# INTRODUCTION
# Opioid Controversies: The Crisis — Causes and Solutions

*Robert M. Sade*

**About This Symposium**
This symposium issue consists of papers presented at the 25th Annual Thomas A. Pitts Memorial Lectureship in Medical Ethics, April 4, 2019. The endowed lectureship, held annually since 1993, is funded by the Medical University of South Carolina Foundation through a bequest from Dr. Pitts, who served on MUSC's Board of Trustees for 36 years, including 25 years as its chair. The conference was presented by the Medical University of South Carolina, the Institute of Human Values in Health Care, the South Carolina Clinical and Translational Research Institute, the Office of Humanities, and the Office of Continuing Medical Education of the MUSC College of Medicine.

The opioid crisis in the United States began in the 1990s, but the problem of drug addiction goes back much further: "Of all the nations of the world, the United States consumes the most habit-forming drugs per capita." That statement was made in 1911 by Dr. Hamilton Wright, US Opium Commissioner.[1] The massive increase in addictive drug use that began about 25 years ago has been variously described as a crisis or as an epidemic, but no matter the label, the problem is enormous. In 2018, 10.3 M Americans were classified as opioid misusers, and 2.1 M suffered from opioid use disorder (OUD).[2] More importantly, 47,000 people died of opioid overdose in 2017, nearly 130 people a day.[3] The economic cost of the crisis is considerable as well. In 2013 losses owing to addiction treatment, health care costs, loss of productivity, and law enforcement involvement amounted to over $78 B; those losses are probably much larger now.[4]

The pharmaceutical industry is widely blamed for generating the opioid addiction crisis, and it certainly has played an important role,[4] but the beginnings of the crisis likely preceded the involvement of Purdue and other drug companies. A series of papers based on the extensive and well-designed SUPPORT study documented what had been well-known for decades: the health professions managed pain poorly and inadequately.[5] This and other studies that reached similar conclusions led to a general perception that something had to be done to reduce the undertreatment of pain, and one of the resulting actions was taken by the American Pain Society, which labeled pain as the 5th vital sign.[6] The Joint Commission on Accreditation of Healthcare Organizations advocated for that idea, asserting the opioids were not addictive, echoing reassurances by the drug industry; in 2001 JCAHO established new standards that made hospitals responsible for ensuring adequate pain management. "Pain went from being an unavoidable part of life to unacceptable."[7] The ground was thus made fertile for expansion of opioid addiction into an epidemic, fueled by the drug industry.

**Robert M. Sade, M.D.**, *is Distinguished University Professor, Professor of Cardiothoracic Surgery, Director of the Institute of Human Values in Health Care, and Director of the South Carolina Clinical and Translational Research Institute (Clinical and Translational Science Award) Clinical Research Ethics Core at the Medical University of South Carolina. He currently chairs the Cardiothoracic Ethics Forum and serves as Associate Editor (Ethics) of the Annals of Thoracic Surgery. He is a former member and chair of the American Association for Thoracic Surgery Ethics Committee, the Society of Thoracic Surgeon's Standards and Ethics Committee, and the American Medical Association's Council on Ethical and Judicial Affairs.*



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The current symposium issue is based on the proceedings of the 25th Annual Thomas A. Pitts Lectureship in Medical Ethics in 2019, which explored aspects of the opioid crisis. The conference was titled "Opioid Controversies: The Crisis — Causes and Solutions," and was divided into four sections that addressed different aspects of the crisis.

In the first session, focusing on opioids and chronic pain, Paul Christo argues the view that opioids may be appropriate for treating chronic pain.[8] Some patients with chronic severe noncancer pain that impairs the quality of life and is unresponsive to other medications and interventions may, on balance, be benefitted more than harmed by the use of opioids. Opioid deaths are caused far more frequently by illicit drugs, such as heroin and fentanyl, than by prescription drugs.

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In a session on policy limitations for opioid prescriptions, Richard Larson and his colleagues favor limiting opioid prescriptions.[9] They point to the frequent role of opioid prescriptions in starting patients on the road to addiction, describe a series of governmental actions intended to restrict opioid prescribing, and explain the effectiveness of those restrictions on patient outcomes. In addition to those limitations, the authors propose an opioid stewardship program similar to the successful antibiotic stewardship programs. In opposing mandated opioid dose reduction, Stephan Kertesz and his colleagues cite evidence that incentives favoring forcible reduction in opioid prescribing are neither safe nor effective, and mention the lack of evidence supporting their safety and effectiveness.[10] Moreover, physicians are placed in an untenable position of dual agency, in which they must do what is best for their patient and must at the same time promote institutional policies that may be contrary to the patient's interests.

The question of whether marijuana serves as a gateway to OUD is answered positively by Arthur Robin Williams in his paper on evidence for cannabis as a gateway drug.[11] He reviews the history and physiology of the gateway theory and points to the particular case of adolescent neurodevelopment, which is differentially harmed by cannabinoid use. Population level studies show a propensity for marijuana users to escalate from cannabinoids to opioids. Commenting on Williams's paper and building on it, Arnold and Sade discuss both the gateway theory and its critics then make policy recommendations to mitigate the noxious effects of cannabinoids in the context of the increasing number of states legalizing marijuana.[12] They argue against Williams's recommendation to prohibit sales to those under age 25 on grounds that this would encourage the longstanding black market that legalization has substantially undermined.

Litigation against drug companies has been used to counter the opioid crisis. Rebecca Haffajee views such litigation as effectively addressing gaps in legislative policies and in market self-regulation.[13] She cites data supporting the greater effectiveness of such litigation compared with earlier litigation campaigns involving tobacco, lead paint, and asbestos. Richard Ausness sees some potential benefit to litigation in mitigating the opioid crisis, but raises a variety of concerns about how effective such litigation could be.[14] Those concerns focus on the complexities of cases filed by multiple local government entities and their consolidation into a single federal district court, state attorneys general suing for large awards in state courts, and complications introduced by pharmaceutical company bankruptcy proceedings. How effective any litigation can be in mitigating the opioid crisis remains to be seen.

## Note

The author has no conflicts to disclose.

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