



## MEDICAL ETHICS

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### The War on Opioids: An Ethical Perspective

There is a war on opioids in this country — and on the people who prescribe them. We are in the midst of a public health crisis of addiction that has already taken the lives of many people and is straining our limited resources for first responders and emergency care.

Because many deaths occur from the misuse of prescription-only drugs — and there have been many highly publicized instances of unscrupulous prescribers running “pill mills” — many people naturally assume that the medical profession is the source of the problem. The power and privilege of prescribing medications are limited to a relative few, and with this great power comes great responsibility; popular resentment is only to be expected whenever power is perceived to be abused. As a result, fear and distrust of the medical profession have increased, along with the intense effort, now well underway, to discourage physicians from prescribing opioids.

*“We all have strength enough to endure the misfortune of others.”*

—François de La Rochefoucauld

However, the opioid crisis involves many deeper causes. Socioeconomic factors have contributed to the profound hopelessness and despair that many people live with every day. And prescription opioids continue to be widely available from illicit sources, as is heroin, which often is combined with fentanyl.

I am not making excuses on behalf of the medical profession — quite the contrary. I want to emphasize even more broadly the moral and ethical responsibility of health care providers, the changing ethos of health care, and the grave risks to all the caring professions and our professional values as we navigate this storm.

#### History of Opioid Use

The history of opioid use is the history of medicine. The first recorded use of opium for medical purposes dates back at least 5,000 years. The Ebers papyrus from 1550 B.C. described the medicinal preparation and use of opium in Egypt. Hippocrates discussed the important medicinal uses of opium in 460 B.C. Opium has been continuously modified for medical use since then. The use of opium in the form of laudanum was described by Paracelsus in 1527. Morphine was commercially

manufactured by Merck and Company in 1827, and its use in injectable form was developed in 1840 in Scotland.

The development of surgery and all its related subspecialties would have been impossible without opioids. Although many other analgesics have been discovered or developed since aspirin, none are as potent or effective as opioids for the treatment of severe pain. But the history of medicine and the history of opium are also the history of addiction.

#### Just Say No

“Just Say No” was the mantra of the war on (illicit) drugs begun in the early days of the Reagan administration some 35 years ago. The same refrain is being heard again today by prescribers of opioids, along with a reminder of Hippocrates’ admonition to “first do no harm” (*primum non nocere*). Some believe that doing no harm supersedes any obligation to do good (beneficence). But the obligation to do good is far more fundamental: it is the guiding principle of all caring professions and has formed the basis of every civil society in history.

It is a mistake, however, to assume that most practitioners even want to prescribe opioids. Most prescribers are generally (and increasingly) afraid to. And most report inadequate training in pain management, fear of enabling addiction, and fear of getting in trouble. Prescribing opioids is more than an inconvenience. We are required to view our patients with suspicion — they could be lying to us or drug seeking. We must check up on them in a database. But if we aren’t allowed to trust them, why should any patient trust us? Our job, our obligation, and our calling is to love and care for others, not to judge them. And we resent it, more than anything, when they judge us.

Indeed, many physicians now are heeding the call to just say no. An increasing number of practitioners, including board-certified pain specialists, are flatly refusing to prescribe opioids for any reason. Even within our professions the suggestion is increasingly being made that we are weak because we can’t stand pain.

But think about what it means to our profession, and to our society, if as prescribers we all just say no.

What if we just say no to cancer patients, to patients with acute fractures or major surgery, to dying people, and to people whose pain is so bad they wish they could die? It means, at a minimum, we are indifferent to human suffering. It means that we keep all the power to prescribe to ourselves yet avoid any of

the responsibilities that go with it. It means that ours are no longer the caring professions — because we no longer care. We become technicians following algorithms, and we can soon be replaced by computers that are better at it and no less caring.

To refuse to accept responsibility for another’s comfort and well-being is to repudiate all our professional values, which thus requires a renunciation of all the associated privileges.

Medical care is inherently dangerous. Our obligation isn’t to avoid practicing medicine, it’s to make it less dangerous. Hippocrates’ admonition to first do no harm was not an admonition to never treat, and it did not supersede his instructions on the use of opioids and other inherently dangerous medicines. We are, however, obligated to know the harm — to weigh the benefits and risks, and to guide decision making through authentic, informed consent, based on real knowledge of the risks and benefits, rather than on collective ritual practice. And we are obligated to monitor and guide the patient, and to accept personal responsibility for the welfare of another whole person, not just our favorite disease or body part.

Strategies to try to limit our responsibility only limit our worth as professionals and as human beings.

#### Accepting Responsibility

The history of medicine is the history of medicines. Indeed, the word physician literally means “drug giver.” Despite our collective history of more than 5,000 years of medicines, however, we do a lousy job of prescribing them. It is estimated that more than 250,000 Americans die every year as a result of taking (mostly nonopioid) medicines exactly as prescribed. That number has likely increased since the introduction of Medicare Part D drug coverage to seniors, the age group that is at highest risk for adverse drug effects. The one-size-fits-all approach to drug prescribing for adults in the United States further increases the risk to older patients.

The benefits of medicines are exaggerated and the risks minimized in the minds of almost every prescriber (and most patients). There is widespread, willful ignorance among prescribers about the risks, benefits, mechanisms of action, and elimination of almost every medicine prescribed. This is a deep cultural flaw in American health care. A student of surgery would be expected to know all the steps of a surgical procedure backward and forward along with the potential complications before ever

being allowed to proceed under close supervision. But that same individual need only know what symptom or problem a medicine is ‘for’ in order to prescribe it. Nor is that student’s teacher expected to know more.

We also do a terrible job of understanding age-related changes in anatomy and physiology, as well as drug–drug and drug–disease interactions to prevent serious problems caused by medicines. Medical specialties do not even take responsibility for disseminating information about new drugs to their practitioners — instead, they leave it to the pharmaceutical sales force. So whatever condemnation we receive for prescribing medications is well deserved, even if at times somewhat misguided.

We should be experts on all the drugs we prescribe. It should be a source of professional pride. If these are the tools of our trade, then we must master them. Prescribers should be leading the national dialogue on safe and appropriate prescribing of opioids, not hanging our heads or running the other way. It is our moral obligation, and maintaining the integrity of our professions requires that we lead the call for monitoring and safeguarding the prescription drug supply in this country, ensuring timely, appropriate access to opioids for the patients who need them, those for whom adequate substitute treatments do not exist. We should be leading the charge for universal access to addiction prevention and recovery, along with access to expertise in effective pain management and control. And we should actively police our own profession for those who abuse the privilege of prescribing by doing so inappropriately, and those who abuse the privilege of practicing medicine by turning a blind eye to human suffering.

The challenges to safe and effective pain management, including appropriate opioid prescribing, are many and are made worse by increasingly fragmented care and communication across settings and across practitioners even for a single episode of illness. But none of these challenges are as great — or as great a threat to our professions and our professional values — as the prospect of becoming indifferent to human suffering and to our awesome responsibility and privilege to relieve that suffering. 

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