IT'S ABOUT PAIN

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This month marks the 2nd anniversary of the updated *CDC Guidelines on Opioid Prescribing.* Dr. Friedman's prediction that its acceptance by pharmacists and insurance companies would be delayed, certainly was clairvoyant. Here's the article.

Joseph Friedman: New hope for fixing a mistake in opioid management that cost people their lives

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Overdose deaths from opioids have continued to soar even though fewer opioids have been prescribed. Because prescription opioids drove the crisis's earlier phases, the nation responded by drastically reducing access to those drugs. Prescriptions dropped by nearly 50% over the last decade.

That approach didn't work well, and it left many patients with painful medical conditions stranded. More dangerous drugs filled the gap: At least two-thirds of overdose deaths are now tied to synthetic opioids, mostly fentanyl, a powerful black market opioid. Meanwhile, physicians have had to balance the risk of criminal prosecution for prescribing opioids against their responsibility to treat patients' pain.

Yet there is promising news. Two key shifts in federal policy this year hint that the pendulum is beginning to swing back toward more access to opioids for patients who need them.

The first is opioid prescribing guidelines that the Centers for Disease Control and Prevention updated last month. They undo a controversial feature of the agency's 2016 guidance: the cap on opioids at 90 morphine milligram equivalents, or MME, per day. Although this number was never meant to serve as a hard line, law enforcement, regulators and health care providers widely interpreted it as one.

The problem is that some patients need more than that amount. Recent studies show that there is no universal standard for calculating appropriate MME, and methods to determine cutoffs vary widely. A patient who is considered "high risk" for overdose or addiction when evaluated using one method could be "undertreated" according to another.

But these arbitrary standards changed the landscape. Following the 2016 guidelines, insurance companies began to deny payment for pain management above 90 MME. Law enforcement agencies, including the Drug Enforcement Administration, cited the 90 MME limit in investigations. Doctors caught scrutiny simply for providing relief to patients in debilitating pain.

After taking higher doses for years, many patients were rapidly tapered under the limit, no matter how painful their health condition was. Some were cut off entirely, unable to find a doctor still willing to prescribe for their chronic pain.

Some health care providers inappropriately reduced opioid prescriptions even for cancer, palliative and end-of-life patients, who were supposed to be exempt from limits. Tragically, recent studies found that chronic pain patients who are rapidly tapered off opioids have high rates of suicide and overdose, as people turn to desperate measures for pain relief, including seeking illicit street opioids.

In a step forward for treatment, this year's CDC guidelines avoid emphasizing specific thresholds. Recognizing the harms of excessive tapering and limits, they instead discuss ranges of dosages appropriate for different conditions and highlight the need for doctors to use their clinical judgment for each patient.

The second major shift on opioids this year was the June Supreme Court ruling in Ruan vs. United States making it more difficult for law enforcement agencies to prosecute doctors for prescribing painkillers. The decision raises the bar for criminal convictions, requiring that prosecutors prove that physicians knowingly or intentionally prescribed opioids inappropriately, not just that their practices deviated from government-defined standards. This will help give doctors more legal cover to treat pain as they see fit.

These shifts are early signs that the tides are beginning to turn back toward more access to opioids for patients who need them. But achieving that access will not be easy.

Physician willingness to prescribe opioids is a cultural phenomenon. Doctors have reduced their level of opioid prescribing not just from fear of prosecution, but also in response to trends in the field. Seminars, institutional guidelines and professional organization statements over the last decade have instilled the idea that prescribing opioids is something to be avoided.

Prescription opioids also remain an enemy in the public consciousness. Although the drugs have been overtaken by black market fentanyl in the overdose crisis, lawsuits against opioid manufacturers continue to command a disproportionate amount of big-swing prosecutorial attention. Of course, companies that deceptively promoted opioids in unsafe ways should be held accountable. Lawsuits against them may give the false impression that prescription opioids still dominate the overdose problem.

Changing these narratives will take time. Similarly, it is not automatic that the Drug Enforcement Administration, other law enforcement, state governments or billing and insurance companies will change their protocols in line with the new CDC prescription guidance. Tangible improvements for pain patients probably will happen over years, rather than days or months.

They will also require attention to deep disparities in pain care and treatment access. My colleagues and I found in a 2019 study that opioid prescription rates in California varied by 300% based on neighborhood income and racial composition. Patients from predominantly white neighborhoods were most likely to receive opioids and other controlled substances. This reminds us that medical guidelines are not neutral and need an intentional focus on equity to be implemented fairly.

Nonetheless, advocates, physicians and researchers working toward the goal of adequate pain treatment have cause for optimism. The question now is how readily doctors, insurance companies and law enforcement will respect the wisdom of current scientific evidence and legal standards.

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