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SundayReview | CONTRIBUTING OP-ED WRITER

How Doctors Helped Drive the Addiction Crisis

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THERE has been an alarming and steady increase in the mortality rate of middle-aged white Americans since 1999, according to a study published last week. This increase — half a percent annually — contrasts starkly with decreasing death rates in all other age and ethnic groups and with middle-aged people in other developed countries.

So what is killing middle-aged white Americans? Much of the excess death is attributable to suicide and drug and alcohol poisonings. Opioid painkillers like OxyContin prescribed by physicians contribute significantly to these drug overdoses.

Thus, it seems that an opioid overdose epidemic is at the heart of this rise in white middle-age mortality. The rate of death from prescription opioids in the United States increased more than fourfold between 1999 and 2010, dwarfing the combined mortality from heroin and cocaine. In 2013 alone,

opioids were involved in 37 percent of all fatal drug overdoses.

Driving this opioid epidemic, in large part, is a disturbing change in the attitude within the medical profession about the use of these drugs to treat pain. Traditionally, opioid analgesics were largely used to treat pain stemming from terminal diseases like cancer, or for short-term uses, such as recovering from surgery.

But starting in the 1990s, there has been a vast expansion in the long-term use of opioid painkillers to treat chronic nonmalignant medical conditions, like low-back pain, sciatica and various musculoskeletal problems. To no small degree, this change in clinical practice was encouraged through aggressive marketing by drug companies that made new and powerful opioids, like OxyContin, an extended-release form of oxycodone that was approved for use in 1995.

The pitch to doctors seemed sensible and seductive: Be proactive with pain and treat it aggressively. After all, doctors have frequently been accused of being insensitive to pain or undertreating it. Here was the corrective, and who in their right mind would argue that physicians shouldn't try to relieve pain whenever possible?

Well, doctors clearly got the message: The medical use of these drugs grew tenfold in just 20 years. Nearly half of all prescriptions by pain specialists are for opioids. But strikingly, primary care physicians, who generally do not have any particular expertise or training in pain management, prescribed far more opioids overall than pain specialists. For example, in 2012, 18 percent of all prescriptions for opioid analgesics were written by family practitioners, and 15 percent by internists, compared to 5 percent for pain specialists. (This partly reflects the fact that there are fewer pain specialists than primary care doctors.)

The consequences of this epidemic have been staggering. Opioids are reported in 39 percent of all emergency room visits for nonmedical drug use.

They are highly addictive and can produce significant depressive and anxiety states. And the annual direct health care costs of opioid users has been estimated to be more than eight times that of nonusers.

But most surprising — and disturbing — of all is that there is actually very weak evidence that opioids are safe or effective for the long-term treatment of nonmalignant pain. So how did they become so popular for these uses? A large review article conducted between 1983 and 2012 found that only 25 of these were randomized controlled trials and only one study lasted three months or longer. The review concluded that there was little good evidence to support the safety or efficacy of long-term opioid therapy for nonmalignant pain. (In contrast, there is little question that opioid analgesics are highly effective for the relief of short-term pain.)

Furthermore, a large 2006 Danish study of a nationally representative sample of 10,066 people that compared opioid and nonopioid users found that opioid use was significantly associated with the reporting of severe pain, poor health, unemployment, and greater use of the health care system. It appears that long-term opioid use did not significantly relieve pain or improve quality of life in this well-designed study.

Worse, there is a well-known syndrome of opioid-induced hyperalgesia in which opioids, paradoxically, can actually increase a person's sensitivity to painful stimuli.

What the public — and physicians — should know is that there is strong evidence that nonsteroidal anti-inflammatory drugs (Nsaids), like Motrin, and other analgesics like Tylenol are actually safer and more effective for many painful conditions than opioid painkillers.

For example, one study found that a combination of Motrin and Tylenol had a much lower so-called number needed to treat than opioids. (The number needed to treat represents the number of people who must be treated for one person to benefit.) A lower number indicates a more effective treatment.

So how should we deal with the national crisis of opioid misuse, addiction and overdose? The Food and Drug Administration has already taken some tiny, though inadequate, steps forward in recent years by issuing a Risk Evaluation and Mitigation Strategy in 2012 that requires the makers of opioids to provide doctors with training and education about using them safely, and adding warnings to drug labels.

WHAT is really needed is a sea change within the medical profession itself. We should be educating and training our medical students and residents about the risks and limited benefits of opioids in treating pain. All medical professional organizations should back mandated education about safe opioid treatment as a prerequisite for licensure and prescribing. At present, the American Academy of Family Physicians opposes such a measure because it could limit patient access to pain treatment with opioids, which I think is misguided. Don't we want family doctors, who are significant prescribers of opioids, to learn about their limitations and dangers?

It is physicians who, in large part, unleashed the current opioid epidemic with their promiscuous use of these drugs; we have a large responsibility to end it.

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