Editorials

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How Family Physicians Can Combat the Opioid Epidemic

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In 2014, more than 28,000 persons in the United States died from opioid overdoses,[1] and more than 2 million currently struggle with opioid addiction.[2] These numbers have increased for the past several years, and family physicians can certainly feel overwhelmed and powerless in the face of such staggering statistics. It can be easy to cede responsibility for reversing these trends to others. Certainly, policy makers, social services organizations, and governments have important roles in combatting this epidemic. Family medicine, however, has a critical role as well.

We must commit to responsible prescribing of opioid medications, as advised by the Centers for Disease Control and Prevention[3] and discussed in *American Family Physician*.[4] The decision to initiate opioid therapy should be a careful and deliberate one, especially in patients who are at risk of addiction (e.g., those with mental illness or a history of substance abuse). Depending on the clinical situation, monitoring of patients on long-term opioid therapy may include regular urine toxicology screening to identify drug diversion and, in states where they are available, checking prescription drug monitoring programs (http://www.pdmpassist.org/content/state-pdmp-websites) to identify patients who are receiving opioids from multiple prescribers.

Preventing new addiction is an important first step, but it is also insufficient. Medications such as buprenorphine can treat opioid addiction, and the scope of the opioid epidemic requires family physicians to be as comfortable prescribing them as antidepressants or medications for diabetes mellitus. A Cochrane review found that patients receiving buprenorphine had less illicit drug use and remained in active treatment more often than patients receiving placebo.[5] Buprenorphine is generally well tolerated, and the only case reports of accidental overdoses involve its injection with benzodiazepines.[6] Dose adjustments are not difficult and follow a simple algorithm.[7]

However, treatments such as buprenorphine work only if patients can access them. Many family physicians defer treating opioid addiction, referring patients to addiction subspecialists instead. But there are simply not enough of these subspecialists in the United States to meet our patients' needs.[8] Family physicians can and should fill this gap. We are already adept at combining behavioral interventions with medication management for chronic diseases such as diabetes, cardiovascular disease, and chronic obstructive pulmonary disease; addiction treatment requires a similar combination of lifestyle coaching and prescription oversight. Obtaining a Drug Abuse Treatment Act of 2000 (DATA 2000) waiver for buprenorphine prescribing requires a worthwhile investment of eight hours of education; buprenorphine is no more complex or difficult to manage than many other treatments routinely used in primary care. Additionally, our specialty has historically embraced the needs of populations labeled as difficult[9] or challenging, such as homeless persons, refugees, and those with developmental disabilities or mental illness. Patients who are struggling with addiction are no less deserving of our attention.

Numerous resources are available to guide family physicians who are ready to get involved. Learning more about the opioid epidemic is an important starting point, and the Centers for Disease Control and Prevention has a wealth of prescribing resources on its website (http://www.cdc.gov/drugoverdose/prescribing/resources.html). The American Academy of Family Physicians recently published

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a position paper on chronic pain management and opioid misuse that outlines practical steps at the physician, practice, community, education, and advocacy levels (http://www.aafp.org/about/policies/all/pain-management-opioid.html), and a summary of this policy was recently featured in *American Family Physician*.[10] The Substance Abuse and Mental Health Services Administration website includes more information about medications to treat opioid addiction and how to obtain a DATA 2000 waiver, as well as an opioid treatment program directory (http://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management).

Family physicians are ideally suited to provide addiction care, and we should be leading the charge in doing so. A recent Graham Center Policy One-Pager found that only a small number of family physicians have DATA 2000 waivers,[11] which suggests that few of us are actively engaged in providing addiction care. We cannot allow our discomfort to prevent us from filling this tremendous unmet need, and waiting for someone else to do it will only result in more opioid-related deaths. I recently had the opportunity to sign up for DATA 2000 waiver training and am looking forward to doing my part in turning the tide of this epidemic. Will you join me?

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