The Truth about "Overprescribing" and the Opioid Epidemic

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Overprescribing - Just don't start

The charge against me is of overprescribing, which is a legitimate public health concern in our state, since historical overprescribing likely contributed to an increase in overdose deaths in the first decade of this century. There were new guidelines published by the Medical Board of California in 2014 that recommended not increasing pain patients offered a trial of opioids beyond a total daily opioid dose of 120 mg MED, and made a number of other recommendations for safe prescribing. The CDC published similar guidelines in 2016.
These guidelines were intended to guide initial therapy, and I have absolutely complied with those, not starting and increasing opioids beyond this dosage range. In fact, most of my patients know I try to work with patients to find alternatives and not start opioids at all for chronic pain. See the slides from my 2014 talk at NCAMHP for my philosophy about opioids for chronic pain - I see them as a bridge to increase activity, but not a long-term solution.

Legacy Patients - correcting past errors vs. throwing away the victims

The issue at hand, however, is whether the guidelines are applicable to pain patients who were historically treated with higher doses of opioids, before the potential harms were fully understood, and what the strategy should be to lower doses towards the guideline limits in these patients. Many physicians have simply dumped these patients or rapidly tapered in order to protect their licenses, but I do not believe this care protects the patients or is the right care for these patients. As the CDC has recently clarified, I believe the guidelines have now been misapplied in the setting of Legacy Pain Patients, and a number of experts agree. That said, some of these patients have problematic behaviors. The one thing I can say is that I have earnestly tried to pick the path of the least harm, to the best of my

ability to identify that path.

CDC Guidelines

What does the CDC(Centers for Disease Control) Say?

CDC is raising awareness about the following issues that could put patients at risk:

- **Misapplication of recommendations to populations outside of the Guideline's scope.** The Guideline is intended for primary care clinicians treating chronic pain for patients 18 and older. Examples of misapplication include applying the Guideline to patients in active cancer treatment, patients experiencing acute sickle cell crises, or patients experiencing post-surgical pain.
- **Misapplication of the Guideline's dosage recommendation that results in hard limits or "cutting off" opioids.** The Guideline states, *"When opioids are started,* clinicians should prescribe the lowest effective dosage. Clinicians should… avoid *increasing* dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day." The recommendation statement does not suggest discontinuation of opioids already prescribed at higher dosages.
- **The Guideline does not support abrupt tapering or sudden discontinuation of opioids**. These practices can result in severe opioid withdrawal symptoms including pain and psychological distress, and some patients might seek other sources of opioids. In addition, policies that mandate hard limits conflict with the Guideline's emphasis on individualized assessment of the benefits and risks of opioids given the specific circumstances and unique needs of each patient.

The Guideline was developed to ensure that primary care clinicians work with their patients to consider all safe and effective treatment options for pain management. CDC encourages clinicians to continue to use their clinical judgment, base treatment on what they know about their patients, maximize use of safe and effective non-opioid treatments, and consider the use of opioids only if their benefits are likely to outweigh their risks.

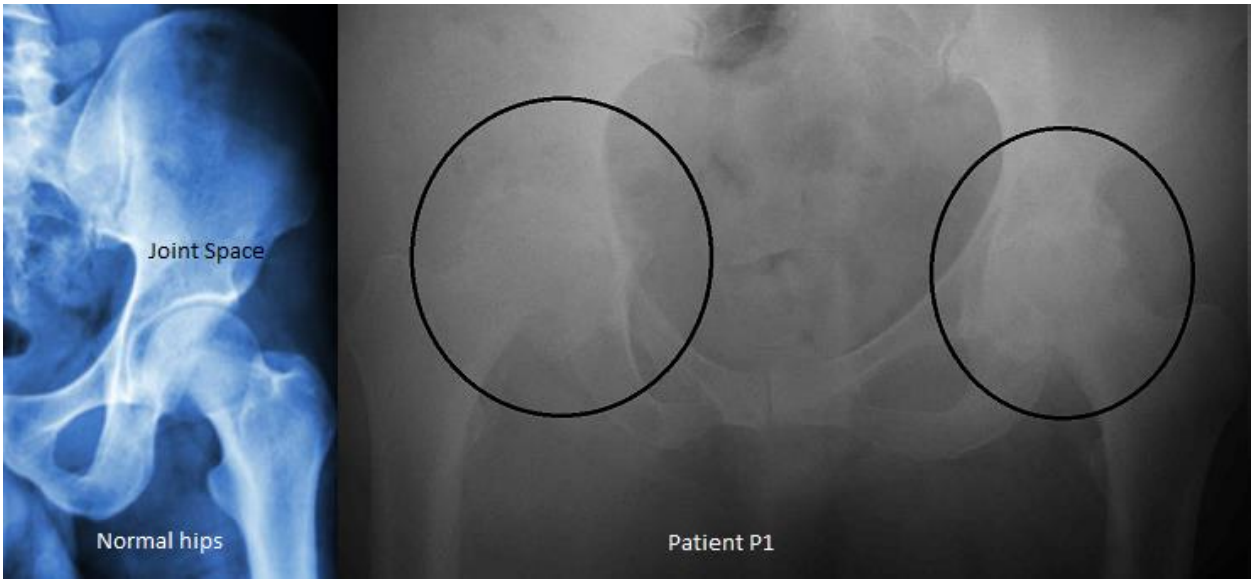
The Guideline includes guidance on management of opioids in patients already receiving them long-term at high dosages, including advice to providers to:

- maximize non-opioid treatment
- empathetically review risks associated with continuing high-dose opioids
- collaborate with patients who agree to taper their dose
- if tapering, taper slowly enough to minimize withdrawal symptoms
- individualize the pace of tapering
- closely monitor and mitigate overdose risk for patients who continue to take high-dose opioids

Patients may encounter challenges with availability and reimbursement for non-opioid treatments, including nonpharmacologic therapies (e.g., physical therapy). Efforts to improve use of opioids will be more effective and successful over time as effective non-opioid treatments are more widely used and supported by payers.

Why were these patients on Pain Medications?

These patients are not just addicts, who are taking the medication for no good reason. As an example, see the hip joints (or lack thereof) in P1(Posted with her consent):



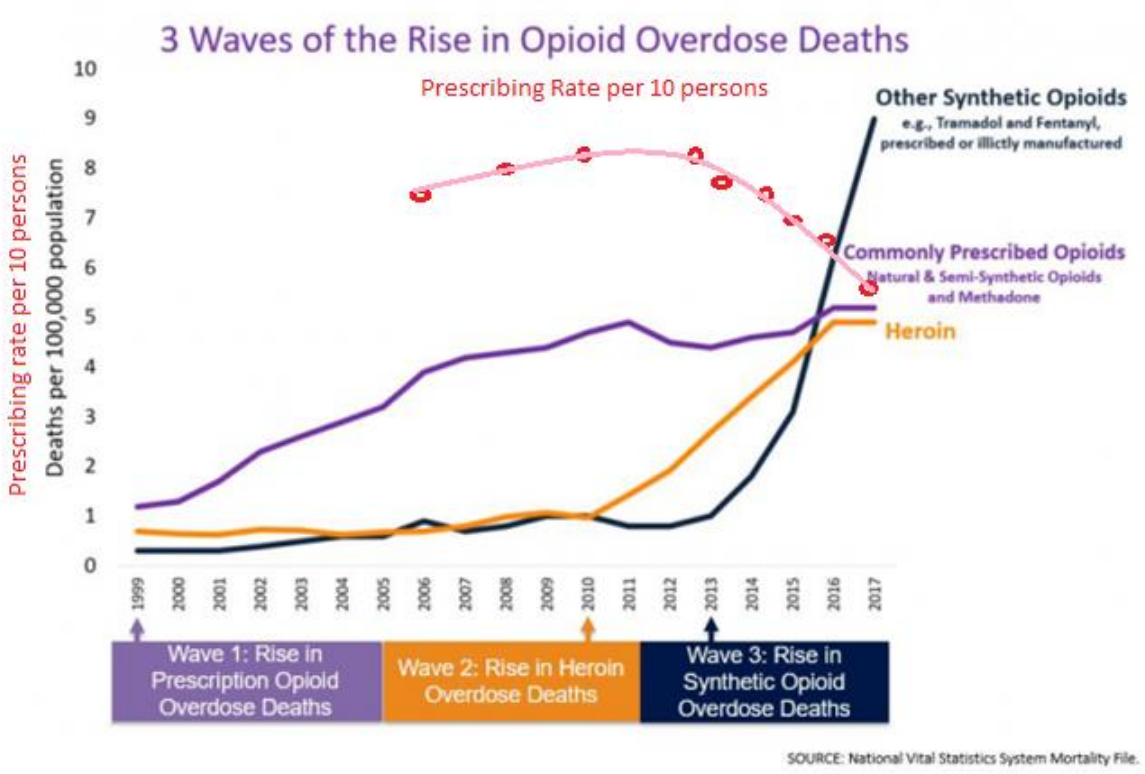
The xray on the left is of a patient with normal hips (the dark space between the thigh bone and pelvis is where the cartilage is.) On the right is the image from P1. Her daughter reported that the orthopedist "in Fortuna we saw recently took one look at her x-rays and could not even believe she was able to stand. He said looking at her x-rays he would expect her to be completely bedbound and was shocked at her fortitude. That is the thing about my mother, she is stubborn as a mule, however the pain is almost

unbearable for her."
And also from her daughter:

> I find it completely ironic, that the first doctor that she has had, that has tried to reduce the amount of medication she takes, that has tried to pursue every possibility to improve her quality of life and sees her as a whole person and not just a collection of symptoms and TRULY HAS provided her excellent care, is now being threatened with losing her license -after all of the years of negligence that she has actually experience with other physicians.

Why not just taper them down by 10% per week or month as the California guidelines suggest?

There are a number of potential harms to forced and rapid tapers, including turning to illicit sources (heroin and pills from the streets), suicide, and significant loss of function of these patients. Just as an example, I took this figure from the CDC website on the rise in overdose deaths And added some additional data (in red) also from the CDC website about decreases in opioid prescribing



I do not feel it takes a genius to see that forcing patients to drop their doses abruptly is NOT preventing opioid deaths, in fact, perhaps the contrary. Most of my patients are somewhere in a taper process, but I actually monitor that process, rather than announcing it and proceeding regardless of response.

There are a great number of stories locally and elsewhere of people who were tapered on a fixed schedule and have:
1. Lost function and independence

2. Contemplated or committed suicide - there is a blog devoted to these cases
3. Turned to illicit sources of medications – heroin or pills purchased on the streets. Even the pills can have fentanyl in them so this is a very dangerous situation. (I saw a recent slide of a pill that appeared to be Percocet which was found to contain fentanyl.)

Alternative to a Forced and Rapid Taper

I have a different approach, which I have been developing and honing over the years, and which I believe is more effective and less risky, though certainly more work, often frustrating, and not always successful. To paraphrase Churchill, "Patient-centered care is the worst form of medicine, except for all of the others." I will let my patients speak for me in some of their Letters of support.

The word doctor comes from the Latin word "docere" meaning "to teach." I think my job is to teach patients about the potential harms of opioids (which include hormonal disruption, mood changes, even INCREASES in pain through hyperalgesia), to help them understand underlying causes of their pain, which include physical injuries but also past trauma and current stressors, to provide them other tools to deal with those things, and inspire them to want to decrease medications. A similar approach is used in treating addiction, to explore the patient's own ambivalence and let them tell me the reasons they want to change.

The Patients in the Complaint

For the patients in the complaint:

MED at Initiating care with me	MED now 5/27/2019
1440	0
937.5	590
Butrans 20 (More than 80 MED)	35
720	693.8
165 Increases related to surgeries and attempts to modify regimen, then tapering	110

MED = Morphine Equivalent Dose

For these patients, when we were attempting taper and adverse events occurred, we backed up and decreased the speed of taper. When they developed new problems like cancer or had surgery, the doses

went up temporarily.
There were times when things I tried did not work as intended. Again, I cannot state that all of my decisions are correct, but I did track the results of what I did, and correct course when there were problems.

Benzodiazepine use

I DO NOT START OPIOID-DEPENDENT PATIENTS ON BENZODIAZEPINES. These patients arrived on these medications. I have encouraged all of my patients on benzodiazepines to taper (as several of the patient letters on the website can attest.) I would certainly have preferred that they do that more rapidly than they did, and am of course looking at ways to be more effective with such patients in the future.

Despite the inflammatory language of the complaint, I believe the patients involved were extremely tolerant to these medications and not in immediate danger, though two of them were clearly overmedicated and had to be tapered. At the same time, IT IS DANGEROUS TO STOP THESE MEDICATIONS SUDDENLY. I looked for alternatives that would control their symptoms and allow them to taper the medications in question, but if I have any regrets it is that I was not more creative in finding ways to limit medication overuse in patients who were at times making poor decisions.

Medication Interactions

Benzodiazepines and opioids are a relatively contraindicated combination of medications. I receive transfer patients on contraindicated combinations all the time, including migraine medicine with antidepressants, a recent hypertension patient placed on clonidine and a beta blocker together, and so on. My most common intervention when a new geriatric patient comes to the practice is to look at their regimen and stop the medications that may be making them worse.

I occasionally prescribe relatively contraindicated combinations of medications myself as well, with monitoring for the possible sequelae of the interaction. When I have a patient on a statin who needs an antibiotic that interacts, we lower the dose of the statin or even hold it for the duration of the antibiotic. This is standard medicine, to balance the risks and benefits of medications and monitor the response. As stated, when patients were having side effects, I tapered them, but did not cut them off.