# Why Doctors Prescribe Opioids to Known Opioid Abusers

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Prescription opioid abuse is an epidemic in the United States. In 2010, there were reportedly as many as 2.4 million opioid abusers in this country, and the number of new abusers had increased by 225% between 1992 and 2000.[1] Sixty percent of the opioids that are abused are obtained directly or indirectly through a physician's prescription. In many instances, doctors are fully aware that their patients are abusing these medications or diverting them to others for nonmedical use, but they prescribe them anyway. Why? Recent changes in medicine's philosophy of pain treatment, cultural trends in Americans' attitudes toward suffering, and financial disincentives for treating addiction have contributed to this problem.

Throughout the 19th century, doctors spoke out against the use of pain remedies.[2] Pain, they argued, was a good thing, a sign of physical vitality and important to the healing process. Over the past 100 years, and especially as the availability of morphine derivatives such as oxycodone (Oxycontin) increased, a paradigm shift has occurred with regard to pain treatment. Today, treating pain is every doctor's mandated responsibility. In 2001, the Medical Board of California passed a law requiring all California-licensed physicians (except pathologists and radiologists) to take a full-day course on "pain management." It was an unprecedented injunction. Earlier this year, Pizzo and Clark urged health care providers as well as "family members, employers, and friends" to "rely on a person's ability to express his or her subjective experience of pain and learn to trust that expression," adding that the "medical system must give these expressions credence and endeavor to respond to them honestly and effectively."[3] It seems that the patient's subjective experience of pain now takes precedence over other, potentially competing, considerations. In contemporary medical culture, self-reports of pain are above question, and the treatment of pain is held up as the holy grail of compassionate medical care.

The prioritization of the subjective experience of pain has been reinforced by the modern practice of regularly assessing patient satisfaction. Patients fill out surveys about the care they receive, which commonly include questions about how adequately their providers have addressed their pain. Doctors' clinical skills may also be evaluated on for-profit doctor-grading websites for the world to see. Doctors who refuse to prescribe opioids to certain patients out of concern about abuse are likely to get a poor rating from those patients. In some institutions, patient-survey ratings can affect physicians' reimbursement and job security. When I asked a physician colleague who regularly treats pain how he deals with the problem of using opioids in patients who he knows are abusing them, he said, "Sometimes I just have to do the right thing and refuse to prescribe them, even if I know they're going to go on Yelp and give me a bad rating." His "sometimes" seems to imply that at other times he knowingly prescribes opioids to abusers because not doing so would adversely affect his professional standing. If that's the case, he is by no means alone.

A cultural change contributing to physicians' dilemma is the "all suffering is avoidable" ethos that pervades many aspects of modern life. Many Americans today believe that any kind of pain, physical or mental, is indicative of pathology and therefore amenable to treatment. (The recent campaign to label "grief" a mental disorder is just one small example of this phenomenon.) At least some segments of our society also believe that pain that's left untreated can cause a psychic scar, leading to psychopathology in the form of post-traumatic stress; thus, doctors who deny opioids to patients who report feeling pain may be seen not only as withholding relief, but also as inflicting further harm through psychological trauma. Trauma today is seen not just as causing illness, but also as conferring a right to be compensated.[4] No one understands this belief better than addicted patients themselves, who use their awareness of cultural narratives of illness and victimhood to get the prescriptions they want. One patient summed it up in this way: "I know I'm addicted to (opioids), and it's the doctors' fault because they prescribed them. But I'll sue them if they leave me in pain."

Furthermore, for physicians, treating pain pays, whereas treating addiction does not. The mainstays of treatment for addiction are education and effective counseling, both of which take time. Time spent with each individual

patient is medicine's least valued commodity, from a financial reimbursement perspective. That's especially true in emergency department settings, where physicians are often evaluated on the numbers of patients seen, rather than the amount of time they spend with each one. Clinicians will not take time to educate and counsel patients about addiction — even if they know how — until they are adequately reimbursed for doing so. Currently, it is faster and pays better to diagnose pain and prescribe an opioid than to diagnose and treat addiction. Busy emergency physicians who would like to refer patients with addiction for appropriate treatment have few resources to call on.

To be sure, the recent shift in medicine's and society's approach to pain represents a response to long-standing neglect of patients' subjective experience of pain, as well as an increasing incidence of chronic pain syndromes in an aging population. Although this shift has no doubt benefited many persons with intractable pain that might previously have been undertreated, it has had devastating consequences for patients with addiction and those who may become addicted owing to lax opioid prescribing.

Some short-term changes that can help address this problem include mandating that all physicians complete a continuing medical education course on addiction, just as, since 2001, they have been required to complete one on pain treatment. Physicians need to learn to conceptualize addiction as a chronic illness that waxes and wanes — an illness similar to diabetes, heart disease, or other chronic illnesses that are influenced by patients' behavior. Physicians can master strategies for brief interventions that have been shown to reduce substance misuse without taking too much of clinicians' time and that are effective even in emergency department settings. In my opinion, all physicians in every state should have access to a database for prescription-drug monitoring and should be required by law to query the database before writing an initial prescription for opioids or other controlled substances. Laws to this effect have already been passed in a handful of states, including New York and Tennessee. Physicians must also be made aware of new billing codes that allow them to pursue reimbursement specifically for addiction counseling.

But the problem of doctors prescribing addictive analgesics to patients with known or suspected addiction will be solved only when the threat of public and legal censure for not treating addiction is equal to that for not treating pain and when treating addiction is financially compensated on a par with care for other illnesses. The former will occur only when addiction is considered a disease by medicine and society, for only then will it be treated as a legitimate object of clinical attention. The latter will occur only when time spent with patients is valued as much as prescriptions and procedures.

In the meantime, countless patients come to emergency departments and doctors' offices throughout the country every day reporting pain and receiving opioids despite known or suspected addiction. Health care providers have become de facto hostages of these patients, yet the ultimate victims are the patients themselves, who are not getting the treatment for addiction they need and deserve.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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1. Results from the 2010 National Survey on Drug Use and Health: summary of national findings. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011 (publication no. SMA 11-4658).
2. Meldrum ML. A capsule history of pain management. JAMA 2003;290:2470-5.
3. Pizzo PA, Clark NM. Alleviating suffering 101 — pain relief in the United States. N Engl J Med 2012;366:197-9.
4. Fassin D, Rechtman R. The empire of trauma: an inquiry into the condition of victimhood. Princeton, NJ: Princeton University Press, 2009.

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# Moneyball and Medicine

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This year, as the *Journal* celebrates its 200th anniversary, we also celebrate the 100th year of another New England landmark about a mile down the road: Fenway Park, home of the Boston Red Sox. The connection is not entirely geographic: if *Journal* articles are any guide, the relationship between medicine and baseball has been enduring and multifaceted. Baseball analogies and meta-