Heroin's Heroine: Implementing Legislation to Curb America's Opioid Epidemic

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"Our friends are dying. Our neighbors are dying. Our co-workers are dying. Our children are dying. Every day. In numbers we can no longer ignore." – Chris Christie

PART I: INTRODUCTION

In 2015, there were three hundred million painkiller prescriptions written around the world, equaling a twenty-four billion dollar market. Though the United States’ population makes up only about five percent of the world, eighty percent of these opioid prescriptions were issued in the United States. Approximately ninety-nine percent of physicians exceed the recommended three-day dosage when it comes to prescribing opioids. Deaths from prescription opioids—drugs like oxycodone, hydrocodone, and methadone—have more than quadrupled since 1999. This has been the deadliest drug crisis in American history, claiming fifty-nine thousand lives in 2016. Ninety-one Americans die every day because of an opioid overdose.

In response to the opioid crisis that has been increasingly plaguing the United States, some states took matters into their own hands, absent any national congressional command. Legislators in at least seventeen states across the country have passed laws to limit the duration of prescription painkillers. Led by former New Jersey Governor Chris Christie, state legislators have enacted one of the strictest opioid prescription restriction laws in the country. Other states

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3 Id.
4 Id.
6 Hirschfield Davis, supra note 2.
7 CENTERS FOR DISEASE CONTROL AND PREVENTION, supra note 5.
have followed similar approaches to that of New Jersey, but with generally more relaxed parameters. Though the new law has seemingly good intentions, the bill has faced numerous and harsh criticisms. Many physicians are opposed to the strict five-day durational limit on initial opioid prescriptions, asserting that this aspect of the statute seeks only to punish patients suffering from acute pain.

Former Governor Christie hopes that by setting strict laws regarding opioid prescriptions, it will not only aid the epidemic in New Jersey but throughout the United States. States can look to New Jersey’s law as inspiration for their own opioid-reform acts. But, should they? Though the New Jersey statute takes a much-needed step towards prescription opioid control, it has gone too far in its restrictions, forcing those who are suffering from acute pain, severe pain typically lasting from three to sixth months, to bear the brunt of this regulation. While other states should follow New Jersey’s lead and pass legislation implementing restrictions on the prescription of opioids, states should stop short of implementing a five-day prescription length limit on all patients with new prescriptions.

This comment will argue for the adoption of opioid prescription restriction laws on both a state and national level, while balancing conflicting interests in implementing such a law. On one side, there is an immense and pressing need for prescription restrictions throughout the entire country in order to combat the worsening opioid crisis affecting the entirety of the United States; and on the other, implementation of such a law may unfairly burden patients who are suffering through acute pain. Part I will set out the background of prescription opioids and the history of

10 See Zezima, supra note 8.
13 Livio, Christie Plan to Limit Painkillers ‘Cruel,’ N.J. Doctors Say, supra note 11.
how this crisis came to be; it will also specifically delve into the effects of the opioid crisis in New Jersey. Part II analyzes the need for state-level legislation, and how the New Jersey relevant statute can be looked to as insight as to what such regulation should look like. Part III concludes.

PART II: BACKGROUND

A. The History of the Opioid Epidemic

With roots tracing all the way back to 3400 BC, opioids can be described as a class of drugs that can be used to treat pain.\textsuperscript{14} Eventually, the use of opioids spread throughout the ancient world, being used to treat pain in every major civilization in Asia and Europe.\textsuperscript{15} By the nineteenth century, a conflict emerged between physicians’ want to prescribe opioids and the recognition that these drugs can lead to abuse and addiction.\textsuperscript{16}

It was not until 1898 that opioids were mass produced for commercial sale.\textsuperscript{17} That year, Bayer Co. began to sell heroin, marketing it as a “wonder drug.”\textsuperscript{18} In the early 1900s, opioids, namely heroin, were frequently used to treat everyday illnesses such as the common cold.\textsuperscript{19} In 1909, Congress enacted the Smoking Opium Exclusion Act, which prohibited the importation, possession and use of “smoking opium.”\textsuperscript{20} However, this Act allowed for doctors to continue

\textsuperscript{14} Andrew Rosenblum, Lisa A. Marsch, Herman Joseph & Russell K. Portenoy, Opioids and the Treatment of Chronic Pain: Controversies, Current Status, and Future Directions, NATIONAL CENTER FOR BIOTECHNOLOGY INFORMATION, July 16, 2009, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2711509/; CENTERS FOR DISEASE CONTROL AND PREVENTION, Supra note 5.
\textsuperscript{15} Roseblum Et Al., supra note 14.
\textsuperscript{16} Id.
\textsuperscript{18} Id.
\textsuperscript{19} Id.
prescribing opium-based medications.21 Only five years later, the Harrison Narcotics Tax Act was passed, which imposed a special tax on all persons who produce, import, distribute, or give away opium or coca leaves or their derivatives.22 This act essentially made opioids illegal for recreational users, as the standards for the tax were unattainable.23 The law was later reaffirmed by the United States Supreme Court.24

By the 1920s, physicians were cognizant of the highly addictive nature of these drugs and began to avoid using them to treat patients.25 In 1924, Congress passed the Heroin Act, which prohibited the importation, manufacture, and possession of heroin, even for medicinal use.26

By the 1970s, President Gerald Ford was compelled to acknowledge the rising rates of opioid use.27 President Ford established a task force to study the issue in 1975; he urged Congress to impose mandatory minimum sentences for drug traffickers and to impose harsher controls on opioid use.28 In the mid-to-late 1970s, Percocet and Vicodin, two of the most used prescription opioids in history, came onto the market.29 However, doctors had long been urged to avoid issuing highly addicting opioids to patients and therefore avoided distributing prescriptions for these drugs.30 It was commonly known by medical professionals that the use of opioid therapy to treat long-term pain was controversial because of the risk of addiction and increased disability and lack of value over time.31

22 Harrison Anti-Narcotics Act, ch. 1, 38 Stat. 785 (1914).
23 See generally THE NATIONAL ALLIANCE OF ADVOCATES FOR BUPRENORPHINE TREATMENT, supra note 21 (imposing high taxes on all parties involved in manufacturing, importing, exporting, and distributing opium or cocaine, only exempting physicians prescribing these drugs).
24 See Webb et al. v. United States, 39 S.Ct. 217 (1919); see also United States v. Doremus, 39 S.Ct. 214 (1919).
25 Moghe, supra note 17.
26 THE NATIONAL ALLIANCE OF ADVOCATES FOR BUPRENORPHINE TREATMENT, supra note 21.
27 Moghe, supra note 17.
29 Moghe, supra note 17.
30 Id.
31 Roseblum Et Al., supra note 14.
The national attitude towards the risk of opioid addiction changed upon the release of two studies in the 1980s. In an eleven-line letter printed in the New England Journal of Medicine in 1980, Jane Porter and Dr. Hershel Jick published the results of a study wherein 11,882 patients were treated with at least one narcotic preparation. The study showed that of those 11,882 patients studied, there were only four cases of addiction found in patients with no history of addiction. Jane Porter and Dr. Hershel Jick concluded that "despite the widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction." 

Six years later, Dr. Russell Portenoy and Katherine Foley published a study wherein they reviewed the use of long-term opioid therapy in thirty-eight cancer patients with chronic pain. Out of the thirty-eight patients who were monitored, only two became addicted to the opioids. The study announced that "opioid maintenance therapy can be a safe, salutary and more humane alternative to the options of surgery or no treatment in those patients with intractable non-malignant pain and no history of drug abuse." 

It was not until several years after the findings were published, in the early 1990s, that the Portenoy and Jick publications began to receive any major attention. Drug companies began to

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32 Moghe, supra note 17.
33 Id. (citing to Jane Porter & Dr. Hershel Jick, Addiction Rare in Patients Treated with Narcotics, 302 NEW ENG. J. MED. 123, (1980)).
34 Jane Porter & Dr. Hershel Jick, Addiction Rare in Patients Treated with Narcotics, 302 NEW ENG. J. MED. 123, (1980).
35 Id.
37 Id.
use the letters as a sort of advertisement for new opioids that were being released on the pharmaceutical market.\textsuperscript{40} In 1996, Purdue Pharma release OxyContin, an extended-release version of the opioid oxycodone, and used the Portenoy and Jick publications to promote the new drug.\textsuperscript{41} In a recent interview, Jick noted that drug companies, such as Purdue Pharma, used his publication to assert the idea that OxyContin was not addictive, but he has made clear "[t]hat’s not in any shape or form what we suggested in our letter."\textsuperscript{42}

Beginning in the early 1990s, the number of painkiller prescriptions that were filled in pharmacies in the United States rose by two or three million each year.\textsuperscript{43} From 1995 to 1996, because of the drastic increase in favorable marketing, the number of painkiller prescriptions grew by eight million in just one year.\textsuperscript{44} In 1998, Purdue Pharma released a promotional video that followed the lives of six chronic pain sufferers who were being treated with OxyContin.\textsuperscript{45} The video featured doctors praising the drug, noting how these patients were able to go on with their regular lifestyles and how there was little to no side effect of the use of the opioid medication.\textsuperscript{46} Purdue Pharma distributed 15,000 copies of the video, which were to be played in physicians’ offices and distributed to patients.\textsuperscript{47} Just one year after the video was released, the overall number of opioid prescriptions in the United States increased by eleven million.\textsuperscript{48}

In 2001, the Joint Commission, a nonprofit organization that sets medical standards and accredits both hospitals and medical centers, announced a new standard that required pain to be

\textsuperscript{40} Id.
\textsuperscript{41} Id.
\textsuperscript{42} Id.
\textsuperscript{43} Id. Moghe, supra note 17.
\textsuperscript{44} Id.
\textsuperscript{45} Id.
\textsuperscript{46} Id.
\textsuperscript{47} Id.
\textsuperscript{48} Id.
assessed in all patients. With the announcement of this new standard, doctors were required to assess their patients' pain levels during every appointment. The standard does not make any sort of reference to opioids as a treatment option; however, the Joint Commission produced books for doctors to be purchased as part of required continued education seminars. These books stated that there was no evidence that addiction poses a significant risk when opioids are prescribed to patients for pain control. Though printed and distributed by the Joint Commission, the book was sponsored by Purdue Pharma. The Joint Commission ultimately eradicated its standard requiring the pain evaluation in all patients in 2009.

As emergency room admissions for abuse of prescription opioids and opioid overdose deaths began to rise, the public started to recognize that these drugs did in fact have a very addictive nature. In 2007, Purdue Pharma and three of its corporate officers were charged with misbranding OxyContin with intent to defraud or mislead consumers into believing that this drug was not addictive. The three executives pleaded guilty to the charges, and the company settled with the U. S. government for $635 million.

In response to the condemnation, Purdue Pharma released a newly formulated version of OxyContin, marketed as “abuse deterrent” with the hope of making it more difficult to crush and abuse by either injecting or snorting it. After the change in OxyContin’s formula, a study

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50 Id.
51 Id.
52 Id.
53 Id.
54 Id.
55 Roseblum Et Al., supra note 14.
56 United States v. The Purdue Frederick Co., Inc. et al., 495 F. Supp. 2d 569 (W.D. Va. 2007) (charging defendants for marketing and promoting OxyContin as less addictive, less subject to abuse and diversion, and less likely to cause tolerance or withdrawal symptoms).
57 Moghe, supra note 17.
58 Id.
published in the New England Journal of Medicine, that surveyed approximately 2,500 patients with opioid dependence, found that the selection of OxyContin as a primary choice of drug to abuse decreased from 35.6% to 12.8% in just twenty-one months.\textsuperscript{59} However, 24% of those surveyed still found a way to overcome the tamper-resistant characteristics.\textsuperscript{60} The study noted that because of the change in the drug’s formulation, 66% of those surveyed indicated that they switched to another opioid, with heroin as the most opted-for substitute.\textsuperscript{61} Though the abuse-deterrent formula successfully reduced abuse of the specific drug, the new construction produced an unanticipated outcome: replacement of the newly-formulated OxyContin with alternative medications and heroin, which poses a much greater risk to public health than OxyContin.\textsuperscript{62} Heroin, no matter how it is used, poses an extremely high risk of physical and psychological dependence as well as an exceedingly high risk of overdose and even death.\textsuperscript{63}

Recently, there has been a trend of drug-users switching from prescription opioids to heroin, a trend that has been particularly prevalent in the younger, less affluent groups of drug users.\textsuperscript{64} This is because heroin is generally cheaper and somewhat easier to obtain – in certain communities – than prescription opioids.\textsuperscript{65} Furthermore, as prescription opioid use has increased, there has been an emergence of chemical tolerance to prescription opioids, causing people to seek the effects of opioids elsewhere.\textsuperscript{66}

\begin{thebibliography}{9}
\bibitem{id} Id.
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There has also been a recent rising of the use of the drug fentanyl.\textsuperscript{67} Fentanyl is a synthetic opioid that is fifty to one hundred times more potent than morphine, and twenty-five to fifty times more potent than heroin.\textsuperscript{68} Fentanyl is often mixed with heroin or cocaine, without the buyer’s knowledge, because it is cheaper than either of them, and much stronger.\textsuperscript{69} There is no difference in the way that fentanyl works on the brain from any other opioids – it is only much more potent, therefore working much quicker than other opioids.\textsuperscript{70} Fentanyl is so potent that accidental overdoses from non-users are possible.\textsuperscript{71} Sources are unable to distinguish how many people die of fentanyl overdoses every year, since the drug is almost always mixed with another drug.\textsuperscript{72} Usage of fentanyl has been sharply rising, though long-term use by users seems unlikely, as the margin for error is so small.\textsuperscript{73}

Between 1999 and 2015, more than 560,000 Americans died due to drug overdoses.\textsuperscript{74} Since 1999, the amount of opioid overdoses has quadrupled.\textsuperscript{75} In that same period, the number of prescriptions written for opioids has quadrupled as well.\textsuperscript{76} In 2015, almost two-thirds of drug overdoses were linked to opioids like OxyContin, Percocet, heroin, and fentanyl.\textsuperscript{77} That year, the amount of opioids prescribed in the United States alone was enough for every American to be

\textsuperscript{68} Id.
\textsuperscript{69} Id.
\textsuperscript{70} Id.
\textsuperscript{71} Id.
\textsuperscript{72} Kevin Sullivan, \textit{A 10-Year-Old’s Overdose Death Reveals Miami Neighborhood’s Intense Struggle with Opioids}, THE WASHINGTON POST (July 20, 2017), https://www.washingtonpost.com/national/a-10-year-olds-overdose-death-reveals-miami-neighborhoods-intense-struggle-with-opioids/2017/07/20/0618e49a-6cee-11e7-96ab-5f38140b38cc_story.html?utm_term=.4d7b5e6ad717 (telling the story of a ten-year-old boy who died of an opioid overdose after going swimming in a neighborhood pool and then walking home, immediately falling ill and fatally overdosing from a combination of heroin and fentanyl).
\textsuperscript{73} Walton, \textit{supra} note 67.
\textsuperscript{75} Id.
\textsuperscript{76} Id.
\textsuperscript{77} Id.
constantly medicated for three weeks.78 There were over twenty-two thousand deaths caused by prescription opioids, equivalent to sixty-two deaths per day.79 That number has now risen, as there is an estimated ninety deaths per day due to opioid overdose.80

Recently, attorneys general have taken action against pharmaceutical companies who allegedly mislead physicians and patients by underplaying the addictiveness of opioid painkillers.81 Several states that have been hit hard by opioid abuse have brought suit against leading drug makers.82 Attorneys general from Pennsylvania, Illinois, Colorado, Texas, Tennessee, Massachusetts, and others are participating in an investigation that began in June that is probing into how major pharmaceutical companies might have contributed to the country’s opioid epidemic.83

Recognizing the increasingly pressing need for national reform, President Donald Trump vowed to make the opioid crisis a top priority in August 2017.84 Though President Trump was originally expected to declare the crisis a national emergency, President Trump declared it a public health emergency on October 26, 2017.85 This declaration of a public health emergency, on its own, does not release any additional funds to be used to combat the opioid crisis.86 President Trump has the power to request federal funding to be directed towards the opioid crisis, but has yet to make such a demand.87

78 Id.  
79 CENTERS FOR DISEASE CONTROL AND PREVENTION, supra note 5.  
80 Hirschfield Davis, supra note 2.  
83 Id.  
85 Hirschfield Davis, supra note 2.  
86 Id.  
87 Id.
In October 2017, President Trump announced his plan to invoke “really tough, really big, really great advertising” which would be directed at motivating Americans to not start using opioids in the first place. The President believes that if young Americans can be reached before they feel any desire or pressure to take opioids, then it will be easier for them to never take opioids. The President’s plan to combat opioid abuse will also allegedly include a mandate that federally employed prescribers be educated in safe practices for opioid treatment, a federal initiative to develop non-addictive painkillers, and increased efforts to prevent shipments of fentanyl (an inexpensive and extremely strong synthetic opioid produced in China) from coming into the United States.

The President’s action in declaring the opioid crisis a public health emergency has been criticized by many for not being drastic enough. In March 2017, President Trump put together an opioid commission with the sole purpose of counteracting the opioid crisis. Led by New Jersey Governor Chris Christie, the Opioid and Drug Abuse Commission recommended that President Trump declare a national emergency so that there would be a substantial commitment of federal funds and a clear strategy to combat the way the country treats opioid addiction. However, President Trump chose to forgo this recommendation. Though President Trump has vowed to direct federal funds towards the opioid crisis soon, there has yet to be any indication of that assurance.

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88 President Donald Trump, Address to the Department of Health and Human Services (Oct. 26, 2017); Hirschfield Davis, supra note 2.
89 President Donald Trump, Address to the Department of Health and Human Services (Oct. 26, 2017).
90 Hirschfield Davis, supra note 2.
91 Id.
92 Id.
93 Id.
94 Id.
95 Id.
The opioid crisis is only getting worse. To tackle this unyielding issue, there needs to be stricter guidelines regulating the prescription of opioids and more education about the deadly side effects of these drugs; American lives depend on it.

B. New Jersey’s Battle with Opioids

Though New Jersey is not one of the states that is most devastated by this opioid epidemic, it is on the forefront of reform, led by Governor Chris Christie, chair of the President Trump’s Opioid and Drug Abuse Commission. New Jersey is ranked forty-fifth in the nation in terms of the number of opioid prescriptions written. However, New Jersey is third in the nation for the number of opioid overdoses, primarily attributable to accessible heroin. In 2015, there were 1,587 drug overdose deaths, a figure which rose by twenty-one percent in just one year. That number is over four times the amount of murders and more than three times the number of people killed in car accidents in New Jersey that year. Deaths specifically linked to heroin rose significantly to 918 deaths in 2015, the highest number since official records started being kept in New Jersey.

It is estimated that in 2015, between 2,090 and 2,250 deaths were caused by drug overdose in New Jersey. Heroin was likely involved in over 1,200 deaths. Fentanyl, which caused overdoses in just forty-six New Jersey residents in 2013, is thought to have killed more

97 Id.
98 Id.
100 LEXISNEXIS, supra note 89.
102 Id.
than 800 in 2016. The total lives that drugs, primarily opioids, claimed in 2016 was greater than the population of more than sixty New Jersey towns. New Jersey faced a statistically significant increase in drug overdose death rate from 2014 to 2015. From 2014 to 2015, the number of drug overdose deaths increased by 16.4%, one of the largest increases in the country.

Fentanyl is an increasingly lethal issue for citizens of New Jersey. The synthetic opioid can be up to fifty-times as powerful as heroin, and it is often unknowingly used as a lacing agent. Overdoses caused by Fentanyl can be hard to reverse with the administration of the overdose antidote Narcan. Furthermore, Fentanyl is difficult to detect, as its potency makes it easier to transport in smaller batches, making it more difficult for law enforcement to intercept. Its potency also presents an issue for K-9 units, as just sniffing the drug can cause a dog to overdose. Though heroin remains at the forefront of the opioid crisis, Fentanyl deaths have risen by eighteen thousand percent since 2013, which demonstrates how quickly and drastically the drug crisis can and is evolving.

As his time as the Governor of New Jersey came to an end, Chris Christie has dedicated the remainder of his term to combating the opioid crisis. The Christie Administration launched a “one-stop” website as well as a hotline to make it easier for those who need assistance to access treatment. The website and hotline will identify locations of rehabilitation

103 Id.
104 Id.
105 CENTERS FOR DISEASE CONTROL AND PREVENTION, supra note 5.
106 Id.
107 Stirling, supra note 94.
108 Id.
109 Id.
110 Id.
111 Id.
113 Id.
facilities, provide insurance guidance, and generally increase public awareness regarding the
disease and treatment options.\textsuperscript{114} New Jersey increased funding for treatment by $127 million in
2017; Christie proposed similar funding for the upcoming year.\textsuperscript{115} Former Governor Christie
pledged an additional twelve million dollars for additional treatment beds, particularly for the
population under the age of eighteen.\textsuperscript{116} Christie also proposed the development of new
curriculum regarding opioids to be taught in every school, beginning in kindergarten.\textsuperscript{117}
Additionally, he increased funding for college housing programs for students in recovery.\textsuperscript{118}

\textbf{PART III: ANALYSIS}

As part of former Governor Christie’s plan to combat New Jersey’s raging opioid
epidemic, he worked with the state’s legislature to update the state’s Dangerous Substances and
Control Law.\textsuperscript{119} On May 16, 2017, the New Jersey State Legislature enacted N.J.S.A. § 24:21-
15.2, which focuses on the control of the prescription of opioids and other dangerous
substances.\textsuperscript{120} The statute demands that before a physician can issue an initial prescription of a
Schedule II controlled dangerous substance – substances that have a high potential for abuse –
the physician must: (1) document a thorough medical history; (2) conduct and document the
results of a physical examination; (3) develop a treatment plan; (4) access relevant prescription

\textsuperscript{114} Id.
\textsuperscript{115} Id.
\textsuperscript{116} Id.
\textsuperscript{117} Id.
\textsuperscript{118} Governor Chris Christie, State of the State Address (Jan. 10, 2017).
\textsuperscript{119} New Jersey Attorney General, Division of Consumer Affairs Unveil Online Information Hub to Help Health Care
\textsuperscript{120} Id.
monitoring information; and (5) limit the supply of any opioid drug that is prescribed.\textsuperscript{121} Physicians are required to discuss the risks associated with the drugs being prescribed, namely the risks of addiction and overdose that are associated with opioid drugs, as well as the reasons why the prescription is necessary and alternative treatments that are available.\textsuperscript{122} A practitioner may not issue an initial prescription for any opioids that exceeds a five-day supply.\textsuperscript{123} If the patient requires another opioid painkillers prescription, he or she must wait four days after the initial prescription was issued to have an in-person consultation with the prescribing practitioner, who may then issue a subsequent prescription.\textsuperscript{124} If a patient requires a third prescription for the opioid drug, the practitioner must enter into a pain management agreement with said patient.\textsuperscript{125} This statute does not apply to prescriptions to patients who are currently in active treatment for cancer, patients who are in hospice or palliative care, or patients who are residents of long term care facilities.\textsuperscript{126} There are no other exceptions to this new law.\textsuperscript{127} The statute goes on to consider further matters, including changes to the way insurance companies admit addicts with the goal of expanding admittance and treatment of addicts.\textsuperscript{128}

The aforementioned law came as a result of a challenge made to the New Jersey state legislature by former Governor Christie; he tasked the legislature to come up with a bill tackling the opioid crisis within thirty days.\textsuperscript{129} The legislature answered Christie’s challenge, only missing the deadline by several days because of a snow storm.\textsuperscript{130} The Senate passed the bill with

\textsuperscript{122} Id.
\textsuperscript{123} Id.
\textsuperscript{124} Id.
\textsuperscript{125} Id.
\textsuperscript{126} Id.
\textsuperscript{127} Id.
\textsuperscript{129} Livio, supra note 9.
\textsuperscript{130} Id.
a vote of 64-1 (with five abstentions). Christie boasts that this immediate response further reiterates how important this issue is to citizens, and notably families, across New Jersey.

However, not everyone had the same reaction to this new piece of legislation. The new restrictions imposed by this statute has proven to be somewhat controversial, particularly within the New Jersey medical community. Though the Medical Society of New Jersey, a physician lobbying group, expressed their admiration and appreciation for former Governor Christie's focus on addiction, representatives from the society condemn the five-day restriction on initial opioid prescriptions.

The statute targets those patients who are experiencing acute pain. The law does not take into account that these patients are typically recovering from some sort of procedure or surgery wherein serious pain is an expected side effect. As Dr. Lewis Wetstein, a thoracic surgeon from Freehold, New Jersey speaking on behalf of the American College of Surgeons, remarked, "I produce pain - I break their ribs, I split their sternum. They are cured, but are miserable post-op. I don't see them until ten to fourteen days when I take out their sutures. To limit this (pain medication) to five days is unfortunate." Patients go into medical procedures and surgeries knowing that they will have to spend time dedicated to recovery, but will not be prepared for the pain that they will have to endure post-op. The medication limits will ultimately decrease the quality of life and care for patients who truly need these painkillers.

131 Id.
132 Id.
133 See Mishael Azam, Response, MSNJ Response to Governor Christie's State of the State Address, MEDICAL SOCIETY OF NEW JERSEY (Jan. 11, 2017).
134 Id.
Since the prescriptions in question are legal, it is unfair to the patients who need and use the medication legitimately.\textsuperscript{137}

New restrictions across states, such as the New Jersey statute at issue, makes physicians reluctant to prescribe any opioid painkillers at all.\textsuperscript{138} More than half of physicians throughout the United States have curtailed opioid prescriptions; furthermore, nearly one out of every ten have stopped prescribing opioids altogether.\textsuperscript{139} Doctors are fearful of the liability that comes from prescribing this type of medicine. Though physicians have drastically cut back on the number of opioid painkillers they prescribe, there is no evidence of any decrease in acute pain that Americans experience.

The New Jersey statute may have inadvertent and undesirable effects on physicians and other patients throughout the state. Since doctors can no longer write extended initial prescriptions, physicians' offices will be flooded with patients who need to see their prescribing doctor for renewal of their opioid painkiller.\textsuperscript{140} The New Jersey statute forces patients to come back to their prescribing physicians' office for additional consultation that were unnecessary prior to the passage of this legislation.\textsuperscript{141} These additionally required visits will cause an adverse ripple effect visible throughout the entirety of the medical community. Doctors in New Jersey may not be equipped to handle all of these newly required visits. Overwhelmed by the immense increase in patient visits, doctors may become more reluctant to prescribe opioids in the first place, knowing the kind of commitment that they must make to the patient when they issue that

\textsuperscript{137} Id.
\textsuperscript{139} Id.
\textsuperscript{140} See Livio, \textit{State Panels Approve 5-Day Limit on Painkiller Prescriptions}, supra note 128.
\textsuperscript{141} N.J. STAT. ANN. § 24:21-15.2 (West 2017).
initial prescription. Moreover, overcrowding in doctors’ offices may impose additional burdens on other patients trying to schedule an appointment.

In addition to the potential inconveniences imposed on other patients, those patients with opioid prescriptions will be unduly burdened by these required additional visits. Many patients will have difficulty getting back to the office for a follow-up consultation. Elderly patients may have issues with mobility.\textsuperscript{142} Patients may have difficulty arranging transportation back to their physicians’ office. A patient may not be well enough to physically make it back into the doctor’s office.\textsuperscript{143} Potentially most problematically, a patient may run out of his or her medication over the weekend, when a majority of physicians’ offices are not open.\textsuperscript{144}

The legislation has also been criticized as a “front end” measure.\textsuperscript{145} The law only targets the prevention of initial independence.\textsuperscript{146} It has been condemned for its failure to address later intervention for addiction problems.\textsuperscript{147} Many practitioners are concerned about the “back end” that is left uncovered by this legislation, wherein the mandated treatment plans have failed, resulting in the self-treatment of chronic pain with opioids.\textsuperscript{148}

Though New Jersey’s new law is one of the strictest in the country, many other states have recently passed laws that are similar.\textsuperscript{149} As of August 2017, at least seventeen states had enacted some sort of rule designed to curb the number of painkillers that physicians can prescribe.\textsuperscript{150} The majority of these states’ laws limit the duration of initial opioid prescriptions to

\textsuperscript{142} See Livio, \textit{State Panels Approve 5-Day Limit on Painkiller Prescriptions}, supra note 128.
\textsuperscript{143} Id.
\textsuperscript{144} Id.
\textsuperscript{145} LEXISNEXIS, supra note 89.
\textsuperscript{146} Id.
\textsuperscript{147} Id.
\textsuperscript{148} Id.
\textsuperscript{149} Zezima, supra note 8.
\textsuperscript{150} Id.
five or seven days. Some of these states enacted dosage limits, rather than durational limits. The only state that passed legislation with durational limits stricter than that of New Jersey is Kentucky, which has the third highest death rate due to drug overdose in the country. As per the Centers for Disease Control and Prevention’s recommendation, Kentucky restricts initial opioid prescriptions to only three days. Most of these state restrictions were implemented within the past year; therefore information regarding whether or not these laws are efficacious in reducing addiction and opioid-related deaths is generally not available yet.

In accordance with state trends, United States Senators John McCain (R-AZ) and Kristen Gillibrand (D-NY) proposed a bill, known as the “Opioid Addiction Prevention Act of 2017, in April 2017 which limits the supply of an initial opioid prescription for acute pain to seven days. Under current federal law, a medical professional must receive a license from the Drug Enforcement Agency (DEA) so that they will be allowed to prescribe a controlled substance. This license must be renewed every three years. The bill would require medical professionals, as a step in their DEA registration, to certify that they will not issue an opioid prescription for the initial treatment of acute pain in volume that exceeds a seven-day supply. As consistent with the New Jersey legislation, the seven-day limit would not apply to cancer patients or those in hospice or palliative care. Though this bill has not yet moved forward in its ratification

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151 Id.
152 Id.
153 Id.; CENTERS FOR DISEASE CONTROL AND PREVENTION, supra note 5.
154 CENTERS FOR DISEASE CONTROL AND PREVENTION, supra note 5.
155 Zezima, supra note 8.
157 Id.
158 Id.
159 Id.
160 Id.
process, it serves as further proof that New Jersey’s five-day limitation on initial opioid prescriptions is overly harsh and restrictive.\textsuperscript{161}

Even pharmaceutical giants have taken note of these new state laws.\textsuperscript{162} In September 2017, CVS Pharmacy announced that it would limit opioid prescriptions to a seven-day supply for certain conditions.\textsuperscript{163} CVS will be the first national retail chain to restrict the amount of painkillers that doctors can give to patients.\textsuperscript{164} Additionally, when pharmacists fill prescriptions for opioid painkillers, they will be required to talk to the patients about the risk of addiction, how to securely store medications in the home, and how to properly dispose of them.\textsuperscript{165} The daily dosage limit will be determined based on the strength of the opioid.\textsuperscript{166} The pharmacists will also require the use of immediate-release formulations of opioids before any extended-release painkillers are dispensed, which has proven to lower the risk of tolerance to these highly addictive drugs.\textsuperscript{167} CVS will begin implementing its new opioids initiatives on February 1, 2018.\textsuperscript{168}

When looking at the totality of facts surrounding New Jersey’s new five-day limitation on initial opioid prescriptions, one can hardly say that this law is fair for anyone involved. Given the nature of the occasions in which opioids are prescribed as a painkiller, it is grotesquely unreasonable to patients to limit their supply of medication. Patients are prescribed these painkillers because their teeth are getting pulled out, their bones are being broken, along with

\textsuperscript{161} \textit{id.}
\textsuperscript{163} \textit{id.}
\textsuperscript{164} \textit{id.}
\textsuperscript{165} \textit{id.}
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\textsuperscript{167} \textit{id.}
extremely excruciating procedures. It is not as though patients are being prescribed these medications for painless procedures. To deprive patients of the ability to recover as comfortably as possible is outright cruel.

Furthermore, imploring patients to physically come back into their prescribing physician’s office for a follow-up consultation when they require a refill on their prescription is burdensome on the patient, the physician, and other patients of that physician. To receive the original prescription, patients must be in a great deal of pain. Mandating that these patients physically return to the office merely four days after their surgery or procedure is unreasonable. Not to mention all of the logistics that come with getting back into an office may make it impossible for some patients.

Though the New Jersey legislation is predominately an acceptable piece of legislation, it has shown to be overly restrictive in certain aspects. In accordance with the majority of state laws, proposed federal legislation, certain pharmaceutical company’s policies, and the Centers for Disease Control’s guidelines, the New Jersey statute should move extend the initial opioid prescription restrictions from a five-day limitation to a seven-day limitation. Setting such a strict five-day limit on opioid prescriptions does not leave necessary flexibility for circumstantial factors that may arise. It is cruel to patients suffering from acute pain to limit their ability to obtain legal painkillers.

However, it is still necessary for any legislation passed, whether in New Jersey, any other state, or even federal legislation, to limit initial opioid prescriptions. History demonstrates that the amount of prescriptions written for opioids directly correlates with the number of deaths from opioid overdoses. If physicians were forced to limit the amount of opioids to which public

169 See Zezima, supra note 8.; see also U.S. Senate, supra note 149; see also Shamard, supra note 155.
had access, less people would logically become addicted to opioids, therefore resulting in less deaths caused by opioid overdoses. The durational limit on opioid prescriptions is necessary to both lessen the chances that patients become addicted to the drugs and to reduce the amount of opioids in circulation.

New Jersey’s new opioid legislation is a great starting point for other states to model laws after in an effort to combat America’s opioid crisis. States should focus on the education of their citizens and their doctors about the risks of opioid painkillers, the reality of addiction to these drugs, and where to get help if someone is already facing addiction. States should increase the availability of treatment to those who are already addicted to opioids, both financially and in terms of number of beds available at treatment facilities. Lastly, state legislators should limit the duration of initial opioid prescriptions to seven days.

Seeing the need for additional resources, officials in New Jersey have recently announced additional resources to be directed at the opioid crisis. On Thursday, February 22, 2018, newly-appointed Attorney General Gurbir Grewal announced a sweeping statewide initiative to be immediately implemented to combat the opioid crisis.171 The sweeping new initiative will include a strengthened prescription monitoring program, to be funded by federal grants, and a 24-hour response team.172 These new response teams will require “local police, mental health advocates, substance abuse counselors and first responders specially trained in dealing with addicts” to be on call at all times statewide.173 New Jersey is expanding the list of prescription drugs to be included in its monitoring program, and it is now allowing access to mental health

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172 Id.
173 Id.
professionals. The comprehensive initiative also created "an inter-agency 'dashboard' that will help state officials share the monitoring data along with data on heroin and fentanyl arrests, Narcan use, overdoses and treatment information." All of these efforts are to be supervised by the newly created Office of the New Jersey Coordinator for Addiction Response and Enforcement Strategies, known as "NJ CARES", to exist within the state’s Department of Law and Public Safety.

The latest New Jersey administration, under new Governor Phil Murphy, has seen the demand for the opioid crisis to be attacked at all angles. It isn’t enough to just limit opioid prescriptions to try to stop opioid addictions before they happen; state and the federal governments need to commit to addressing existing opioid addictions. By implementing initiatives to address pre-existing opioid addictions, such as the newly effected New Jersey initiative, and methods to prevent opioid addictions from forming, such as initial opioid prescription restrictions, the country will begin to move towards rectifying its opioid addiction.

PART III: CONCLUSION

Opioid painkillers have been an accepted part of medical treatment for thousands of years. However, the use of opioids increased significantly over the last forty years, as a result of fervent marketing from pharmaceutical companies, reassuring both physicians and the general public that use of these drugs had little to no consequences. As a result of this misleading marketing, physicians began to issue more and more opioid painkiller prescriptions. As the

174 Id.
175 Id.
176 Id.
177 Roseblum Et Al., supra note 14.
178 NATIONAL PUBLIC RADIO, supra note 39.
179 Id.
availability of opioids became more widespread, addiction to opioids followed. When opioids became too expensive or too difficult to come by, addicts were forced to turn to cheaper, more available alternatives, such as heroin and fentanyl. By the early twenty-first century, America was facing a massive and widespread opioid epidemic.

This opioid crisis has been recognized by leading officials throughout the country. Recently, President Donald Trump declared a national health emergency in an effort to curb America’s addiction to opioids. This initiative was led by former New Jersey Governor Chris Christie. Towards the end of Chris Christie’s time as governor, he vowed to dedicate his term to tackling New Jersey’s opioid crisis. In efforts to curb that state’s opioid reliance, former Governor Christie has worked with the state’s legislature to pass a new statute governing the distribution of opioid painkillers. The new legislation requires physicians, amongst other things, to disclose the risks of opioids and the likelihood of addiction, to take a thorough medical history of the patient, and most controversially, to limit the length of an initial opioid prescription to just five days.

Though the new legislation is a step in the right direction, it is overly restrictive. The law will inevitably unduly burden those who are suffering from acute pain. The legislation requires though who need a subsequent prescription to return to their prescribing physician’s office for a follow-up consultation in order to receive a new prescription. The law allows for no flexibility

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183 Hirschfield Davis, supra note 2.
184 Id.
187 Id.
188 Id.
in this area, and does not take into account whether a patient might not physically be able to get
back into their doctors’ office. If a patient cannot arrange to make it back into the office within
the five-day period, or if the office is closed on the day of the would-be follow-up visit (i.e. if the
prescription runs out over the weekend), then the patient will be forced to suffer through the
pain. The mandatory follow-up appointment will also likely lead to overworked physicians
and a more difficult time scheduling appointments for other patients. Furthermore, strict
limitations, such as those imposed by this statute, will discourage physicians from wanting to
prescribe opioids at all.

Though the opioid epidemic desperately needs to be addressed, those patients suffering
from pain should not be the ones who are forced to endure the negatives arising from this law.
Other states looking to adopt similar legislation to tackle the opioid epidemic should look to New
Jersey’s for inspiration, but should stop short of implementing a five-day restriction on initial
opioid prescriptions. It would still be wise to adopt legislation with a durational limit on initial
opioid prescriptions, but a seven-day restriction should suffice. This give patients more time to
heal before having to come back into their physicians’ office, and it eliminates the possibility of
having a prescription run out on the weekend. Though it still does not completely alleviate the
patient of the responsibility of figuring out how to get back into the doctor’s office, the patient
will, at the very least, have more time to making arrangements to do so. States should look more
towards the education and treatment of addiction, ensuring that the problem of addiction is
addressed from all angles.

189 Livio, State Panels Approve 5-Day Limit on Painkiller Prescriptions, supra note 128.
190 Id.
191 Freyer, supra note 131.
Though a noble effort on behalf of the legislators in New Jersey, N.J.S.A. § 24:21-15.2 goes too far in restricting opioid prescriptions. New Jersey should continue to focus on creative solutions to reducing opioid-related deaths by implementing treatment and education programs. Through the implementation of these programs and strong legislation, it is foreseeable that the opioid crisis could soon be over, both in New Jersey and throughout the entire United States.