notable for its lack of data about long-term safety and efficacy. In 2014, the NIH conducted a Pathways to Prevention research project that looked into the use of opiates for chronic non-cancer pain and found no studies lasting longer than 12 weeks. Yet in 2000, the FDA approved the broader use of opiates for these conditions despite the lack of data. This expansion of opiate prescribing has been very profitable for certain stakeholders, notably the pharmaceutical industry. Purdue Pharma routinely sells over \$2 billion worth of OxyContin per year.

The public health consequences have been nothing short of a disaster. CDC data show that the number of accidental prescription overdose deaths have increased dramatically since 1999 and continue to get worse. According to CDC data just released this past December, almost 19,000 Americans died of inadvertent prescription opiate overdose. In 1999, that number was 4,030. In lockstep with the rise of prescription opiate abuse has been the increasing use of heroin and subsequent overdoses, with over 10,000 dead in 2014. We would not tolerate a war where this many Americans died. Yet the vast majority of these deaths come at the hands of modern medicine. From 2005 through 2014, the total number of Americans who have died due to



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inadvertent prescription opiate overdose is a stunning 154,159. This is a badge of shame on the medical profession.

The good news, if one can call it that, is that Minnesota does better than most states in avoiding the worst of the carnage. Our death rate per 100,000 is among the lowest in the nation at 7.4, whereas West Virginia is the worst at 28.9 per 100,000. It was not a surprise therefore that President Barack Obama chose to speak about this crisis from Charleston, the capital of West Virginia, this past October. But our trends are no less worrisome—according to the Minnesota Department of Health there were 317 opioid-related deaths in 2014, a sixfold increase from 2000. That 317 represents more deaths than from motor vehicle accidents.

The role of the ED

Most patients do not get the majority of their opiates from the ED. According to the FDA, only about 5 percent of opiates are prescribed in the ED whereas about 43 percent come from primary care providers—internists and family medicine practitioners. However, the ED is very much affected by the costs associated with visits due to abuse of these medications. According to data published in JAMA in 2014, there were over 92,000 emergency visits for prescription opiate overdose in 2010 at a cost of \$1.4 billion. Even more common are visits for non-medical use. According to the CDC, in 2009 there were almost 500,000 ED visits nationally for opiate misuse, contributing to over \$70 billion in cost per year to insurers. Locally, we have been first-hand witnesses to this tidal wave of patients. According to the 2012 report from the Drug Abuse Warning Network, from 2004 to 2011, the number of ED visits in the Twin Cities related to opiates increased from 1,940 to 4,836. Hardly a shift goes by without my seeing at least one patient who is on chronic opiates for pain. The bottom line is despite the fact that we may not be the major source of the

medications for these patients, we still see and are impacted daily by the vast numbers of patients who are caught up in this crisis. As ED physicians we must act together with our partners in other specialties to help solve this.

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The solution

So what are we going to do about this? I would like to assure you that with better education and “awareness” this problem will be solved. But I can't. Because despite attempts to educate people about this problem nothing has happened. Despite pain contracts, opiate policies, task forces, and educational forums, the numbers are not improving and, in fact, are getting worse. Not even the Prescription Monitoring Program has had any impact on patient outcomes. In my opinion, medicine does not have the incentive structure to solve this on its own. The pressures an ED or primary care doctor faces to meet corporate imperatives, such as making sure the patient has a good “experience” and fills out a favorable survey, are substantial. Patient complaints always come to the attention of the administration. Even if you provide responsible care, a patient can go elsewhere if they are not satisfied. Administrators and hospital executives are incredibly sensitive to this and want to keep as many patients as possible. In short, the incentives are to make a patient happy in the short term even if the care provided contributes, however incrementally, to long-term adverse consequence but for which no long-term culpability exists. In the earlier scenario, the doctor could simply have written a prescription for 20 tablets of Percocet

to avoid confrontation and no one in hospital administration, the Board of Medical Practice, or a malpractice attorney would even notice.

To solve this will require a revision of what we consider to be appropriate conditions

for opiate pain medicine and support for the clinicians to make that happen. Above all, we have to show, as a profession and health care industry, that we care and are not simply maximizing relative value units. We have to turn back the clock to when the first disastrous, ill-informed

decision was made to expand opiates for chronic non-cancer pain. We need to stop creating these patients who, over years, become completely dependent on opiates. For those patients already over-medicated, if not outright dependent, we have to help them. If at all possible we should try to wean them of these medicines and find safer alternatives for their pain. We need to introduce transparency in prescribing practices. A “dashboard” should be created on a state level that lets physicians know how much they are prescribing per patient relative to his or her peers. This should be normalized for specialties—an ED doctor will prescribe more opiates than an ophthalmologist and both will prescribe less than a pain or addiction specialist. This should not be a means to target physicians or “get them in trouble.” Rather, getting this information out in the open is an

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important way of showing that we care—that we are paying attention. To continue in secluded anonymity, even secrecy, is to convey the message that what really matters to us in medicine is repeat customers, not safety.

We also need to be honest with ourselves and our patients and acknowledge these medicines for what they are—oral versions of heroin. Heroin is not a malevolent, bizarre category of opioid. It has a scientific name, diacetylmorphine, and was first brought to us by the good people at Bayer Pharmaceuticals in the late 19th century. Furthermore, diacetylmorphine is used every day in the United Kingdom for a responsible purpose—the treatment of pain for acute injury. The United Kingdom should serve as an important lesson to us as well—namely, that we can get by in life with our aches and pains without a river of opiates

in our systems. The British population suffers the same maladies as we do including chronic back pain. However, they do not take nearly the amount of opioids we do nor do they die at the same rate. The reason is they simply do not treat chronic pain with opioids. According to their bureau of statistics, in 2011, less than 750 died of

be over 3,500. That roughly corresponds to 2,800 lives saved in that one year alone. I think we should be capable of similar results. There is no reason to think the British are inherently more able to cope with chronic pain than we are. The lives we save will number in the tens of thousands.

From 2005 through 2014, the total number of Americans who have died due to inadvertent prescription opiate overdose is a stunning 154,159.

prescription opiate overdose (which was still very worrisome to them). If they died at the same rate as those in the U.S. and adjusted for their smaller population of 63 million, their total of overdose deaths would

Conclusion

Such an extensive culture change is ambitious and will take time to implement. There will likely be protest to such change, especially from those who are actually thriving in

this current environment. But the sheer numbers showing the devastation to our patients and their families has to win the day. We have to change. This will require investment from all those with a stake in public health—from our health care providers and clinics, to our political and community leaders, to insurance payers and law enforcement, to patients and families. This will not be corrected overnight, but it is time that we start to fix our opiate epidemic. Our patients deserve better. In fact, we all do. ■

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