Nonconsensual Dose Reduction Is Neither Justified Nor Reasonable: An Evidentiary and Ethics Analysis

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Disclosures and my background

- No pharmaceutical grants, honoraria, contracts, history of such
- I once owned stock in Abbot & Merck (<3%), sold it. My wife has same + J&J
- Perspectives here do not represent positions of the United States Federal Government or the State of Alabama

Specialties: Internal Medicine, Addiction
- Birmingham VA: Opioid Risk, Opiate Advice & Opioid Safety
- Governor’s Opioid Addiction Task Force committees

A thesis of sorts

- I hope we can agree:
  - Opioids overprescribed -> systems-level decline is desirable

- Thesis
  - Forced dose reductions are highly incentivized, and, in effect, mandated
  - This reflects institutional incentives worth understanding
  - Violate CDC Guideline and aren’t based on sound evidence
  - Doctors face a dilemma of “dual agency”
Context of Tragedy

- >49,000 opioid OD deaths (USA, 2017)
- Rising Heroin (0.2%-0.7%) & Rx OUD (0.4%-0.9%)
- Implicated, doctors’ prescriptions

The crisis, and the response to it involve:
- Individuals, families, communities in jeopardy
- Institutions who must
  - show good faith
  - manage political, regulatory or financial jeopardy

Questions liability and responsibility

Opioid prescriptions falling in US since 2012

1. USA: Prescriptions per 100,000 (Bohnert, 2018)
CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

- Reduce tendency to start opioids, offer better approaches
- If considering long-term opioids, closely scrutinize risks and benefits
- Exercise special caution when escalating >50 or >90 MME
- For patients already on opioids, evaluate harm vs benefit (#7)
  - No dose target
  - No mandated reductions
  - Not a law

Case Example

- I cared for this patient during one hospitalization and reviewed the record
- Presented 2017, AMERSA

73 yo man with kidney transplant

- Chronic pain/polyarthritis late 1990's, renal transplant 2003
- Opioids since 2001, doses ~105-140 MME until 2014
  - Reduced dose with 30-60% cut from 2014 to 2016
  - Down to 22.5 MME by July of 2017
- Progressive loss of energy → inability to keep up with meds
- 3/2017: admitted with renal failure
  - 1970s: 2 psych hospitalizations, prior alcohol use until 1989
- Evaluation
  - Renal biopsy: acute and chronic rejection
  - Acute rejection is prevented by meds he no longer could manage as he declined

Approved for presentation at the 2017 AMERSA meeting
73 year old man

- Dialysis→ restabilized
  - Bumped to oxycodone 10 mg four times a day

- PCP reduced immediately
- Readmitted twice in next 6 months
- Died in September, 2017
- Hydromorphone 0.4 mg/hour for final 24 hours

Policy Questions

- Did this human being’s opioid reduction count as entirely favorable in quality metrics upheld by National Committee for Quality Assurance, by CMS, by the OIG (HHS), by state health authorities and by payers?

- Was this man protected by this reduction?
- Is any agency accountable for that last part

Clinical Account (Digression)

- Not acute withdrawal
- This is prolonged abstinence syndrome
  - Resurgent pain & dependence, “Things Fall Apart”
  - Never qualified for Opioid Use Disorder
- We know Some patients do feel better after slow taper
- Other outcomes seen: churning of medications, invasive procedures, loss of care relationships, patient seeking substances/alcohol & suicidality.
Policies taken by institutions

“POLICY IS MADE BY MANY ACTORS AND AGENCIES, NOT ONE”

Example A: quality metric

Use of Opioids at High Dosage (UOG)*

*Adapted with financial support from CMS and with permission from the measure developer, Pharmacy Quality Alliance (PQA).

Summary of Changes to UOG for 2020
- Updated the age criteria: 65 years or older who received prescription opoids at a high dosage category.
- Revised the HEDIS definition.

Score Descriptors:
The proportion of members 65 years and older who received prescription opioids at a high dosage category.

Example B: insurer mandates taper

► Taper required by the insurer to “align with” CDC
► Except the CDC didn’t say that
Example C: Walmart to prescriber

- Invokes “corresponding responsibility”
- 21CFR §1306.04
- “In reviewing your controlled substance prescribing patterns and other factors...
- “...we have determined that we will not be able to continue filling your controlled substance prescriptions”

Example D: Oregon Medicaid

- Oregon Medicaid
- 2018: no opioids for back disorders of any kind, no matter the history, or diagnosis
- 2019 proposal: mandatory taper to 0 mg for all, but now under debate and reconsideration

Example E: private pharmacy to patient

- “We now require the following documentation...”
- Medical records, for example: MRI, X-ray, doctors' notes,
- A recent urine drug test positive for the opioid
- This liability reduction exercise positions the pharmacist as ultimate assessor
Example F: DoJ warnings

- 30 MDs “identified for prescribing opioids in greater quantities or doses than their peers”
- “DoJ has not determined if the 30 doctors put on notice have broken the law”
- “Part of an initiative to reduce opioid prescriptions by one third”
- Will threat of prison reduce prescribing? Probably

What data support dose-lowering voluntarily or by mandate?
Odds of overdose increase by dose

<table>
<thead>
<tr>
<th>Dose (mg/day)</th>
<th>Dunn</th>
<th>Gomes</th>
<th>Bohnert</th>
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<tr>
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<td>1.00 (REF)</td>
<td>1.00 (REF)</td>
<td>1.00 (REF)</td>
</tr>
<tr>
<td>20-50</td>
<td>1.2 (0.4-3.6)</td>
<td>1.3 (0.9-1.8)</td>
<td>1.9 (1.3-2.7)</td>
</tr>
<tr>
<td>50-100</td>
<td>3.1 (1.0-9.5)</td>
<td>1.9 (1.3-2.9)</td>
<td>4.6 (3.2-6.7)</td>
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<tr>
<td>100-200</td>
<td>11.2 (4.8-26.0)</td>
<td>2.0 (1.5-2.5)</td>
<td>7.2 (4.9-10.7)</td>
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<tr>
<td>≥200</td>
<td>2.9 (1.8-4.6)</td>
<td></td>
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</tr>
</tbody>
</table>

*morphine equivalent


Findings

- Voluntary, well-run programs, with experts
- Dose reductions were achieved for some patients, in several trials
- Patients tended to feel better
- No studies showed a safety benefit
- "Low- or moderate-quality"

Frank et al. Annals of Internal Medicine. August 1, 2017

What data might not support dose lowering as point of emphasis?
VA FY2013 Overdose/Suicide Mortality

VA-wide analysis presented at 2018 National Rx Drug Abuse and Heroin Summit

MH/SUD and Non-Opioid Related Factors Have Higher Odds Ratios than Opioid-Related Factors in VHA Predictive Model

STORM Analysis: Oliva et. al, Psych. Services 2017

Risk increased slightly with increasing MEDD • e.g., 120 MEDD would increase modeled risk by about as much as a PTSD or AUD diagnosis

Odds Ratios for Overdose/Suicide-Related Events by Stefan Kertesz, MD (UAB) skertesz@uabmc.edu

Does tapering work? In Rx OUD:
• failure rate with time-limited buprenorphine =91%
  ▶ NIDA RCT
  ▶ Tapered, +/- buprenorphine
  ▶ 100% Voluntary
  ▶ This study reflects one end of a spectrum of dependence
  ▶ Recognizing that people are in a zone of grey, how do we know that everyone else should be tapered by policy?
Patient Outcomes in Dose Reduction or Discontinuation of Long-Term Opioid Therapy: A Systematic Review

Limitations

- No studies of mandatory policies of taper
- Insufficient data on adverse events “overdose, switch to illicit opioids... suicidality”
- 4 papers under review

Frank et al. Annals of Internal Medicine. August 1, 2017

The Policy Conundrum

- Policymakers have prioritized opioid counts (dose, # of persons) as the indicators of quality
- Most invoke CDC, inaccurately
- Opioid counts are de facto standards for legal risk & professional liability
- The patient who seeks an “opt out” is now a defendant to providers
- What do professionals normally do with liabilities?

- There is a case to be made that taper, is helpful to some individuals
- Institutionally mandated taper?
- Policy moved ahead of science

Crucially, mandating agencies do not measure and are not accountable for any patient outcomes, including mortality

General Hospital Psychiatry

Suicidal ideation and suicidal self-directed violence following clinician-initiated prescription opioid discontinuation among long-term opioid users

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Ethics of Dual Agency

“Dual agency means simply an avowed requirement to act simultaneously on behalf of two different parties with competing interests”

Why it applies:
- Because evidence for mandated taper is not settled (favoring individualized care)
- And there is risk of harm
- Patient interest: individualize
- Because institutions that regulate do demand that the number go down, but have no accountability for patient-level outcomes (and they don’t check)

Addressing Dual Agency

- Generalized Solutions are challenging (Tilburt)
  - Bunkering: “patient first, no matter WHAT”
  - Bailing: “given how we are, stop pretending to Hippocratic ideals”
  - Balancing: risk of mealy-mouthed unclarity

My priority “first, do no harm”
This should win out if “harm” is on the table
Secondarily, risky changes to treatment normally require a consent

Systems-level correctives

- No patient is safe if no doctor can assume their care
- We should repudiate metrics, policies, and legal threats that jeopardize protection of legacy patient
- Entities using metrics based on Rx #’s must be accountable for patient outcomes
  - Dead or alive?
  - Continuous care or loss of care?
  - Hospitalized or not?

Enacting health policy with (a) no patient outcomes and (b) no accountability?
That’s how we got into this mess in the first place
A narrow discourse cones down our field of view

NPR March 13:
- "70,000 opioid overdoses"
- "Over 100 die of prescription opioids a day"

Technically:
- 47,600 opioid overdose events
- 10,564 died of potentially n’ed opioids.
- Absent heroin or fentanyl (NVSS for 2017)

- A recent Rx found in 40-50% (14-15 Americans per day)
- Long-term Rx: ~10-11m Americans, assuming decline from 2014

Shot glass