Redefining “Epidemic”: Nursing an end to the opioid crisis

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Abstract
Aim: This paper examines the complexity of epidemics by addressing the multifaceted interaction of social meanings, biological forces, and collective public responses to the opioid epidemic and Opioid Use Disorder in the United States. Charles Rosenberg’s 1989 essay, “What is an epidemic?” is reconsidered using nursing as a lens.

Methods: The methods used were historical research and analysis of the social, cultural, and political context of the opioid epidemic.

Results: Medical and nursing personnel are in key positions to identify and treat those suffering from the opioid epidemic and Opioid Use Disorder as well as screen those at high risk. They can do so without placing the blame on personal misconduct and instead focus on treatment.

Conclusion: Epidemics leave behind lessons that can either be forgotten or used to inform future practice. In the aftermath of an epidemic, the community is faced with creating meaning and dealing with related challenges.

Key words: opioid epidemic, blame, collective responsibility, COVID-19

You don’t want to fuel their addiction, you don’t want to set them back, but you want to treat them!

This quotation from a nurse reveals the perspective that the duty to care for patients suffering from Opioid Use Disorder (OUD) is mired by internal conflict. Nurses are taught to relieve suffering; however, they struggle with the potential of contributing to their patient’s addiction when it comes to administering pain medication. Over the past thirty years, opioid usage and opioid-related overdoses in the United States and elsewhere have exploded, resulting in an “epidemic” label. The “opioid epidemic” is fitting in the sense that drug overdoses now account for the leading cause of death in the United States for those under the age of fifty; however, greater implications are associated with the label.

Over the past year, historians of nursing and medicine have found many instances when a history of epidemics finds new relevance. In this paper, we argue that, to understand the complexity of epidemics, it is helpful to study the multifaceted interaction of social meanings, biological forces, and collective public responses.” Charles Rosenberg distinguishes between the terms “pandemic” and “epidemic,” with “pandemics” considered as a geographically global phenomenon, limited to the “medical [realm] and infectious disease.” By contrast, “epidemics” have evolved into a more generic term to classify events people do not like or want to target as a social problem. The opioid crisis can be considered the more generic term in Rosenberg’s classification. The label “epidemic” serves to trigger the emotional urgency associated with previous outbreaks. Similarly, labelling the opioid crisis as an “epidemic” intentionally instigates a fear response. Yet when considering the opioid epidemic, Rosenberg’s question of “What is an epidemic?” can also take on a different form, and one can see connections and disconnections within his framework.

The late-twentieth-century HIV/AIDS epidemic

DOI http://doi.org/10.24298/hedn.2021-0007

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Received 11 June 2021; accepted 15 June 2021; J-STAGE advance published 27 July 2021.
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prompted Rosenberg to compose his essay. He compared the ideal type of epidemic to a storyline’s well-defined order of events as seen in a play with three acts. “Act I” involves “progressive revelation,” which acknowledges the epidemic only when it becomes otherwise unavoidable. In terms of opioids, the Center for Disease Control (CDC) first acknowledged the opioid crisis as an epidemic in 2011, when 27,000 Americans died from drug overdoses, of which opioids were the driving force. By 2019, more than 70,600 Americans had died from drug overdoses, showing how the crisis continued to pervade the United States.

Rosenberg’s “Act II” relates to “managing randomness” - i.e., the creation of a framework to address the epidemic at hand and to try to contain it. Strategies may include religious and social assumptions, secular explanations, and a “blame the victim” response during this act. As for the opioid epidemic, OUD was introduced into the DSM-5 in 2013, standardizing the identification and diagnosis of individuals suffering from opioid abuse and dependence. While in Act II, Rosenberg takes social class into account, he neglects other stratifications, leading Keith Wailoo to reframe the plotline. Wailoo acknowledges that class structure is only one component of the social disparities made apparent by epidemics. To him, the intersection between class and racial explanations must be considered when examining the uneven susceptibility and impact of disease. Alexander Tsai argues that the “burden” of OUD has “disproportionately increased among blacks compared with whites,” thereby reinforcing Wailoo’s narrative. Indeed, OUD is stigmatized, and access to care is barred by race, gender, and socioeconomic status.

Rosenberg’s last stage of the epidemic storyline, “Act III,” concerns “negotiating public response,” during which time the community tries to deal with the problem. Here again, the opioid epidemic complicates a strict sequence because it has yet to reach a conclusion. In line with Rosenberg’s framework, however, social meanings of the epidemic persist; and for those struggling with OUD, cultural and social perceptions surrounding their disorder have impeded their recovery. Specifically, the negative attitudes associated with the “addiction” label result in their disorder being classified as “choice,” thereby blaming them, rather than a pathological disease.

Neurobiology of Opioid Use Disorder
Rosenberg asserts that epidemics are biological as well as social events. As nurses engage with patients at the point of clinical contact – the bedside – it is essential that nurses understand the underlying biological explanation of OUD to provide informed and empathetic care. Opioids refer to a class of drugs derived from the opium poppy plant with both stimulatory and depressive effects along with pain reduction. Opioids include prescription analgesics such as morphine and codeine (natural opioids from the opium poppy), the semi-synthetic heroin (made from chemically processed morphine), and synthetic opioids (synthesized in a laboratory). Numerous risk factors - such as genetics, the body’s way of responding to stress, and prior exposure to opioids - affect whether a patient will develop tolerance, dependence, and addiction. How far persons are willing to go to experience pleasure and avoid pain also factors into their risk for eventual development of OUD. Once opioids enter the bloodstream and arrive in the central nervous system, they stimulate the release of dopamine, a neurotransmitter that is responsible for creating pleasurable feelings and stimulating the brain’s reward circuit. With continued use, the body will require opioids in greater and greater quantities in order to experience the same level of pleasure and pain relief, ultimately leading to uncontrolled drug use and addiction. Additionally, opioids disrupt the brain’s hypothalamic-pituitary-adrenal axis, which controls how the body responds to stress.

As shown above, the chemistry of the brain is dramatically altered by opioids, hampering a patient’s ability to cope with the stress of withdrawal and sustained sobriety. Thus, nurses’ responses include compassion and recognition that OUD is a chronic, relapsing condition, while acknowledging patients’ challenges when choosing to seek treatment and remain free of opioids.

History of Opioid Usage: From Discovery to Epidemic Proportions
As one considers the identification of epidemics, managing their randomness, and the public’s response, it is helpful to situate the opioid epidemic in historical time and focus on critical periods when multiple forces were at work. Significantly, OUD has long been framed as a racial, criminal justice issue, placing the blame on personal misconduct rather than treatment. Although underestimated, the addictive quality of opioids has been known for some time. Treating pain using opioids dates to the Civil War, when laudanum, a tincture of opium, was first given to manage battlefield injuries. Eventually, heroin and synthetic opioids became available. In response to their addictive quality, numerous regulations were enacted in the first half of the 20th century. Opioids never entirely went away, and wars only exacerbated the prevalence of opioid misuse and abuse. In the aftermath...
of World War I, WWII, and the Vietnam War, for example, veterans continued taking opioids long after their combat injuries had healed. Oxycodone and hydrocodone, prescription opioids, entered the pharmaceutical market by the time the Vietnam War ended, with the drugs used for acute and cancer pain. Oxycodone and hydrocodone expanded access to opioids, in turn increasing the number of people who eventually became addicted to prescription drugs.\(^17\)

As the community mobilized in the 1980s, numerous studies concluded that opioid therapy was not associated with abuse or dependence, emphasizing the safety of opioid usage. However, the results of these studies were confounded by small sample sizes and extrapolated out of context.\(^15\) By the 1990s, legislation, along with recommendations from major health organizations in the United States, marked a turn for the worse, as misconceptions and misuse led to a substantial increase in prescription opioid related deaths.\(^19\) No longer were opioids prescribed only for severe or acute pain. States began passing Intractable Pain Acts, eliminating punishments for doctors who prescribed long-term opioid therapy. Thus, between 1990 and 1995, opioid prescriptions increased from two to three million. The Food and Drug Administration approved OxyContin in 1995, and with aggressive marketing to the American public, the number of annual OxyContin prescriptions increased from 670,000 to 6.2 million. Purdue Pharma, the company that manufactured the drug, deliberately misled the public with information downplaying the potential for addiction and was fined in 2007; however, the damage had already been done.\(^20\)

By the early twenty-first century, the Joint Commission and the federal government itself further contributed to the crisis. In 2001, the Joint Commission announced new standards for monitoring and treating pain, designating pain as the “5th vital sign.” These new guidelines created an illusion correlation between quality of care and patients’ perception of their healthcare, including pain control. Although the Joint Commission reneged on these recommendations eight years later, like OxyContin’s legacy, the effects would be irrevocable. Only a year later, the Patient Protection and Affordable Care Act of 2010 expanded the role of patient satisfaction as a payment incentive, resulting in more liberal prescription of opioids, as patient experience accounted for 30 percent of the total performance score (despite the fact that no evidence demonstrated a relationship between patient experience scores and quality of care).\(^21\)

The case we are making here reveals how the opioid crisis is multifaceted and responsibility is complicated. Individual insurance companies have also played a role, having restricted reimbursements on less addictive pain treatments. Some pharmacies began charging less to fill a larger number of pills. On an individual basis, some physicians wrote prescriptions for large supplies of opioids to limit fill requests. Ultimately, these prescribing practices increased the risk for dependence. Prescriptions also served as a gateway to the use of illegal opioids, including heroin and synthetic opioids such as fentanyl. On the other hand, if a patient did not become dependent and had pills left over, issues still lingered: the drugs could be sold illegally or misused by family members.\(^22\)

In 2017, the crisis became a public health emergency, accompanying the release of national strategies by the US Department of Health and Human Services in an effort to combat the crisis.\(^23\)

**Perpetuation of the Crisis**

Different from Rosenberg’s explanation is that the opioid epidemic is not so episodic because it has not ended. Health disparities, stigma, the COVID-19 pandemic, and healthcare practices are all hindering the ability to make progress on both an individual and federal level. Numerous social determinants of health factor into the crisis, with racial, gender, and rural disparities the most salient. Blacks and Latinos are especially affected by the racialization of OUD, and yet they are less likely to receive the resources they need to overcome their addiction.\(^24\) While opioids impact all demographics, access to care is especially limited for those in rural settings,\(^25\) leaving a gap between urban and rural areas.\(^26\) Additionally, gender affects access to care when it comes to opioid treatment. Not only do women experience a greater sense of “shame…embarrassment…discrimination,” but treatment programs have been traditionally designed for the needs of men.\(^27\) Women suffering from OUD are also more likely to experience mental health conditions that go unaddressed and untreated, reducing the efficacy of treatment. Fears over child custody also affect a mother’s decision to seek treatment.

Thus, multiple dimensions of stigma surrounding OUD and treatment undermine the response to the opioid crisis. Research has demonstrated that substance use disorders, OUD included, are more stigmatized than other chronic diseases.\(^28\) Negative stereotypes, which may include perceived dangerousness or moral failure, along with discriminatory behaviors, not only impact treatment compliance, but also result in psychological distress and a reduced quality of life. All forms of stigma, including structural, public, enacted, internalized, anticipated, and courtesy, are reinforcing of one another,
creating a self-fulfilling prophecy when patients with OUD begin to experience stigma. Stigma does not just stem from public attitudes, but it is also apparent in the attitudes of healthcare professionals and policies affecting how care is financed and delivered. One nurse ascribes the stigma of her coworkers to a lack of education, emphasizing that “people who aren’t educated in opiates...don’t understand the psych component.” Public policy classifies those suffering from OUD as though they are “unworthy of investment and underserving of treatment” as patients are excluded from receiving certain forms of care or must otherwise overcome barriers to receive care. Furthermore, the “epidemic” label of the opioid crisis not only fails to suggest appropriate responses, but also calls to mind images of isolation and quarantine, which have their own set of negative implications.29

Amid the ongoing opioid crisis, America is also undergoing the COVID-19 pandemic. According to the National Institute of Environmental Health Sciences, the pandemic is “fueling” the current opioid crisis. In the first two months since the start of the pandemic, thirty states reported increases in opioid-related fatalities, and in one New York county, there has been a two-fold increase in deaths from overdoses. COVID-19 has increased the risk for misuse and addiction by those struggling with pain and substance use because the pandemic has exacerbated stress and social isolation. Additionally, people of color are disproportionately affected by COVID-19, which places an entire population at greater risk for experiencing disruptions that challenge recovery.30

Aside from reevaluating prescription practices, healthcare procedures within hospitals require special attention when it comes to mitigating the opioid crisis. The emergency department plays a major role, as the efficient turnover of patients results in the inappropriate prescription of opioids. In reference to the patients, one nurse described how the ED “treat[s] them and stre[t] them...to get them out the door.” To “get [patients] out the door,” providers fail to collect a comprehensive medical history and form a relationship that would allow them to distinguish between the patients who are experiencing true pain from the patients who are seeking out opioids to abuse.31 Before nurses are even licensed to provide care, they are taught to relieve suffering. Thus, nurses are presented with an ethical dilemma when tending to the needs of their patients, which may ultimately result in feelings of burnout that reduce the availability and quality of care.32

Prevention, Modification, and Treatment

The public response to the opioid epidemic requires widespread efforts. To ameliorate the crisis, it must be addressed from three fronts: preventing deaths from overdose, helping people recover, and preventing addiction.33 Upstream preventative measures concentrate on minimizing exposure to opioids, while downstream interventions expand evidence-based treatment for OUD.34 Between prevention and long-term harm reduction, short-term efforts can focus on reducing the nonmedical use of prescription opioids. Since 80% of those who use heroin today used prescription opioids first, preventing the misuse of opioids will have a trickle-down effect.35 Prescription opioids act as a gateway to heroin and synthetic opioids, and to end the opioid crisis, efforts must address where OUD first takes root - in the healthcare system.

At the state and federal levels, legislation has the power to limit prescribing. As of mid-2017, twenty-three states have set a maximum number of days a prescription is allowed to last,36 and federal legislation restricts prescriptions for acute pain to 7 days.37 More laws need to address patients who legitimately need prescription opioids, while limiting the availability of opioids for nonmedical use. Additionally, legislation needs to implement programs that expand the distribution of drugs used in treating OUD, specifically when it comes to allowing nurse practitioners to administer buprenorphine alongside physicians. Buprenorphine reduces opioid cravings and is more effective than drugs traditionally used to treat OUD, like methadone, because it has an “effective ceiling.”38 Therefore, increased quantities of the drug will not have an enhanced effect. Over the past twenty years, doctors have been gaining expanded access to the prescription and distribution of buprenorphine. Nurse practitioners have been slower to gain full access, as 28 states still limit their access to the drug. Nurse practitioners face additional barriers because, in many states, they must be supervised by a physician. Future policies also can focus on decriminalizing low-level drug violations, which would destigmatize OUD and allow more mothers to seek out treatment without fear of losing custody over their children.39

Failure to bring about institutional change within hospitals and a reevaluation of insurance policies will make the opioid crisis endemic within the United States. Medical and nursing personnel are in key positions to identify and treat those suffering from OUD as well as screen those at high risk. Along with modifying prescription practices to minimize harm and maximize benefit, they can provide education on opioids and their
associated risks, which will reduce stigma and increase awareness. It is also essential that hospitals support the continuum of care through providing resources for treatment and social support. As for the stakeholders, insurance companies must reevaluate their reimbursement policies to support those already suffering from OUD without putting other patients and their family members at risk of developing OUD.

The “Art and Science of Nursing”

Although Rosenberg’s framework is helpful in thinking about the public response, it does not address tools for treating pain in patients, regardless of whether their techniques, including acupuncture and meditation, when encouraging pain reduction rather than pain alleviation. In assessing and managing pain, nurses can set goals that encourage pain reduction rather than pain alleviation. Pain contracts are another way of setting expectations for pain control. Nurses can also utilize naturopathic techniques, including acupuncture and meditation, when treating pain in patients, regardless of whether their patient is suffering from OUD.

It is also important for nurses to be educated on the risks of opioids to their patients. A survey of nurses revealed their preference for education that focuses on the realities of addiction, such as the specifics of providing care to patients suffering from OUD, rather than the academic perspective, which lectures on the etiology and pathophysiology of OUD. While an interprofessional approach is necessary for the success of treatment and remission for those with OUD, without nurses, recovery would not be possible.

Conclusion

Rosenberg’s framework is useful for understanding the biological and sociological aspects of an epidemic along with the public’s understanding of it. Yet, as Fairman notes, a consideration of nursing as “expert actors” can enhance our understanding of epidemics. Furthermore, Rosenberg asserts that an epidemic’s storied conclusion “end[s] with a whimper . . . is flat and ambiguous.” By contrast, the opioid epidemic has not yet ended, and this paper has examined how much of a role nurses can play in this script. As Fairman argues, when viewed from a nursing perspective, “we can glean different ways nurses and patients construct meaning, which engages with Rosenberg’s acts while also departing from them.” She continues, “[T]he public’s expectation of expert nursing care does help to alleviate fear and promise some control over the randomness of illness and the management of the disease course.” While nurses provide care whether an epidemic is present or not, “it becomes more visible when the need is great . . .” shifting the focus from the disease itself (in this case, OUD) to the experience of care.

At the same time, a reconsideration of epidemic endings is important. The opioid crisis is not the first time America has witnessed a drug crisis of epidemic proportions, and likely will not be the last. Whether or not epidemics end with a whimper has been disputed by historians, as Samuel Cohn argues. Epidemics since the 16th century have often ended with a “bang.” While no drug crisis has reached the epidemic proportions of the opioid crisis, by allowing past drug crises to end with a “whimper,” each crisis has given way to a new crisis. Every generation continues to perpetuate the “war on drugs” because the lessons of the past have failed to guide current policies and practices. Therefore, ensuring that the opioid epidemic ends with a “bang” will leave behind a legacy likely to dispel future drug crises.

Anticlimactic or not, epidemics leave behind lessons that can either be forgotten or used to inform future practice. In the aftermath of an epidemic, the community is faced with creating meaning and dealing with related challenges. Reflecting on past epidemics, Rosenberg emphasizes the need for collective responsibility and communal identity, rather than a sole focus on individual behavior change.

In redefining “epidemic,” the opioid crisis has demonstrated the need for collective policy commitments in the healthcare system, pharmaceutical industry, and government, alongside the reduction of stigma. Nurses get starring roles in any drama of epidemics as they fulfill an indispensable role in stemming the tide of the crisis at
hand. Nurses spend more time with patients than any other clinicians and are in key roles to address complex social, behavioral, and medical issues impeding a patient’s recovery. By adopting a patient-centered view of pain and addiction, nurses have the power to reverse the opioid crisis, one patient at a time.

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