COMMENTARY

Can Medical Licensing Boards Swing the Pendulum Towards Judicious Opioid Prescribing Practices?

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In the initial wave of the opioid crisis, uninformed prescribing practices and lax oversight were the drivers of opioid addiction and death. Although opioid prescriptions have decreased by 44.4 percent between 2011-2020,[1] the number of deaths linked to prescription opioids has decreased only marginally.[2] The marked fall in opioid prescribing without a concomitant reduction in opioid-related deaths suggests that an at-risk population continued to receive prescription opioids, whether directly or indirectly, from a medical professional. Currently, illicitly manufactured fentanyl (IMF) is the culprit for the majority of the approximately 81,000 annual opioid-related deaths.[3] This finding has been misleadingly used to suggest that prescription opioids for chronic pain are no longer (and never were) a relevant concern,[4] while the reality is that their lethal consequences are simply dwarfed by the marked rise in IMF deaths.[5]

It was not until October 2017 that the opioid epidemic was declared a public health emergency. Tools for judicious prescribing, such as the CDC prescribing guidelines,[6] prescription drug monitoring programs (PDMP), prescribing defaults in the electronic health record, and peer report cards,[7] were key steps to help mitigate opioid overprescribing. However, these efforts were largely voluntary or unmonitored, not broadly followed, and few had sustained success.

Although these efforts are intended to address excessive prescribing, in some cases prescribers remained unwilling or unable to revise their opioid prescribing behaviors. The paper by Galletly, et al., highlights numerous examples of prescribing practices sufficiently egregious to catch the attention of the state medical licensing boards (MLB).[8] The authors reviewed 140 cases appraised by three states' MLBs over 5 years to shine a light on the inputs and outputs of their deliberative processes and provide a snapshot comparison across the three states.

The findings by Galletly, et al. are wide-ranging and interesting. Their discovery that primary care providers are the most frequently implicated in adverse findings is not surprising.[9] The efforts to prescribe opioids for pain were driven primarily by collaboration between the pain medicine community, pharmaceutical companies, and advocacy groups who claimed that pain was vastly undertreated and that opioids were the best option to address this challenging condition.[10] This advocacy was accompanied by industry-backed incentives and programming for primary care providers and others, supported by broad professional organizational guideline changes that promoted the use of opioids for pain management.

Furthermore, because there are a small number of cases included in the dataset, the significantly larger denominator of primary care providers makes them more likely to be identified. In one study, family medicine accounted for 20.5% of all opioid prescriptions and pain medicine for 8.9%, although family medi-

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cine has 20-fold more practitioners.[11] Nonetheless, the average number of opioid prescriptions per pain medicine physician was 1,314.9, while for family medicine it was 428.4 [12] It is possible that primary care providers were scrutinized more by MLBs than pain medicine physicians because of a perception of lesser expertise in the domain of pain management. However, it's also possible that they were driven by patient shared decision making in an era that supported opioid overprescribing and then did not have the resources or alternatives to safely scale back.

Galletly, et. al., found that most of the actions taken by MLBs focused on educational interventions. Continuing medical education is invaluable to improving knowledge, though it likely is a necessary yet insufficient activity to ensure practice change.[13] Early efforts to enhance education, driven by the Food and Drug Administration's Risk Evaluation and Mitigation Strategies, or REMS, were voluntary and focused not on using alternatives to opioids but rather on using opioids safely. This has subsequently changed, and the process has become more standardized.[14] The recent action by the Drug Enforcement Administration to require 8 hours of opioid prescribing and pain management education, as required by the Medication Access and Training Expansion (MATE) Act, is a step towards educating the older workforce about the newer paradigm of judicious prescribing; however, the pendulum has already swung away from opioid overprescribing and this culture change is likely to have more impact than these new mandates.

Galletly, et al found wide variability across the three states in how the infractions are assessed and adjudicated by their MLB. Although attempts to objectify the internal decision process of the MLB would add fairness within a state, it may be difficult to do this across states. A deeper understanding of the changes in the within-state decision process over time would add perspective, since, as pointed out by the authors, the decision-makers, landscape, and policies may change. Additionally, more information on how these cases were identified would help systematize the process; the "not reported" category is larger than any individual trigger suggesting that other mechanisms, such as cash prescriptions or PDMP surveillance, may help further identify aberrant prescribing.

Due to the limited data available to the authors, it is not possible to understand the details of many of the adjudicated cases. Although "pill mills" are the most damaging form of overprescribing and are often pursued criminally, prosecutors and MLBs are now somewhat hamstrung by the recent Supreme Court ruling in Ruan that raised the bar for license suspension for prescribers accused of such deceitful prescribing.[15] This ruling requires an understanding of the intent of the prescriber, not the actual practice that was observed. At some level, this is reasonable given that medicine can be an art, but, as hinted at by the authors, most of these situations are obvious to an MLB.

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There remain concerns over whether MLB review is invoked sufficiently often given the large number of apparent overprescribers. Although there are numerous barriers to the actions of MLBs to curtail clinical practice even when overtly inappropriate,[16] these decisions cannot be taken lightly. For example, when a high prescriber is removed from clinical practice, their orphaned patients need to seek care elsewhere. Such care is often hard to obtain due to capacity limitations and concerns by other clinicians about the practices of the original prescriber.

Because nurse practitioners and physician assistant practices are often overseen by nursing or physician assistant boards, one of the limitations of the current study of MLBs is missing data on their opioid prescribing practices. This is important because their overall opioid prescribing rate is typically higher than that of physicians.[17]

A surprising finding is that 19% of the cases involved physician review for buprenorphine and methadone. Although the proportions of the two are not evident, the application of sanctions for exceeding the number of patients beyond the limit for buprenorphine, unless reaching "pill mill" levels, which is unlikely, seems

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inappropriate. Ironically, with the DATA 2000 waiver requirements during this era, there were more restrictions on buprenorphine prescribing than full agonists opioids and the scrutiny of buprenorphine prescribing, especially by pharmacists, continues today.[18]

Galletly et al highlight the challenging landscape in which MLBs function and the limited information on which they often must base consequential decisions. In the role of MLBs as stewards of safe and ethical physician practice, we should standardize their tools and processes to assure that the pendulum lands solidly on judicious opioid prescribing.

Note

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