Be Aware: State Opioid Prescribing Regulations

Robert Broida, MD, FACEP

Emergency physicians should be aware that they have been singled out as an important source of abused prescription opioids and that regulatory bodies are taking aim at us. Further, outrageous statistics are being brandished which have little, if any, basis in fact. Each emergency physician should be aware of these faulty stats, to be able to educate well meaning, but misinformed regulators.

As in many states, Ohio has a huge problem with narcotic abuse and diversion of prescription pain meds. The deaths were piling up and Governor Kasich wanted to do something. He created a Governor's Cabinet Opiate Action Team (GCOAT) task force to address the problem. From the state's perspective:

- In 2007, unintentional drug poisoning became the leading cause of injury death in Ohio, surpassing motor vehicle crashes for the first time on record. This trend continued in 2010.

- From 1999 to 2010, Ohio's death rate due to unintentional drug poisonings increased 372%, and the increase in deaths was driven largely by prescription drug overdoses.

- In Ohio, there were 327 fatal unintentional drug overdoses in 1999 growing to 1,544 annual deaths in 2010.

In May 2011, the state closed the "pill mills" in southeastern Ohio[1]. Next, they looked towards the prescribers. Using two published articles, they concluded that the ED was the biggest source of narcotics and took aim at Ohio's emergency physicians; first with guidelines, and now with regulations (in development). Unfortunately, they either failed to carefully read the articles or grossly misinterpreted / misapplied their results.

The quotes were:

A. EDs are "a major source of opiate prescriptions, with 39% of all opioids prescribed, administered or continued in the U.S."[2]

B. "Studies show that emergency departments are an important source of opioid analgesic prescriptions for people from 0-39 years of age.[3]

Quote A was taken from a CDC paper[4]. It has been widely quoted and is grossly misleading. I took the time to read the paper and noted several key points:

1. This is based on a paper survey where practitioners (or others) completed a one page form after an ambulatory visit.
2. 'Each entry of a medication on the form is referred to as a "drug mention"…' (p2, Methods)
3. The actual form (p45 of 48 on the pdf) shows how the drug data was collected.
4. If a drug was ADMINISTERED or PRESCRIBED, it was listed.
5. There is NO mention of how many units were prescribed.
6. The ED was also the biggest prescriber of NON-PRESCRIPTION products and products of "undetermined" status. These were primarily the NONPRESCRIPTION PAIN RELIEVERS acetaminophen and ibuprofen. (p5, Drug Characteristics)

Thus, it was not 39% of all opioids, it was 39% of all drug mentions. A single injection of morphine in an ED does not have the same community impact as does a prescription for 200 Oxycontin from a pain management specialist. The ED injection cannot be sold, diverted or otherwise abused. Further, the ED physician's single prescription for 12 Vicodin for a gymnast who broke her ankle (on Friday night when drugstores may be closed) was given the same weight in this study as the Family Physician's regular monthly prescription for 180 pills for the chronic back pain patient. They are not equivalent. All "drug mentions" are not alike.

Quote B was taken from JAMA[3]. It is only a brief (3 page) Research Letter which clearly lists the Top 4 prescribers: "Overall, the main prescribers were primary care physicians (general practitioner/family medicine/osteopathic physicians) with 28.8% (22.9 million) of total prescriptions, followed by internists (14.6%, 11.6 million), dentists (8.0%, 6.4 million), and orthopedic surgeons (7.7%, 6.1 million)." Emergency Medicine was not even mentioned as a "main prescriber." Moreover, even a cursory look at Figure 1 in the article shows that the ED contribution is dwarfed by the other specialties. Emergency Medicine was mentioned as the #3 prescriber in only two of the five age groups: 10-19 and 20-29. In both age groups, Dentists and GP/FM/DOs prescribed more. The conclusion was: "For patients aged 10 to 19 years, dentists were the main prescribers (30.8%, 0.7 million), followed by primary care (13.1%, 0.3 million) and emergency medicine physicians (12.3%, 0.3 million)."

I suspect that the ED total is due to the higher (relative) number of injuries in these age groups (broken bones, burns, etc.) requiring appropriate use of pain meds. In terms of the overall opioid problem, I believe it is well understood that individuals in these two age groups are known to divert opioids prescribed to family members. Thus, the number of prescriptions to the age group may not be a true reflection of the source of their opioids. Also, this report uses the number of prescriptions written, NOT the number of pills prescribed. So it is of limited usefulness (as discussed above).

The opioid problem is severe enough that all physicians should be aware of it and work to limit unnecessary opioid prescriptions (or excess number of pills). There is no need for regulators to single out the ED as an "important source," especially when this is only weakly supported by a careful analysis of the facts. Most emergency physicians will respond to unbiased educational efforts. In fact, ACEP has recently released a Clinical Policy on the subject [5]. In the ED, we see patients with severe, painful, acute conditions (broken limbs, car accidents, lacerations, headaches, back strain, etc.) as well as some with painful chronic conditions (cancer chemotherapy patients, etc.). We do our best to adequately and compassionately address all of their medical needs, including pain relief. While all providers would welcome further education on the opioid problem, arbitrary rules and regulations limiting emergency physician judgment in acute patient care, especially when based on faulty or misleading statistics, are not in the best interest of those we serve.

References

1. http://www.cleveland.com/open/index.ssf/2011/05/battle_against_prescription_dr.html
2. http://depts.washington.edu/fammed/files/CE_WA%20ED%20Opioid%20Abuse%20Work%20Group_51.pdf;http://governor.ohio.gov/Portals/0/05.07.12,%20Opiate%20Summit%20ED%20Guidelines.pdf
3. http://jama.jamanetwork.com/article.aspx?articleid=896134
4. http://www.cdc.gov/nchs/data/series/sr_13/sr13_163.pdf
5. http://www.acep.org/WorkArea/DownloadAsset.aspx?id=86527