

Opioid as a Wicked Problem

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A wicked problem is one that seems so intractable and resistant to solutions that people either give up trying or experience so much discord and conflict that they retreat from working on it together. The term was first used in the business literature to characterize a sense of “stuckness” that trapped businesses and industry in practices that threatened their existence.¹ The term has been applied in environmental and health policy to reflect on long-term issues – climate change, smoking behavior, gun deaths, and environmental degradation – that seem immune to proposed solutions. Certainly, the issue of narcotic overuse, opioid-related overdoses, deaths, and the destruction that the overuse is causing to communities all over the country should be classified as a wicked problem.

Wicked problems require approaches that are collective, collaborative, nonjudgmental, and incremental with clear measures of progress and clear goals. They also require patience and hope. The flood of opinions, publicity, and blame about how, who, and why opioids are such a pervasive problem has the potential to take planning away from stepwise, collaborative approaches to one that pits positions against one another in constant adversarial arguments. One of the largest problems with the opioid crisis is that it is not a we/they problem but much more of an “us” problem, with terrible loss of life in all communities. One would think that the pervasiveness would make everyone want to join in solutions, and while we may be making some progress, it’s not enough.

We need information and thoughtful

research to begin to tackle this wicked problem. This issue of the *WMJ* brings together a number of articles written about the opioid overdose problem from a number of perspectives. Kohlbeck and colleagues² interviewed a

group of emergency department physicians, residents, and allied health personnel to learn what they know and understand about the Prescription Drug Monitoring Program before its use was mandatory, as it is now. The program was designed to avoid over prescribing of narcotics from multiple sources, and one important assessment about its use was to identify obstacles that might find it used less than it should. Kohlbeck et al found that health systems, hospitals, clinicians, and patients all posed challenges to the use of the system and provide valuable information to help implement the program successfully.²

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Chouinard, Prasad, and Brown³ carried out a survey of medical students and practicing family physicians to find out knowledge, attitudes, and beliefs about patients and opioid use. As might be expected, students—most of whom were in their preclinical years—were more focused on problems of addiction, and the practicing physicians wanted more infor-

mation about alternatives and discontinuation of opioids. Both groups demonstrated some gaps in information and some underlying misconceptions about who would not be a high-risk patient. Their work, just like that

of Kohlbeck, should be used to design educational methods for the medical community. Rooney and colleagues⁴ used data from their hospital in LaCrosse to better understand the epidemiology of intentional and unintentional overdoses in their region. Perhaps one of the more interesting aspects of their study was the differences they found in their patient population compared to national trends: the majority of their patients were insured, there were not the rural/urban disparities to the degree that there are nationally, but their trends of sex and age did match national trends. The most interesting aspect of their study was the use of geographic mapping using census tracts to identify “hot spots” or high-risk areas in their region that might be addressed with focused community interventions rather than global ones. Coupling their approach with clinical information about people at high risk to overdose could be replicated in all regions of the country as a way of guiding resources to where they are most needed.

Faryar, Kohlbeck, and Schreiber⁵ examine the trends in alcohol and drugs found in the blood of people who died in motor vehicle accidents in Milwaukee County. They used Medical Examiner's findings from deaths from 2010 to 2016 and found that two-thirds of those who died had at least one substance in their blood and more than one substance was found in 27%. Alcohol remains the primary problem in Wisconsin, even though its use decreased in the timeframe of the study, with deaths in the state still at a higher rate than national averages. We are a binge drinking state and seemingly disregard its effects on our communities, particularly in rural communities.⁶ But the authors report a significant increase in opioids and other drugs that is worrisome since, as the campaign to decrease drunk driving succeeds, it is being replaced by drugged driving.

Prevention really has to start early, particularly as more studies report on adverse childhood events and their effects long term on children and adults. The program described by Budzak-Garza and colleagues from the Gunderson Clinic identifies newborns of mothers who have struggled with addiction issues and concentrates a number of services, community-based resources, and medical care to improve the chances for those newborns and their families.⁷ GunderKids is a proactive program that has been met with relief rather than resistance from at-risk mothers and families.

If society genuinely wants to address wicked problems like addiction rather than engage in endless handwringing about it, investments need to be made in supporting time, effort, and a workforce that will work on ideas like GunderKids. America has lost the idea of long-term investment, whether in its people or the environment but if it can begin in communities and states, perhaps there is hope for the future.

In Other News

A review of cases of heparin-induced thrombocytopenia matched with controls from a large North Dakota health system discovered a much higher than predicted link to autoimmune diseases, leaving open the importance of studying the nature of the relationship. More importantly perhaps, for clinicians, patients with autoimmune diagnoses should be alert for thrombocytopenia and perhaps monitor patients preventively.⁸

Finally, an important study from the University of Wisconsin-Eau Claire about the attitudes of directors of palliative care programs in Wisconsin found that the majority felt that giving patients oxygen at the end of their lives was not helpful.⁹ They said that the reasons that oxygen was used, despite evidence that it was not comforting and may be irritating, is for emotional support of family or staff. The lesson from this study is that all clinicians who care for patients at the end of life

and the programs in which they work should counsel both patients and families about the lack of effect of oxygen so that all are prepared better for the dying process.

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