COMMENTARY

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Prescription Narcotics: Action, Reaction, and Unintended Consequences

We are very familiar with unintended consequences in the world of medicine. Whether they be the note bloat that occurred when the electronic medical record was rolled out,[1] the increase in mortality for certain diagnoses when shorter length of stays were mandated by the Centers for Medicare & Medicaid Services,[2] or when attempts to reduce the cost of oncolytics changed cancer practice models and increased costs.[3] Sometimes the unintended consequences can be more immediately impactful to our patients. I bend your ear today with a story about one such unintended consequence and urge regulators and physicians alike to remember to be mindful of the potential repercussions of new standards after they are put in place.

No one would argue that the United States has a problem with opiate addiction. This epidemic was facilitated not only by lies propagated by drug companies about the addictive potential of some of these drugs, but also by our decision to make physician response to patient pain complaints a quality measure (another discussion of unintended consequences for another day?).[4,5] Increased death rates, an epidemic of crimes, and the mounting costs of addiction understandably led to a backlash. This backlash included sanctioning physicians identified as over-prescribers, computer monitoring of narcotic prescriptions, computer alerts about the hazards of narcotics, limits on the number of narcotics that could be prescribed at any given time, and social and peer pressure to vilify narcotic users and prescribers. This hypervigilance about narcotic prescriptions has had real repercussions for at least 2 populations of patients and has stigmatized not only patients who may legitimately need narcotics but also the providers who prescribe narcotics.

The first population that has suffered is cancer patients. It was never intended that narcotic prescriptions for cancer pain undergo the same scrutiny as prescriptions for non-cancer pain. But as a practical matter, the widespread misinterpretation of narcotic regulations by well-meaning but poorly informed pharmacists led to consequences for cancer patients and doctors alike. The following examples are from my experience, though conversations with colleagues and friends who are patients demonstrate my experience is not unique. Patients with bone metastases were turned away from pharmacies because their narcotic doses were deemed "too high." Patients with stage 4 cancer, for whom frequent visits to the pharmacy can be onerous, were inconvenienced by the rule that first time narcotic prescriptions could only be for a 7-day supply! Similar repercussions are seen for rural patients who have to drive great distances multiple times to pick up limited narcotic prescriptions. The mandate that narcotics only be prescribed electronically (to facilitate monitoring of these scripts) led to headaches for providers but, perhaps more importantly, significant inconvenience for patients. The requirement to specify the pharmacy for electronic prescriptions meant if the provider forgot to change the prespecified pharmacy during the electronic prescribing process, an acutely needed narcotic could get sent to the preferred mail order pharmacy and immediate pain needs would go unmet. Finally, the electronic prescription format meant if the preferred pharmacy was out of the narcotic of choice (often the case with large prescriptions), the patient could not simply go to another pharmacy with a paper prescription. An entirely new prescription had to be electronically sent to another pharmacy or the patient and provider would be inconvenienced by the partial fill with a requirement for another later e-prescription and trip to the pharmacy for the balance. Can anyone argue that these cancer patients are getting better care due to the brave new world of narcotic prescriptions?

The second population that has suffered is the population of patients who may experience genuine acute pain, due to a dental abscess, a kidney stone, a diverticular abscess, or severe soft tissue injuries. While I agree that most of these patients should seek medical care for the described conditions, immediate health care may not be available, due to rural location, weekend or night occurrence of pain, or lack of insurance or money for health care. Others with acute pain seek care but the frightened dentist or urgent care doc

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refuses to write a narcotic prescription for conditions known to cause severe pain for fear of being labeled an overprescriber. These patients are sent home with the recommendation to take 3 ibuprofen and 2 extra strength acetaminophen every 4 hours with disregard for underlying peptic ulcer disease, renal insufficiency, congestive heart failure or liver damage that would make these regimens more dangerous than short-term narcotics. The well-meaning (or put-upon) neighborhood doc can no longer write neighbors a prescription for a small supply in the era of electronic-only scripts for controlled substances. These patients are also not getting better care due to the brave new world of narcotic prescriptions.

The regulations instituted to control narcotic scripts may have deterred a portion of potential addictions; however, I would argue that most of both the determined recreational abusers and the individuals who turn to addiction to avoid a hopeless life will find a way around this barrier. And what of our responsibility to current real patients instead of theoretical future addicts? Have we served them well?

Our reaction to the opioid crisis has had unintended consequences for many of our patients who are now worse off. How do we reestablish a rational approach to narcotic prescribing? I firmly believe narcotics are not the problem. Despair, and the need to alleviate it, is the driver of opioid addiction for many.[5] This despair has become more familiar to all during the COVID-19 pandemic-induced quarantine. Even if you eliminated all the opioids in the world, people can turn to something else—kratom, valium, methamphetamines, heroin, etc. What we should strive to eliminate is the need to escape the hopelessness of life, poor access to healthcare, and other barriers to health equity.

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References

1. Maguire P. Today's Hospitalist. Note bloat: problems with cut and paste. Available at: https://www.todayshospitalist.com/note-bloat-electronic-health-records/. Accessed March 17, 2021.
2. Jang SJ, Yeo I, Feldman DI, et al. Associations between hospital length of stay, 30-day readmission, and costs in ST-segment-elevation myocardial infarction after primary percutaneous coronary intervention: a nationwide readmissions database analysis. *J Am Heart Assoc* 2020;9(11):e015503.
3. Polite BN, Ward JC, Cox JV, et al.. Payment for oncolytics in the United States: a history of buy and bill and proposals for reform. *J Onc Pract* 2014;10:357–62.
4. Rummans TA, Burton MC, Dawson NL. How good intentions contributed to bad outcomes: the opioid crisis. *Mayo Clin Proc* 2018;93:344–50.
5. DeWeerdt S. Tracing the US opioid crisis to its roots. *Nature.* 2019;573:S10–2.