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Confronting the Opioid Crisis by Taking a Long Look in the Mirror...and at our Peers

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National attention to our current opioid epidemic continues to increase at a numbing pace. According to the latest estimates from the Centers for Disease Control and Prevention

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(CDC), opioids claim 115 lives per day in the United States [1]. Although black market fentanyl and other street synthetics are getting some blame for these deaths, recent data confirm that prescription opioids remain a large contributor to our opioid problem [2]. The number of prescriptions written for opioids increased by almost 400% in the last decade as a result of pressure from patients, regulatory agencies such as the Joint Commission, and pharmaceutical companies, so physicians must honestly examine their own prescribing practice as the nation lends further scrutiny to this discouraging issue [3].

Engaging in this candid self-assessment is important now because the public's perception of the reasons for our opioid problem is shifting. In a recent public opinion poll, respondents placed the most blame for our current opioid epidemic on physicians for inappropriately prescribing opioids for pain [4]. Have we really contributed to the epidemic by overprescribing opioids or under-recognizing signs of dependence? The public seems to think so. And as we often see, there is now a surge of legislative action following the tide of public opinion. This phenomenon is evident in the promulgation of Clinical Practice Guidelines (CPG) being released state by state [5]. Most of these CPGs are simply imposing restrictions on the number of opioids that can be prescribed per patient encounter, so naturally we must ask if our patients will be seeing benefit [5,6]. Yes, early reports confirm the supply of pills has dropped, but it is unclear if the intended effect on reducing misuse and morbidity has happened. Furthermore, we need to acknowledge if real pain that in some cases warrants an opioid has been unfairly ignored as a consequence.

Even though a recent expert consensus panel concluded that enhanced treatment, reducing the demand, and harm reduction should all be federal priorities before efforts aimed at reducing the supply of available pills, most published interventions to date have focused primarily on just restricting the front line clinician's ability to write for opioids [7]. But these interventions have also made clear that no universally agreed upon standard practice exists

with respect to acute pain control and appropriate opioid use. This is particularly challenging in the emergency department where variable patient presentations, differing community standards, and availability of resources all play a role in the individual prescriber's clinical decision making. Even well-intentioned guidelines by ACEP and other national societies are written broadly to allow each prescriber to make the best choices possible for the patient in front of him or her [8]. Where faced with the difficulty of applying a broad national standard to our patients in our ED, it makes sense to be guided by the practice of our peers, or what we perceive that practice to be.

In this issue of *Academic Emergency Medicine* Dr. Sean Michael and co-authors examine how emergency physicians perceive their own opioid prescribing habits relative to their peers [9]. Furthermore, they investigated what happened to prescribers when given their actual data in comparison to their peer group's overall prescribing patterns. This relatively simple study provides important insights and adds to the evolving complicated literature on the prescription opioid epidemic. Unlike the plethora of recent studies that attempt to quantify how the opioid supply is reduced by new society or state mandated guidelines [5], this study examined emergency physician practice in comparison to an alternative but reasonable metric: the practice of one's own peers. The participants here staffed 4 different EDs but were all part of the same clinical practice in the same geographic region. In this study they were randomized to two groups. Those in the intervention group first estimated their opioid prescribing load with respect to their peers, then were shown their true position in the group. The control group was given no data about themselves or their peers. This study was coincidentally launched concurrently with the release of a new state-issued CPG, so it is no surprise the investigators reported an overall decrease in opioid prescribing across both groups. Most interestingly, they found the greatest decreases in those prescribers shown their own prescribing data who initially underestimated their own opioid prescribing.

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What is novel about this trial is its focus on "perceived" knowledge of one's own practice in comparison to that of one's peers in the same group, and how that knowledge might have changed behavior. As physicians we are frequently striving to practice within the standard of our group. Individual physicians do not usually think they are contributing to a problem when they hear about one: physicians are high performers who are trying to do what they think is right, so it is natural to assume others are the source of a problem. Here it was not knowledge of practicing outside the mean itself that led to changes in behavior: it seems to have been the realization that one had perceived one's own behavior inaccurately within the context of the peer group, and perhaps that led to the greatest change.

Perception is important. How the public perceives us, how we perceive ourselves, and how we perceive our colleagues greatly affects our day-to-day work. Studying such perception and its effects on our own behavior is difficult. This study is one small step towards understanding our role in the current opioid crisis. Better understanding of our own behavior will impact those same behaviors. Mindful practice will lead to more deliberate practice and, hopefully, improved patient care.

Like it or not, the public believes this issue is, at least in part, up to the house of medicine to fix. We know the ED is not the source of most prescription opioids, but the opioid epidemic is ever present on the ED doorstep each day a patient is bagged in the ambulance bay by an EMS crew or throwing up all over the triage desk after getting naloxone from a concerned bystander[10]. Intervening at the moment we write the prescription may be as important as intervening after we push naloxone. We must own the problem to engage it properly by understanding behavior and intent. Simply restricting the ability to write prescriptions is only a short term fix. This problem is too complex to have a legislative 'one size fits all' solution. Treating pain fairly and preventing associated morbidity is an ethical obligation that should not be driven solely by a number. Emergency physicians are skilled

problem solvers, and this may be our next great challenge. We will try many solutions and some will fail. We cannot know which methods are effective until we try. This study suggests that perhaps one such solution is to take a long look at our own practice habits. If it will help us care better for those in our charge, it is worth a shot.

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