The Ochsner Journal 15:124–126, 2015
© Academic Division of Ochsner Clinic Foundation

The Ethics of Opiate Use and Misuse from a Hospitalist's Perspective

Marianne Maumus, MD

Department of Hospital Medicine, Ochsner Clinic Foundation, New Orleans, LA

The Controlled Substances Act, adopted by Congress in 1970 and signed by President Nixon, created a system for classifying prescription drugs; required all healthcare providers who prescribe, dispense, and administer controlled substances to register with the US Drug Enforcement Administration; and established disciplinary measures related to prescribing controlled substances. More than a decade later, to quell patient complaints about inadequate pain management, the Compassionate Pain Relief Act of 1984 highlighted that pain was poorly treated. Following the passage of that act, the use of prescription narcotics underwent exponential growth. Concurrently, death from unintentional overdose from prescribed as well as illicit use rose exponentially and has now surpassed the rate of death by automobile accidents. The US Centers for Disease Control and Prevention (CDC) has outlined the explosion in narcotic prescription use in numerous articles over the past 15 years. The CDC has called narcotic deaths an "epidemic" and has called on policy makers to address this important issue with the goal of curtailing physician prescribing habits. Research reveals that most users who die of prescription medication overdose get their narcotics from a friend, indicating diversion of the script within the community. Research has also shown that prescription narcotics are gateway drugs to more dangerous illegal drugs such as heroin and cocaine.

Hospital admissions and lengths of stay undoubtedly have increased as a result of the narcotic epidemic. The cases of addicted patients are frequently complicated by a host of psychiatric, medical, and surgical conditions. Such patients often require long hospital stays so clinicians can observe their patterns of behavior and make proper decisions about their medical care. These patients also frequently have poor social support and lack the educational and financial resources required to battle addiction. The healthcare system in the United States offers inadequate psychiatric services and drug treatment centers, so it is not surprising that addicted patients often become unemployed, engage in illegal activities, join the ranks of the homeless, and turn to the emergency department for respite or a quick fix. If their pain management is not appropriate at discharge, they frequently come back through the revolving door of the emergency department with withdrawal symptoms. All of this is predictable and manageable.

The doctor on the front lines cannot solve this crisis alone. The ethical issues involving the use of dangerous addictive drugs transcend all levels of our healthcare system, from the doctor who provides direct patient care to administrators and policy makers. Prior to 1970, the physician was viewed as an autonomous entity, capable of assessing a patient's needs, having the proper knowledge to make a wise and just decision, having the authority to look out for the best interests of the community, and was depended upon by society to practice in an ethical manner. Much has changed. Today, the physician is viewed as a team player, and care guidelines are mandated by Congress or best practices and passed down through administrators who direct physician decision-making directly or indirectly.

The physician is in the precarious position of needing to make decisions in the best interest of the patient while receiving pressure from system administrators to reduce lengths of stay or clinic visit time. Complicating the situation even more, drug-seeking patients are not usually inclined to act in their own best interests. This dilemma is frustrating to the hospitalist who by necessity becomes the de facto primary care physician, pain management specialist, and even a surrogate parent trying to steer these patients away from self-harm. We must turn to the textbooks and to the basic principles of ethics, looking for best practices.

Skills required for the proper assessment of patients with misuse include how to identify and define misuse, how to assess the risks of therapy, and how to withdraw narcotic therapy. These skills are not ubiquitously practiced in our current environment, yet they are desperately needed. Many of these patients are chronically ill, have failed multiple treatments, and are willing to do anything to get better—even stop their narcotics. On the other hand, many of these patients exaggerate their pain and believe it is their right to get high-potency drugs because they have been hospitalized. Distinguishing between these two types of patients takes practice, time, and experience. Time is a valuable commodity in the practice of medicine, and resources need to be allocated if we are to help eliminate preventable opioid misuse in our communities.

Patients receiving end-of-life care and those with painful malignancies or orthopedic conditions need their pain to be treated adequately, but these are not the patients who keep coming back to the hospital. Hospitalists see patients who repeatedly pick their skin to the point of ulceration, take too much insulin to induce hypoglycemia to get admitted, neglect their wound care to get readmitted, refuse needed treatments so they can prolong their stays in the hospital, and take laxatives to fake Crohn colitis. I even had a patient rip open his abdominal surgical scar for the pull of Dilaudid

and another who took a nasogastric tube out of her purse, put it down her nose, and blew into the open end to fake a small bowel obstruction. Every day, hospitalists encounter patients with opioid-related problems.

To address this problem, 6 ethical practices are, I believe, the responsibility of the physician:

1. We must properly identify patients with narcotic abuse or misuse. We should not be afraid to document it when we encounter it. We should use the proper diagnosis-related group codes and ask patients about their narcotic habits on a routine basis. If we do not properly identify these patients, how will administrators or policy makers know the prevalence in the population?
2. We must all learn to identify misuse and document the specific aberrant behaviors for reference. Such documentation justifies our decision not to prescribe harmful substances. Physicians need to check with their state's Board of Pharmacy Prescription Record when they suspect improper narcotic use and perform toxicology screens.
3. We must recognize side effects and failure of therapy and reduce therapy appropriately. We can and must seek alternatives to narcotic therapy.
4. When we find misuse, side effects, or long-term complications such as gastroparesis or narcotic bowel syndrome, we should recommend cessation and withdrawal.
5. We must remember that the goal of therapy for patients with chronic noncancer pain is to improve their functional status. It is not pain relief. We must resist the pressure of time constraints, educate our patients requesting narcotic therapy about the varied reasons for not prescribing it, and not worry about our physician satisfaction score. The patient's best interest should be above our own.
6. We should never abandon the patient in pain. Whether a patient with advanced cancer who is dying in a hospice unit, a 20-year-old heroin abuser in active withdrawal in the hospital, or a psychiatric patient with manipulative behavior, all deserve supportive care, assurance of safety, and attention to their specific needs. It is our responsibility to see their care through its natural course: in one instance to liberally dose with narcotics, in the others to hold and restrict them.

These 6 practices based on sound ethics are a start. In my experience, younger patients when encouraged are more likely to stop narcotics than older users. Addressing their misuse and referring them for treatment is absolutely the right ethical decision to make when we encounter addicted patients, even if this approach delays discharge or requires extra time in the clinic setting. Otherwise, we are allowing them to walk blindly on the path of self-destruction. I am amazed that many young people think prescription drugs are not harmful because they come from a factory rather than the street. We physicians need to limit the number of tablets and monitor our legitimate pain patients more closely to reduce diversion of tablets.

System administrators also have a responsibility to make ethical decisions and direct the care of these patients. They need to communicate prescribing habits with their providers so providers can be cognizant of norms. Because recommending cessation and withdrawal is not likely to make patients happy, physician satisfaction scores should not be linked to payroll when poor scores are associated with patients who are misusing narcotic drugs. The computerized medical record could be optimized to track and monitor progress, graph functional status, and show 24-hour morphine equivalent dosages so inpatient and outpatient physicians can communicate better and gradually taper patient dosages in a stepwise manner. While our addiction psychiatry services are excellent and can direct the withdrawal process, they frequently do not have the daily encounters required to witness, manage, or document the aberrant behaviors or to understand the nature of the alleged painful medical condition. Pain management doctors often cannot follow the patient once discharged. Frankly, the uninsured patients who require these services outnumber the available doctors, and public psychiatric services are woefully inadequate. These patients need increased monitoring in the outpatient setting to reduce diversion and supervise compliance. Administrators could help this situation by including these patients in future postacute care networks and by lobbying at the political level for their care in nursing homes or new inpatient chronic pain management centers and for more psychiatric facilities. In general, administrators can expand pain management services with an emphasis on detoxification.

Another act of Congress may be required to stop America's prescription epidemic, but by working together and using sound principles of ethics, we can reduce local prescription epidemics. Together we can make a difference in the lives of our patients that will have positive repercussions throughout our community and country. Physicians and providers on the front lines face a formidable challenge. We must remind ourselves that we can only handle the patient in front of us, at this moment, one at a time. We are not obligated to capitulate to their disease. We must provide the right advice to our patients and let them choose a course of action for their lives. That is what we are called to do and why we practice medicine.

SELECTED READINGS

Girion L, Glover S. Preventable deaths from drugs, motor vehicles and firearms. *Los Angeles Times*. September 18, 2011. http://graphics.latimes.com/fever-drug-death-chart/. Accessed March 17, 2015.

Imhof S, Kaskie B. How can we make the pain go away? Public policies to manage pain at the end of life. *Gerontologist*. 2008 Aug;48(4):423-431.

Kirschner N, Ginsburg J, Sulmasy LS; Health and Public Policy Committee of the American College of Physicians. Prescription drug abuse: executive summary of a policy position paper from the American College of Physicians. *Ann Intern Med*. 2014 Feb 4; 160(3):198. doi: 10.7326/M13-2209.

Smith HS, Passik SD, ed. *Pain and Chemical Dependency*. New York, NY: Oxford University Press; 2008.

US Centers for Disease Control and Prevention. Opioid painkiller prescribing: where you live makes a difference. July 2014. http://www.cdc.gov/vitalsigns/opioid-prescribing/index.html. Accessed March 17, 2015.

US Centers for Disease Control and Prevention. Unintentional drug poisoning in the United States. July 2010. http://www.cdc.gov/homeandrecreationalsafety/pdf/poison-issue-brief.pdf. Accessed March 17, 2015.

US Dept of Health and Human Services. Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings. NSDUH Series H-41, HHS Publication No. (SMA) 11-4658. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2011. http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm. Accessed March 17, 2015.

US Government Accountability Office. Prescription Pain Reliever Abuse: Agencies have begun coordinating education efforts, but need to assess effectiveness. Report GAO-12-115. December 2011. http://www.gao.gov/products/GAO-12-115. Accessed March 17, 2015.

Volkow ND, Frieden TR, Hyde PS, Cha SS. Medication-assisted therapies—tackling the opioid-overdose epidemic. *N Engl J Med*. 2014 May 29;370(22):2063-2066. doi: 10.1056/NEJMp1402780.