EDITORIAL

DOI:10.5055/jom.2016.0338

Physician conviction for prescription related deaths: How will this affect the opioid debate?

Humair Rana, MD; Brian Braithwaite, MD

With the recent second degree murder conviction and sentencing of Dr Hsiu-Ying Tseng in California for three patient deaths linked to her opioid prescribing habits,[1] many in the medical field are seeking to better characterize the role medical providers play in the opioid epidemic in our country. Recent data from the Center for Disease Control and Prevention[2] along with the growing number of lives being lost to opioid overdose have highlighted the fact that we, as medical providers, are contributing to this growing problem. While this case, with years of adverse events and deaths related to her prescribing habits before indictment, is a far cry from common practice, stories such as this are unfortunately surfacing more often. Whether the underlying issue is financial incentive, inadequate training, misplaced trust in our patients, willful ignorance, or some combination of these factors, we are confronted with the issue of irresponsible opioid prescribing that merits greater attention and an effective response. Media and law enforcement have focused on extreme cases; however, the epidemic is due to a larger contingent of medical providers with inappropriate prescribing practices. A recent article in *JAMA Internal Medicine*[3] revealed that while it appears that a small subset of specialty physicians, most likely in pain management, are prescribing the most opioids, the overall volume is actually dominated by primary care, including mid-level providers. Accordingly, it is imperative that the opioid epidemic problem, along with the solution, be viewed as a shared responsibility amongst all opioid prescribers.

While the Tseng case is not the first homicide conviction of a physician,[4,5] it occurs at a time of nationwide debate on how to best rein in the number of unintentional opioid deaths. Throughout the nation, we are witnessing a dramatic shift in the utilization of opioids due to changes in guidelines for opioid use, various proposals from national organizations,[6] legislative changes,[7] and an increase in criminal prosecutions against physicians for inappropriate prescribing. While the use of opioids for chronic pain remains controversial, few would argue that it should be considered in select cases. The responsible use of opioids in the medical management of pain conditions requires a paradigm shift from treating opioids as the panacea for all bodily ailments, to us, as a community of healthcare providers, working together to ensure that the prescribing, dispensing, and consumption of opioids is appropriately considered and carefully monitored. Opioids, like all other medications, need to be prescribed sensibly and responsibly. It starts with:

- Identifying cases for which there is genuine need;
- Establishing realistic pain expectations along with a treatment plan with realistic functional and analgesic expectations;
- Utilizing a well-conceived co-analgesic adjunctive medication and non-pharmacologic regimen to minimize opioid use;
- Having family members and loved ones present at clinic visits to allow them to participate in treatment plans;
- Executing an opioid contract that highlights the risks and benefits of opioid therapy and establishes patient responsibilities for continued prescribing;
- Arranging regular follow up evaluations for "red flags," gains in functional status, analgesic benefit and medication side effects, and

- Engaging in appropriate decision-making regarding therapy duration, including cessation, and properly judging when to make a referral to a pain or addiction specialist for heightened care.

In no way is this easy. The solution involves all medical providers working together to solve this growing and evolving epidemic. Instead of inspiring trepidation, the lesson from the Tseng case is that irresponsible and reckless opioid prescribing should not, and will not, be tolerated. When we depart the realm of medical practice, we must appreciate not just the gravity of our actions, such as the possibility of unintentional overdose and the promulgation of addiction, but be reminded of the harsh penalties that await. However, we must also remain mindful of those patients with genuine opioid needs who will most likely experience the greatest impact of the pendulum swing in favor of opioid under prescribing. We need to avoid the temptation of undermanaging pain, as a way to limit our own liability, and not confuse the withholding of opioid prescriptions to deserving patients with responsible prescribing methods. While there has been less sanction and prosecution related to the under-treatment of pain,[4,5,8] this does not change the fact that undertreatment of patients leaves them suffering, along with the clear ethical and professional transgression.

Hopefully, with improved systems in an environment of cross collaboration amongst physician specialties, we should be able to stop the pendulum swing and move forward in a coordinated fashion to address this issue with a single voice.

Humair Rana, MD, Department of Anesthesiology and Pain Management, University of Texas Southwestern, Dallas, Texas.

Brian Braithwaite, MD, Department of Anesthesiology and Pain Management, University of Texas Southwestern, Dallas, Texas.

REFERENCES

1. Drug Enforcement Agency: Doctor Convicted of Three Murders in Prescription Drug Overdose Case. Available at *http://www.dea.gov/divisions/la/2015/la103015.shtml*. Published October 30, 2015. Accessed January 31, 2016.

2. Centers for Disease Control and Prevention: Prescription Painkiller Overdoses in the US. Available at *http://www.cdc.gov/vitalsigns/PainkillerOverdoses/index.html*. Published November 2011. Accessed January 31, 2016.

3. Chen JH, Humphreys K, Shah NH, et al.: Distribution of Opioids by Different Types of Medicare Prescribers. *JAMA Intern Med.* 2015; Dec 14: e1-3.

4. Hoffmann DE: Treating Pain v. Reducing Drug Diversion and Abuse: Recalibrating the Balance in our Drug Control Laws and Policies. *Saint Louis University Journal of Health Law & Policy*. 2008; 1(2): 231-310.

5. Barnes MC, Sklaver SL: Active Verification and Vigilance: A Method to Avoid Civil and Criminal Liability when Prescribing Controlled Substances. *DePaul Journal of Healthcare Law*. 2013; 15(2): 93-145.

6. Physicians for Responsible Opioid Prescribing: Available at *http://www.supportprop.org/*. Accessed January 31, 2016.

7. Drug Enforcement Administration: Schedules of Controlled Substances: Rescheduling of Hydrocodone Combination Products from Schedule III to Schedule II. Available at *http://www.deadiversion.usdoj.gov/fed_regs/rules/2014/fr0822.htm*. Accessed January 31, 2016.

8. Hoffman DE, Tarzian AJ: Achieving the Right Balance in Oversight of Physician Opioid Prescribing for Pain: The Role of State Medical Boards. *Journal of Law, Medicine & Ethics*. 2003; 31(1): 21-40.