Better patient education is necessary

# The Opioid "Epidemic"

## Why we need to dial back the sensationalism and find common-sense solutions

*By Geneviève Clavreul, RN, Ph.D.*

One of nurses' most important and underappreciated duties is advocating for our patients. While much of that advocacy takes place at the bedside, we are also in a unique position to address the larger issues that affect the practice of nursing and medicine.

The latest issue that demands our attention is the controversy over prescription opioids and the efforts of the Medical Board of California to crack down on these dangerous but necessary medications.

### THE PERILS OF STATISTICS

If you listen to the fearless pundits of the Fourth Estate, deaths related to prescription drugs are a national crisis. According to the Centers for Disease Control and Prevention, 38,329 Americans died of drug overdoses in 2010 and about 60 percent of those deaths involved prescription medications, many of them opioids.

Back in 2012, the *Los Angeles Times* ran a four-part investigative report on the human cost of opioid abuse and the role of some physicians in overprescribing painkillers. The story reported that between 2006 and 2011, there were 3,733 deaths related to opioid use in just four Southern California counties: Los Angeles, Orange, San Diego and Ventura. That story and others like it have put pressure on the Medical Board of California to respond to the growing "epidemic."

I put the word "epidemic" in quotes because the outcry is somewhat out of proportion to the reality. As alarming as the number of opioid-related deaths sounds in isolation, the *L.A. Times* report failed to contextualize that statistic in terms of the combined population of those four counties (16.9 million as of July 2011), the population of California as a whole (37.7 million) or the number of deaths due to other causes during the same period. For example, according to the California Highway Patrol, car crashes killed 18,416 Californians between 2006 and 2011: almost five times the death toll of the headline-grabbing opioid menace.

### PSE AND THE METH EPIDEMIC

I don't mean to diminish the significance of those deaths or suggest that there isn't a problem, but it's important not to let alarmism triumph over common sense. While the number of collision-related deaths may indicate a need for better traffic safety, no one is seriously suggesting closing our freeways or restricting how far commuters are allowed to drive!

Unfortunately, when it comes to drugs, such overreaction is the rule rather than the exception. For instance, many of us are familiar with the federal Combat Methamphetamine Epidemic Act of 2005 (CMEA), which sought to stem the rise of methamphetamine abuse by restricting the sale of products containing the nasal decongestant pseudoephedrine (PSE).

PSE is not a prescription drug in most states, but the CMEA limited how much PSE a customer could buy at one time, mandated behind-the-counter placement in stores, required photo identification for purchase and forced sellers to maintain logbooks of sales and customer information. Those measures have had little impact on the meth epidemic. At a conference this February, DEA Office of Diversion Control Deputy Assistant

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Administrator Joseph Rannazzisi admitted that "NEITHER of these systems [tracking or rescheduling PSE] will have ANY impact on methamphetamine availability in the United States." [emphasis in the original]. In short, these restrictions have not curbed the meth supply, but have added a considerable bookkeeping burden for retailers while inconveniencing millions of cold and allergy sufferers.

The effects of the state medical board's response to the outrage over opioid-related deaths may be far worse. Some of the suggestions I heard at a recent meeting of the board's Prescribing Task Force left me wanting to tear out my hair in frustration.

## THE ROLE OF ALCOHOL

California's medical community has good reason to be embarrassed by the *L.A. Times* expose, which linked a substantial number of overdose deaths in Southern California to a surprisingly small number of doctors.

The story also raised serious questions about the medical board's effectiveness in responding to complaints about excessive or reckless prescriptions. The board seldom suspends a doctor's prescribing authority even if he or she is being actively investigated or has already been disciplined for reckless prescribing.

Given all that, you might expect that the Prescribing Task Force's focus would be on improving the medical board's oversight of its own members. Instead, I listened to hour after hour of experts proposing new restrictions on patients. The suggestions ranged from requiring patients to sign a contract with their physician prior to receiving prescription opioids to forcing all patients to submit to pill counts and random urine tests. Such measures would be tantamount to treating patients like criminals!

There were more sensible proposals calling for greater patient education, but overall, I was dismayed by the lack of clear-headed perspective on the issues involved. For example, one expert pontificated at length about the evils of opioid abuse without once mentioning the role of alcohol in many painkiller overdose cases. When I asked him about it, he replied that he would touch on that point at the end of his presentation, suggesting that he considered alcohol a trivial footnote rather than a significant contributing factor in many overdose deaths.

**The Prescribing Task Force suggested requiring patients to sign a contract with their physician prior to receiving painkillers and forcing patients to submit to random urine tests. Treating patients like criminals is not the answer.**

## PUTTING PATIENTS LAST?

As a nurse and as one of the estimated 100 million Americans living with some degree of chronic pain, I am well aware of both the power and the dangers of opioid painkillers. There's no argument that opioids carry a high potential for abuse and can kill if misused.

However, I've also witnessed the consequences of overzealous protocols that prevent patients from getting needed medication. If you suffer chronic pain, draconian limits on how much painkiller you're allowed do not protect you; they just reduce your ability to function and increase the chances that you'll find some other way to self-medicate — possibly with lethal consequences.

Tools like pill counting or contracts may be appropriate in certain cases, but imposing such restrictions on all patients would only have a chilling effect on the provider-patient relationship. If our approach to patients defaults to suspicion and mistrust, we only discourage our patients from communicating openly with us about issues like abuse and addiction.

## COMPREHENSIVE APPROACH

So, what should be done? A better solution would include *all* of the following:

- Improved education for patients about the dangers and proper use of opioids, including the risk of adverse interactions with alcohol or other drugs.
- Better educating physicians and their healthcare teams about the signs of opioid abuse, including how to recognize potential risk factors like addictive personalities.
- Fully implementing a real-time prescription drug monitoring program that can flag suspected prescription shoppers and physicians who may be recklessly prescribing opioids or running "pill mills." California's CURES (Controlled Substance Utilization Review and Evaluation System) could be but currently isn't used for that purpose due to a lack of resources and interest.
- More effective sanctions for doctors whose prescription history suggests a pattern of reckless or inappropriate prescribing.
- Finding and funding alternative treatments for chronic pain and conditions that cause it. If you remove the source of the pain, you also remove the need to treat it with opioids.

Obviously, many of these are long-term solutions. In the short term, it's important that nurses get involved in the debate. The Prescribing Task Force's next meeting is in May. (See *www.mbc.ca.gov* for a schedule.) The meetings are open to the public and I urge readers to attend and participate.

This is an issue that directly affects many of us, our loved ones and our patients. We should not sit idly by while the medical community devises quick-fix solutions that may ultimately do more harm than good. WN

Editor's note: More details on the facts presented in this article can be found in the online version at *WorkingNurse.com*.

Genevieve Clavreul's earlier article on this topic, "The Great Opioid Debate of 2012," was published in WN127, Sept. 3, 2012. It can be found at *WorkingNurse.com*.

*Geneviève M. Clavreul, RN, Ph.D., is a healthcare management consultant who has experience as a DON and as a lecturer on hospital and nursing management. She can be reached at (626) 844-7812 or gclavreul@solutionsoutsidethebox.net.*

# What the ACA Means for Nurses

For the past several years, *Working Nurse* has run a monthly column tracking the four-year implementation of the Patient Protect and Affordable Care Act (ACA). On April 1, 2014, the ACA reached its penultimate milestone, which means the end of this column.

The ACA, often called "Obamacare," was signed into law by President Barack Obama on March 23, 2010. Intended as a comprehensive overhaul of healthcare in the U.S., the law's most noteworthy aspect has been the attempt to make affordable healthcare available to all Americans. Provisions include the elimination of lifetime caps and exclusions for preexisting conditions and the establishment of a baseline standard of coverage that includes services like prescription drugs and maternity care.

It remains to be seen how well the ACA will meet its intended goals and it would be an understatement to say the law has been contentious. An ABC News/*Washington Post* poll taken on March 28–30 shows Americans almost evenly split, with 49 percent approving of the ACA and 48 percent opposed.

## HEALTHCARE, NOT POLITICS

*Working Nurse* has chosen to approach the new law not as a political matter, but rather as one of the many healthcare issues affecting nurses today. There is no question that the ACA will have a major impact on nursing, including:

- **Greater employment:** Expansion of health coverage will mean increased demand for services and greater need for nurses.
- **New roles for NPs:** With physicians in ever-shorter supply, nurse practitioners are stepping in to bridge the gap, although scope-of-practice limitations remain a barrier in California and other states.
- **Greater political involvement:** Nurses serve on the 15-member National Healthcare Workforce Commission, advising congressional leaders on healthcare issues.
- **New loan repayment options:** Nurses willing to work in medically underserved areas have new opportunities for partial loan cancellation, such the expanded National Health Service Corps.

## THE FUTURE

There are still a few milestones remaining for the ACA, including implementation of the employer mandate, which was delayed until Jan. 1, 2015, and there will undoubtedly be twists and turns to come. However, this will be the last of our regular columns.

We thank Geneviève Clavreul, RN, Ph.D., for her excellent reporting on this controversial subject. WN