OPINION

How doctors can stop the opioid crisis at its source: Quit overprescribing

By Marty Makary, Opinion contributor

4 August 2017
FIRST
A.7

For most of my surgical career, I gave out opioids like candy. My colleagues and I were unaware that about one in 16 patients become chronic users, according to new research by doctors at the University of Michigan. Even more alarming, research shows that relapse rates after opioid addiction treatment could be as high as 91%. In addition to expanding treatment, it's time we address the root of the problem — overprescribing.

My own aha moment came recently after my father had gallbladder surgery and recovered comfortably at home with a single ibuprofen tablet. Wow. It directly contradicted my residency training 15 years ago, when I was taught to give every surgical patient a prescription for 30-90 opioid tablets upon discharge. Some of my mentors told me that overprescribing prevents late night phone calls asking for more. The medical community at that time ingrained in all of us that opioids were not addictive and urged liberal prescribing. So that's exactly what we did.

The hundreds of excessive opioid prescriptions I wrote in 2015 alone (the last year for which national data are available) were a tiny part of the country's 249 million opioid prescriptions filled that year, almost one for every American adult. Last year, America produced 14 billion opioid pills (40 for every U.S. citizen), mostly paid for by the American public in the form of tax dollars or increasing health insurance premiums.

Take C-section for example, one of the most common operations paid for by Medicaid tax dollars. Some doctors appropriately prescribe five to 10 opioid tablets after the procedure (in combination with non-opioid meds as recommended by the American Pain Society), while other doctors are still doing what I did for years — give every patient a bottle of 30-60 highly addictive opioid tablets.

We need to take away the matches, not put out the fires.

My colleagues at Johns Hopkins and I have used data to identify the average number of opioids a doctor prescribes after a routine C-section, excluding patients with pre-existing opioid use or pain syndromes. The range of doctors' prescribing patterns is stunning. Some doctors fall within what our Johns Hopkins pain specialists call "best practices range," averaging three to 10 opioid tablets after C-section, while other doctors still average 30 or 60 tablets.

We have repeated the analysis for many minor procedures, including operations that can be managed with non-opioid alternatives alone. The doctor distribution graphs keep showing us the same thing: There is wide variation in opioid prescribing today.

By allowing the data to tell us which doctors are outliers, we can identify who we can help and offer them expert guidance on prescribing wisely. Using physician-developed metrics of appropriateness, data should be harnessed to laser in on the root of the overprescribing problem. Hospitals should be rewarded rather than penalized financially for adopting these data-driven peer benchmarking programs.

Second, we need to address the consumerist pain-rating system that has elevated pain as a leading quality measure and overshadowed true medical quality. The question "How often did the hospital staff do

everything they could to help you with your pain?" is a measuring stick by which all U.S. hospitals are rated, creating a perverse incentive to generously distribute opioids. While many doctors reserve opioids for conditions such as terminal cancer, burns and major surgery, the classic indications for opioids have been broadened to now include things such as backaches and very minor procedures. We need to change the quality metrics in health care so doctors can be free to practice sound medicine.

Third, we need to change several perverse financial incentives in the market. It is very difficult to find doctors interested in carefully managing a patient's pain medications because doing so pays so little (a 30-minute visit can pay as little as $50). Our reimbursement system should value expert advice and counseling on pain management. Moreover, pain specialists should be paid not just for doing procedures, but also for their time managing pain.

Ironically, acetaminophen and NSAIDs (non steroidal anti-inflammatory drugs) are over-the-counter medicines and thus rarely covered by insurance, yet opioids are. Those who think that the $10-$30 cost for a bottle of NSAIDS is not a barrier to patients buying them should meet some of my poor patients from inner-city Baltimore. All non-opioid pain meds should be fully covered after surgery with no co-pay or deductible.

Finally, payers should give surgeons and anesthesiologists more incentive to do nerve block procedures. It's well established that when patients are injected in a surgical area or root nerves with anesthetics, they require fewer pain pills.

Using data to identify overprescribing patterns and changing incentives to reward pain management best practices is far less expensive than addiction rehabilitation. Engaging with rather than blaming doctors who routinely overprescribe, as I did, can have a broad impact.

While opioid treatment is an important priority, we should remember that the most effective treatment is still prevention.

Dr. Marty Makary is a professor of surgery and health policy at the Johns Hopkins School of Medicine in Baltimore and an adviser to Practicing Wisely. Follow him on Twitter: @MartyMakary