One year after Prince's death

Time for increased accountability

BY CHRIS JOHNSON, MD, AND SENATOR CHRIS EATON, RN

April 21, 2016 will forever be a sad day in the cultural memory of Americans in general and Minnesotans in particular—the day that Prince died. His death was a tragic event for those closest to him and for the rest of us who were moved by his musical creativity and genius. His passing was a loss that truly reverberated around the world. It was a death made all the more tragic because of its manner—overdose. However, the death of Prince was merely the most public episode of a crisis that has claimed the lives of over 200,000 Americans in the last 16 years—the prescription opioid and heroin epidemic. Patients with faces known only to their friends and family have passed in a similar manner to Prince—years of doctor-prescribed opioids that led to dependence, addiction, and overdose by either pill or illicit opiates such as heroin. So far, the medical profession and pharmaceutical industry has done little to stop it and, in some instances, behaved in ways very much at odds with the admonitions of the Hippocratic Oath. For this reason, the legislature needs to partner with medicine to take bold steps to rein in this epidemic.

Troubling realities

Recently, documents were unsealed that reveal some very troubling realities about Prince's death. One fact in particular that shocked all of us was the revelation that one of his physicians prescribed oxycodone for Prince in the name of his drummer—Kirk Johnson. This was done supposedly to protect Prince's privacy, which makes no sense. Patient privacy is already protected and the doctor/patient relationship is one of the few granted special privileged status under the law. Yet that was not the worst of it. Even more shocking was that we learned that one of the oxycodone prescriptions was written the *very same day* Prince's plane dove out of the sky for lifesaving Narcan. So, Prince had an immediately life threatening overdose and was prescribed more of the same compound that almost killed him. By a physician. Within hours.

Before we cast stones at Prince's physician, however, it is important to note that we have evidence that writing prescriptions for opioids for people demonstrating risk for adverse outcomes is something that is happening all over this country, every day. In the December 2015 issue of the Annals of Internal Medicine, researchers in the Boston area studied almost 3,000 patients who were treated in the emergency department or admitted to the hospital for opioid overdose. In 90 percent of those patients, they were back on prescribed opioids in less than two months, and in 70 percent of those patients, it was from the same physician that prescribed the opioids *before the overdose*. There is no other way to put this—physicians are actively putting patients' lives at risk. This is a betrayal of the trust that patients place in the medical profession. Some have speculated that maybe those physicians were unaware that their patients experienced an overdose, but that stretches the boundaries of believability. That would mean that somehow in the era of electronic records, the Boston area amassed the most grossly negligent doctors in the country. The reason those doctors still prescribe opioids to those patients who have demonstrated high-risk behavior related to those opioids is simple—the patient demands it, and our business model demands we have happy customers who will come back again.

Stopping the epidemic

So far, the loudest noises about what to do about the epidemic have focused on treatment—increased access to Narcan for those acutely overdosing and increased access to medication-assisted therapy (MAT), for those demonstrating symptoms of opioid use disorder (OUD). We support such efforts. But patients can lose their jobs, homes, and important relationships well before they have gotten to the stage of needing such remedies. To truly reverse this crisis, we need to focus increased attention on prevention. Prevention means physicians must stop initiating these medicines for patients with most chronic pain conditions and by dramatically reducing the size of prescriptions for pain from acute injury. The studies out of Dartmouth published in the Annals of Surgery March 2017 demonstrated that with specific education and controls, the number of pills taken by patients after surgery can be cut by more than half. Such exposure reductions are critical because other recent studies have shown that patients can become dependent or addicted astonishingly fast. The Kaiser Family Foundation

report released in December 2016 showed that a full 34 percent of patients taking opioids for *just two months* reported they were dependent or addicted. Such data demonstrate how crucial it is to avoid starting patients on these medications because in the time it takes to come back for a three-month follow-up visit, the damage might already be done. The critical importance of preventing opioid use disorder from ever occurring was underscored in the April issue of the Journal of Addiction Medicine where a large study demonstrated that almost 1 in 5 patients with OUD were dead within nine years. This corresponds to a yearly mortality rate roughly *10 times that of the unaffected population*.

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Legislative response

To those who think that lawmakers should remain out of what is essentially an issue for medicine to solve, it should be pointed out the Legislature has already gotten involved and passed measures proven to help save lives. In 2014, the Minnesota Legislature passed "Steve's Law," allowing for first responders and third parties to carry and administer naloxone. This legislation provides limited immunity for the person calling for help when someone is overdosing, and legal protection for the prescriber and the person administering the medication. The following year the Legislature was able to secure $270,000 for naloxone for eight EMS districts. With these prior achievements in mind, The Product Stewardship bill was introduced in both the House and Senate in the 2017 session and Governor Mark Dayton has included it in his budget. The bill would require pharmaceutical manufacturers who sell opioids in Minnesota to add to their licensure fee—$.01 per morphine milligram equivalent on any opioid shipments into Minnesota. The Board of Pharmacy will calculate the amount owed each March from the previous years' sales. The money is to be used to develop and administer opioid education, prevention, and treatment. Legislation was also proposed to require 10 hours of pain management/medication education for all medical students and practicing prescribers. One bill restricts the validity of a prescription to 30 days; another requires a prescriber to check the PMP when prescribing unless the patient has a terminal disease. Not all of the provisions passed, but increased action on the part of lawmakers to address an issue that medicine is not solving is becoming more common in this country. Similar proposals are being introduced in states like Colorado where state Senator Kevin Lundberg observed, "This issue [of opioid overdose] is significant enough that we need to be part of the solution, not just watch the problem."

The legal measures described here were designed in part to help physicians feel more support and act in ways better aligned with patient health, rather than business imperatives. Even if a single physician occasionally is able to

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strictly curtail the amount of opioids they personally prescribe, that will not have any overall meaning in terms of outcomes unless the whole profession buys in and changes together. This is where legal measures, as expressions of the will of the people, have a completely appropriate role.

Accountability

One of the great challenges in trying to fix a problem such as opioid overdose is that, in terms of accountability, the final lethal act is always self-inflicted as was the case with Prince. This allows medical providers, or even society in general, to "blame the patient" in a way that is not possible when medicines were found to be unacceptably risky for causing other conditions. For example, no doctors insisted that thalidomide still helped "some patients" and should be kept on the market despite revelations that it caused flipper limb deformities in a small but significant number of newborns. A number of physicians continue to make that claim with respect to opioids for chronic pain. Furthermore, death by addiction to opioids has often been described as death by a "thousand bee stings." With so many prescriptions from multiple doctors for years, it is not fair or appropriate to single out one that proved to be the ultimate culprit, not even the last one. Additionally, our medical malpractice laws do not have any provision for processes that are gradual and accumulative even though they lead to bad outcomes. However, many of these tragic outcomes are preventable. We know this for a fact because we did not die at this rate 20 years ago. And even if death by addiction is due to a thousand bee stings, it is still the bees that did it, not the patient—at least with respect to our ability to control exposure to prescribed opioids.

Physicians are actively putting patients' lives at risk.

It is long past the time for us to better manage our hive. It is time to work together and take bold steps to stop this obscene tragedy. We must do this in memory of Prince and the thousands of others that have died too soon.

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