Opioid Abuse and Addiction

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A Current Moral Crisis

Dr. Tom Frieden, Director of the Centers for Disease Control (CDC) recently wrote, "We know of no other medication routinely used for a nonfatal condition that kills patients so frequently." He wrote concerning prescription opioids that are used to treat long-term pain management. Frieden also states that “One out of every 550 patients started on opioid therapy died of opioid-related causes a median of 2.6 years after their first opioid prescription.” Opioid addiction is defined as “. . . a primary, chronic and relapsing brain disease characterized by an individual pathologically pursuing reward and/or relief by substance use and other behaviors (ASAM, 2011). Such drugs include the illegal drug heroin as well as the legal “prescription pain relievers oxycodone, hydrocodone, codeine, morphine, fentanyl and others (ASAM, 2016).” The problem of opioid abuse and addiction is not a recent one.

Background to the Problem

Opioid addiction is not a new phenomenon having been evident in the United States as early as the Civil War. Opioids were often the best available substances for pain relief at that time. By the late 19th century, about 2/3 of those addicted to opioids such as opium, morphine, and laudanum, were middle- and upper-class White women. Opioids were often prescribed for menstrual and menopausal discomfort. Society in the late 19th and early 20th century viewed sympathetically addictions among women and disabled war veterans that were caused by medical examinations or treatments. Heroin was introduced by 1898 as a cough suppressant, but it began to be used for its "euphoric qualities," hence attracting a new type of user. The use of the hypodermic technique between 1910 and 1920 aided the rapid spread of opioid use and addiction.

The arrival of the wave of European immigrants changed the stereotype of the "addicted matron" to that of "the street criminal." These individuals began to be considered as a threat and public attitudes began to change toward addiction. These same attitudes hardened even more following WWII as "a portion of U.S. society appeared to view with disdain and fear the poor White, Asian, African-American, and Hispanic people with addiction disorders who lived in the inner-city ghettos" (Courtwright et al, 1989).

The sharp rise in illicit drug use in the post-Vietnam era led to major medical problems and became an "explosive social issue." By the 1990s, the growing abuse of prescription opioids began to become a cause for concern primarily because of their damaging effects and the potential to serve as a gateway to other substance abuse. Presently, a person abusing opioids could be not only a college-aged student but also a working mother or a senior adult. "Americans aged 50 to 69 years represent the fastest growing population of opioid addicts" (Medscape). There are statutes regulating the use of opioids.

Significant Regulatory Controls for Opioid Use

The Harrison Act (1914) and the Harrison Anti-Narcotic Act (ratified 1920 by SCOTUS) made illegal the practice of doctors prescribing maintenance supplies of narcotics to people addicted to narcotics. The law "does not prohibit doctors from prescribing narcotics to wean a patient off the drug" (e.g. methadone). The Drug Enforcement Agency (DEA) was formed in 1973 to replace the Bureau of Narcotics and Dangerous Drugs. The Narcotic Addict Treatment Act of 1974 amended the Controlled Substance Act of 1970 to allow the registration of practitioners conducting narcotic treatment programs. The Drug Addiction Treatment Act of 2000 enabled qualified physicians "to prescribe and/or dispense narcotics" in order to treat opioid dependency. Physicians are able for the first time to treat this addiction from private offices or other clinical settings. Patients are now able to receive treatment in the privacy of a doctor's office, rather than in a drug treatment facility. The law limited the number of patients to 30 per practice. There remain significant costs associated with opioid abuse and addiction, despite regulatory efforts.

The Costs of Opioid Addiction

The Centers for Disease Control and Prevention estimates that the economic costs of prescription opioid abuse are $78.5 billion annually. This includes "the cost of health care, lost productivity, substance abuse treatment and the criminal justice system." The social impact includes twenty and one-half million Americans age 12 and older that had a substance abuse disorder in 2015, with 2 million of those involving prescription pain relievers and 591,000 involving heroin. The leading cause of accidental death in the United States is legal drug overdose (52,404 in 2015). There were 20,101 deaths due to prescription pain relievers and 12,101 due to heroin overdose in the same year. The situation has reached epidemic proportions and holds key ethical implications.

An Ethical Intersection

Relief of pain is one of the basic obligations of medical professionals. As new, long-acting opioids were developed and became available,

acute and chronic pain. However, a proverbial catch-22 emerged from within this clinical reality—prescribe opioids to reduce the pain, while risking abuse and addiction that creates more pain and suffering. Clinicians operate within a widely applied ethical principle construct that has been championed by Beauchamp and Childress (cf. Hippocrates and beneficence/nonmaleficence). The focus is placed upon beneficence/non-maleficence, autonomy, justice, and rights (Beauchamp and Childress, *Principles*; cf. Jonsen et al, *Clinical Ethics*). Of course, knowing and applying these principles to the prescribing of opioids require careful judgments about: "needs and interests, risk and benefits, and fairness and responsibility" (Kotalik, "Controlling pain and reducing misuses of opioids: ethical considerations"). Statistics show, for example, that opioid-related deaths occur most frequently among patients treated by physicians that prescribe opioids most often.

A key (and ethical) first step will be to reflect upon prescribing practices and adjust them as needed to reduce possible harms without increasing the risk of undertreating or leaving a patient in pain. Ceasing to prescribe opioids is not a panacea. It is well understood that patients who live with chronic pain often face "loss of function and productivity, economic losses, and increased risk of depression and suicide." Patients also have responsibilities related to opioid use. There is a patient obligation to take ownership of possible pain treatments. Choosing a less potent but safer medication may be a wise consideration. Patients also should respect the physician and not use their autonomy to pressure physicians or levy unwarranted demands upon them. There is a right to receive medical care for pain, but there is also a corresponding need to exercise responsibility. The ethical realities of opioid use and abuse are broad and highly complex. There is no one certain path forward, but there are some important first steps.

A Christian Way Forward

"Addiction knows no boundaries of status, lifestyle, or even faith" (Beddoe, "Christian Pill Addicts," CT, November 2013; see above who is addicted). In 2010, 210 million prescriptions were written for narcotics, so dependence can be as near as our medicine cabinets! Therefore

opioid addiction is no respecter of persons. Furthermore, serious education concerning the dangers of opioids is needed for both clinicians and patients. First, whenever an addict tries to stop, withdrawal ensues and the symptoms can be easily mistaken for the original pain. Secondly, poorly applied Christian theology often hinders those suffering from pain and addiction from seeking help among their families and faith communities. This attitude must stop based upon Christian support for life's sanctity.

A person's right to privacy concerning his or her treatment should not lull him or her to sleep regarding the need for community support. As the cultural stereotypes of addiction have shifted from benign euphemisms (addicted matron) toward blame and rejection (street criminal), countless numbers of people have been forced to live as social outcasts when they needed support (See social estrangement in Luke 8:42b-48). This must cease, as well. Rejection will not stem the tide of opioid abuse and addiction. Pastors have often been uncooperative and, at times, condemning, in their attitudes and responses to parishioners that suffer from prescriptive opioid addictions. Lay folks, as well, are often poorly equipped to render assistance. However, there is a careful ministry that can be offered that will supply critical care between the first prescription for opioids and their potential abuse; namely, constant contact. Keeping informed about opioids and remaining committed to those that suffer from chronic pain is a critical need as we all face the epidemic of opioid abuse and addiction.

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