Q&A

The Opioid Crisis: An Interview With Douglas C. Throckmorton, MD

Value & Outcomes Spotlight had the honor to interview Douglas C. Throckmorton, MD, the FDA's Deputy Director for Regulatory Programs in the Center for Drug Evaluation and Research. Dr. Throckmorton received his medical degree from the University of Nebraska Medical School and completed his residency and fellowship at Case Western Reserve University and Yale University, respectively. Prior to coming to the FDA in 1997, he conducted basic science research and practiced medicine at the Medical College of Georgia, Augusta, Georgia and Augusta Veterans Administration Hospital. He is a board-certified physician and as Deputy Director for Regulatory Programs, Dr. Throckmorton shares the responsibility for overseeing the regulation of research, development, manufacture and marketing of prescription, over-the-counter, and generic drugs in the United States.

Value & Outcomes Spotlight: **FDA has identified opioid addiction as the biggest public health crisis currently facing the United States. What do you view as the key measures FDA has taken to address this problem?**

Throckmorton: At FDA, we've set out to address the opioid crisis forcefully, using all the agency's tools and authorities. We've taken a range of new steps as part of a comprehensive approach, in concert with the steps that the Secretary of Health and Human Services has outlined to confront this crisis. We're leveraging our authorities to the greatest extent possible with a focus in four main areas. First, our efforts encourage more appropriate prescribing to decrease exposure to opioids and prevent new addiction and the risk of overdose; second, advancing innovation in novel pain medicines and treatments that don't have the same risks as opioids; third, the development and use of better treatments to help those with opioid use disorder; and fourth, increasing our enforcement and interdiction work aimed at illicit drugs such as fentanyl, especially when it comes to products being shipped illegally through the international mail facilities. In addition, part of our ongoing work is ensuring that drug approval and removal decisions are made within a benefit/risk framework that evaluates not only the outcomes of opioids when used as prescribed, but also the public health effects of inappropriate use of these drugs. We are continually re-evaluating the safety of approved opioid products based on both post-market data the FDA has required from sponsors and additional sources of information as part of our safety surveillance.

For members of ISPOR, a close eye is kept on the cost-effectiveness of medical and public health interventions. How is FDA evaluating the impact of its latest initiatives to combat the opioid crisis?

We are keeping a close watch on trends related to prescribing and opioid-related deaths. However, while some of the FDA's initiatives are designed to have an immediate impact, the majority may have the largest impact over time. For example, we've implemented several measures, including the Opioid Analgesic Risk Evaluation and Mitigation Strategy (REMS) to help better communicate the serious risks about the use of opioid pain medications to patients and health care professionals and provide them with tools to use these powerful medicines appropriately. That REMS requires that training be made available to health care professionals to cover broader information about appropriate pain management, including alternatives to opioids for the treatment of pain. We've also awarded a contract to the National Academies of Sciences,

Engineering, and Medicine to help advance the development of evidence-based guidelines for appropriate opioid analgesic prescribing for acute pain resulting from specific conditions or procedures. These steps can help over time to reduce the rate of new addiction by decreasing unnecessary and/or inappropriate exposure to opioids and ensuring rational prescribing practices, while still providing appropriate treatment to patients who have medical need for these medicines.

Examples of those FDA initiatives aimed at having a more immediate impact include, the marked increase of our enforcement and interdiction work aimed at illicit drugs such as fentanyl, especially when it comes to products being shipped illegally through the international mail facilities. We've also been focused on criminal investigations conducted by the FDA in partnership with other federal agencies to identify suspect shipments and refer them for prosecution. Additionally, we're targeting the operations of international criminal groups, both public and on the darknet. Every package stopped, and every online network shut down and every criminal convicted reduces the risk that illegal and dangerous drugs will get into the hands of unknowing consumers. Another example is our work to spur innovation in drug development that will have an impact on opioid use and addiction. For example, if we can effectively advance new pain medicines and treatments that don't have the same risks as opioids and the development and use of better—and more accessible—treatments to help those with opioid use disorder. Just recently, we took an unprecedented step of developing a model drug facts label and conducting the necessary consumer comprehension testing to encourage drug companies to develop an over-the-counter version of the antidote to opioid overdose, naloxone, which could help save companies both time and money in developing nonprescription versions of the drug.

How did we get here? When you look at the opioid crisis, how does the blame get distributed among health system stakeholders—providers, patients, manufacturers, payers?

Many groups helped fuel this crisis. For too many years, we as doctors were too cavalier about prescribing these powerful and addictive drugs. An entire generation of physicians was trained—inappropriately we now know—on opioid prescribing practices that were far too loose. My generation of physicians fell squarely in the cohort that were trained to view pain as the fifth vital sign and to believe that the risk of addiction from opioids was very low. In the hospital, a standing order for an as-necessary prescription for Percocet was the norm.

We now know that these beliefs, and these practices, were wrong.

The FDA is also not immune from responsibility. We were too slow to act at some key moments. We were too slow to change labelling on certain drugs to discourage chronic prescribing in situations where it is inappropriate. We were too slow to recommend changing the scheduling of hydrocodone to restrict its access when there were signs of mounting abuse. And we were too slow to advance efforts to make proper physician education more routine. We need to learn from these mistakes and tragic consequences. Going forward, we need to embrace a shared commitment to correct the burdens of our collective mistakes. At the FDA, we need to make sure that our actions today are forceful enough to reverse this while in no way harming patients in need. Having allowed a crisis of historic proportions to get firmly planted, our actions today are going to have to be more forceful than the steps that might have been sufficient to address these same challenges two or five or ten years ago—if we had the foresight to intervene earlier and more aggressively as this tragedy continued to grow in depth and proportion.

Looking back, were there early warning signs of a growing crisis that policymakers were slow to act upon?

As I previously stated, the public health crisis of opioid addiction and overdose is a tragic situation that has evolved over a number of years and has been the result of a confluence of factors. Collectively we could have done better. We should have done better. And right now, we have to do better. We don't want to look back in the future again and say we didn't act quickly enough or forcefully enough to address this crisis. Importantly we know it requires an all-of-the-above approach that will require each of us to work together—the FDA and other government agencies, health care providers, the medical products industry, policy makers, patients and their families. At the FDA, we remain steadfast in using all facets of our regulatory authority to change the trajectory of this epidemic. One of the unique ways we are doing this is by using new tools to detect potential warning signs sooner and remain vigilant to recognize shifting trends in the addiction landscape. This includes recognizing patterns of prescription and illicit drug use and determining the reasons behind them using the agency's clinical, epidemiologic, basic science, and social science expertise. Taking a systematic approach to monitoring such trends should allow us to intervene promptly and appropriately and protect the public from associated risks.

The opioid epidemic is widely considered a United States problem. Is that fair or is it really a global problem?

Our focus is looking at ways within our authorities—which are limited to the U.S.—in which we can help stem the tide of the opioid crisis, which has become a public health tragedy in the U.S. and may differ across the globe. At the same time, we are aware of issues related to drug abuse worldwide, as well as approaches to treating pain, and look to other countries for lessons learned and potential best practices that we can apply to our authorities here. However, I will also say that despite much of the focus being on the U.S., there are certain global aspects that have a tremendous impact on the crisis here, such as illicit drugs like fentanyl that are being manufactured overseas and shipped to the U.S. illegally, and potentially leading to numerous fatal overdoses. Ultimately, I think it's important for everyone to be mindful of the issue regardless of where they live.