Medical News & Perspectives

Will the New CDC Opioid Prescribing Guidelines Help Correct the Course in Pain Care?

Rachel Rabkin Peachman

On November 4, the US Centers for Disease Control and Prevention (CDC) released an updated Clinical Practice Guideline for Prescribing Opioids for Pain, the first revision since the agency's controversial 2016 recommendations. The new guidelines are aimed at helping primary care physicians and other clinicians offer safe and effective treatment for adults with acute, subacute, and chronic pain, while reducing risks associated with opioids.

Multimedia

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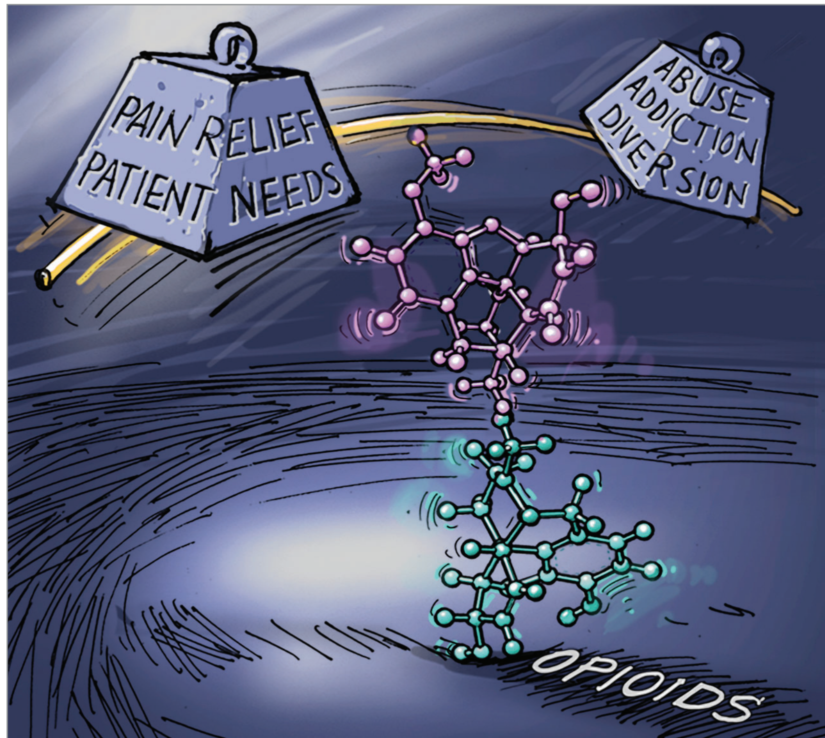
The previous guidelines were widely criticized for focusing too much attention on reducing prescribing to curb the opioid epidemic while leaving many patients with chronic pain few other avenues for care. In interviews with *JAMA*, physicians, researchers, advocates, and patients talked about the fallout from the 2016 guidelines and what effect the 2022 version may have.



Understanding the Backlash

A primary criticism of the 2016 guidelines was that they suggested upper limits for pain medication dosages and durations of use that seemed to encourage a one-size-fits-all approach to prescribing opioids. In 2019, the CDC acknowledged that those limits were widely misapplied by regulators, insurers, pharmacies, and physicians, severely limiting patients' access to medications to treat pain.

"The 2016 guidelines were not very patient focused, and whether it was intended that way or not, they were applied quite rigidly," said Francesca Beaudoin, MD, PhD, a practicing emergency physician and interim chair of epidemiology at Brown University who has expertise in opioid use disorder and pain management. She explained that the language around prescribing opioids in the previous recommendations "almost codified some of the durations of time or doses as more than a guideline," and many state laws were written "stemming directly from that 2016 policy." According to a 2020 study published in the *Journal of Pain Research*, from 2016 to 2018, 35 opioid-related policies were approved across 25 states and the District of Columbia that directly referred to or incorporated the CDC opioid prescribing guidelines, or both.

The tragic consequence was that many patients who had been taking stable doses of opioids for long-term pain management were forced to rapidly wean off their medication or were abruptly dismissed by their physicians, which frequently caused harm. Tapering of long-term opioid therapy has been associated with worsening pain, withdrawal, overdose, illicit opioid use, mental health crises, and suicides.

"We started getting tons of desperate messages from people living with pain, saying that they had been forced off their opioids or dropped from care, and some said they were going into withdrawal," said Cindy Steinberg, director of policy and advocacy for the US Pain Foundation.

Dmitriy Dvoskin, MD, an interventional pain physician at Pain Management NYC, said that in many instances, physicians who did not specialize in treating pain "didn't know what to do because they didn't want to get in trouble with the [Drug Enforcement Administration] or their medical board," which left many patients without adequate care "because the rules changed."

Even with her expertise, Beaudoin felt that the 2016 guidelines limited the strength, duration, and quantity of opioids she could prescribe. She also described how many other emergency physicians felt restricted in how they could treat pain, even for patients experiencing acute pain.

Beaudoin recalled a patient she'd seen in the emergency department for severe hand pain. The day before, he'd been treated at the hospital after a snowblower had amputated

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4 of his fingers. Before seeing him, she initially thought his pain must have intensified due to a complication with the wound. But when she looked at his chart, she saw that he'd been discharged with "three pills of oxycodone—not even one per finger," she said.

The guidelines had caused some physicians to "defy common sense logic," she said. "We knew that the pendulum needed to swing a bit because of the opioid epidemic, but it was done with blunt force when it needed the precision of a scalpel."

Shift in the New Guidelines

When presenting the 2022 CDC guidelines, the authors made clear that a main goal was to highlight the importance of individualized care.

In an email to *JAMA*, guideline coauthor Christopher M. Jones, PharmD, DrPH, MPH, acting director for the CDC's National Center for Injury Prevention and Control, wrote: "We recognize that pain comes in a variety of forms and different patients will respond to different treatments in different ways. So, it is critical that clinicians and patients have flexibility in their pain treatment decisions."

The 2022 guidelines reflect this in several ways. The main recommendations omit mention of specific upper dosage limits, offer guidance on how to work with patients to slowly and carefully taper opioid medication when appropriate, and emphasize talking with patients about opioid therapy's risks and benefits while setting realistic treatment goals. They also suggest use of nonopioid multidisciplinary therapies and urge regular reevaluation of both the patient and the treatment plan, keeping in mind each individual's pain and function. And the guidelines recommend offering treatment for patients with opioid use disorder.

Dvoskin said the 2022 guidelines are "overall, a step in the right direction" and indicate that "the CDC listened to the feedback that was provided."

Magdalena Cerdá, DrPH, professor of population health at NYU Grossman School of Medicine and director of the Center for Opioid Epidemiology and Policy at NYU Langone Health, agreed that the recommendations are an improvement over the previous ones. "The new guidelines seem to be a shift in perspective, in many ways, from the prior guidelines," she said. "There is this increasing recognition of the need to balance the treatment of pain with addressing the adverse consequences of opioids."

She's hopeful about the recommendations' potential to improve patient care going forward. She would like to see the guidelines—in coordination with the CDC, Health and Human Services (HHS), the National Institutes of Health (NIH), and state departments of health and medical boards—trickle down to the training and recommendations that physicians receive. "I think it will likely be a gradual effect," she said.

Missed Opportunities

Not everyone, however, is as optimistic. Beth Darnall, PhD, a professor of anesthesiology and pain medicine at the Stanford University School of Medicine, said the document "does not go far enough to protect patients who are already prescribed opioids."

Darnall served as a scientific member of the CDC Opioid Work Group, which was consulted during the drafting of the 2022 guidelines. She said that although the new recommendations highlight that patients are at risk of harm when forced to stop their medications abruptly or taper them too quickly, they don't address the nuances of how, when, and why a physician might begin to taper a patient's opioid medication.

"There's an implicit assumption in this document that tapering means go to zero," said Darnall, who is also director of the Stanford Pain Relief Innovations Lab. But that approach doesn't work for everyone, she said. She noted that even for patients who are engaged in nonopioid therapies, such as physical therapy, acupuncture, and cognitive behavioral therapy, these modalities may not provide sufficient pain relief, and opioids may still be needed.

Not all patients need to be tapered off opioids, she said, particularly those with chronic intractable pain.

"Even when you taper slowly, in the wrong patient, we're imposing risk for iatrogenic harm—grave harm," Darnall said, citing mounting evidence to support this. "I would have liked to have seen more language in this document that really addresses this crucial minority of patients who are very vulnerable and have just faced so much adversity in the medical system."

Darnall remarked that, in general, the new guidelines do a good job of recognizing the need for improved patient care and low-risk approaches to pain management. But, she said, they still leave "a lot of room for language to be misapplied."

Steinberg also worries that the new guidelines will be misconstrued. For example, while the recommendations no longer explicitly urge clinicians to avoid prescribing dosages higher than 90 morphine milligrams equivalents (MME), they don't completely back away from dosage limits. "In the supporting narrative in the guideline, there are repeated warnings about increasing dosages above 50 MME," she said. "Yet these dosage limits are unscientific and arbitrary." Those numbers were misapplied before, she cautioned, and could be again.

Steinberg and others mentioned an additional concern: the guidelines state that they don't apply to patients with sickle cell disease or cancer or to those who are receiving palliative or end-of-life care. "Pain is pain," Steinberg said. "It does not make sense to exclude certain conditions."

For Darnall, making distinctions about a few conditions is confusing and runs counter to an ethos of treating each patient individually. "Of course, you need to treat end-of-life pain differently based on the circumstances, but that's true for every single person in pain," she said.

Steinberg added that the CDC missed an opportunity to spotlight the HHS Pain Management Best Practices Inter-Agency Task Force Report published in 2019 in response to the backlash surrounding the previous guidelines. Steinberg served on the congressionally mandated task force, which helped to inform the development of new Centers for Medicare & Medicaid (CMS) bundled codes for multidisciplinary chronic pain treatment. The codes go into effect on January 1, 2023, and are meant to increase patient access to holistic pain therapies, Steinberg said.

Putting It Into Practice

For the past 23 years, Kristi Haight has been living with debilitating back pain caused by a series of complications originating with a sequestrated vertebral disk. The pain has upended nearly every aspect of her life, prohibiting her from working outside her home, cooking, or even going to the movies, she said in an interview with *JAMA*. After undergoing 15 surgeries, meeting with countless physicians, and trying a slew of therapies and medications, the 56-year-old, who lives in North Carolina, has found that the opioid tramadol allows her to have a semblance of normalcy in her life. "I'm never not in pain," she said. "But it's enough

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that it takes the edge off, so to speak, so that I can function somewhat."

Haight said she's been doing well with tramadol for 10 years but has suddenly found herself in-between physicians and unable to find a new one who will prescribe to her. "It's very, very scary," she said. Her most recent primary care physician quit her practice, and the doctors Haight has called to take over her care said they don't feel comfortable writing the prescription.

So far, she said, the release of the CDC's new guidelines does not seem to have swayed the physician practices she has contacted. "It hasn't affected anything," she said.

Darnall said that she still regularly hears about obstacles patients face when trying to obtain their opioid medications. She noted that not only are many physicians refusing to write prescriptions, but some pharmacies are also refusing to fill them, which is legal in many states and difficult to contest.

Marc A. Helzer, MD, a family medicine physician at University of Michigan Health-West, said the new guidelines don't lessen many of the constraints that primary care practitioners encounter when prescribing opioids, particularly for patients with chronic pain.

For example, he explained that patients taking opioids typically need frequent monitoring and follow-up appointments, along with regular treatment plan reevaluations, but many physician practices don't have the bandwidth to provide these. Furthermore, he said, the new guidelines encourage physicians to help patients access nonopioid solutions for pain, such as yoga, acupuncture, or physical therapy, while attempting to slowly taper them from their opioid medication. But these efforts require time and training that primary care physicians don't always have. "We're really not built to deal with chronic pain in an outpatient setting as family practice providers," he said.

That's partly why many primary care physicians won't accept patients with chronic pain who need opioids, and instead often refer them to overrun pain clinics, he noted.

Physicians also continue to have longstanding fears about prescribing opioids, despite the new guidelines' allowance for flexibility in treatment decisions. "We all worry about losing our licensure, and the last thing you want is the government coming in and raiding you," he said. "Usually when the government comes in, it's like you're guilty till proven innocent, and your practice is on hold."

Helzer said he wants to help his patients, but he's walking a tightrope balancing their health with the inherent risks—to them and to himself—that come with prescribing opioids.

"At the end of the day, guidelines are guidelines," said Beaudoin, and it's not yet clear how they will be used. "There are still many steps from the guidelines to implementing change in how physicians prescribe and practice patient care," she said. "[T]he CDC guidelines only take it so far." ■

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Conflict of Interest Disclosures: Dr Beaudoin reported receiving grant funding from the NIH, the CDC, Arnold Ventures, and the Institute for Clinical and Economic Review and being a member of the Board of Directors for Brown Emergency Medicine from 2017 to 2021. Dr Cerdá reported serving as an expert witness in opioid litigation for Motley Rice LLC. Dr Darnall reported being chief science advisor at AppliedVR; receiving royalties for 4 pain treatment books she has authored or coauthored; being the principal investigator for 2 pain research awards from the Patient-Centered Outcomes Research Institute, 1 of which is investigating patient-centered prescription opioid tapering, being principal investigator for 2 NIH pain treatment grants; serving on the board of directors for the American Academy of Pain Medicine and the Institute for Brain Potential; serving on the medical advisory board for the Facial Pain Association; and being a scientific member of the NIH Interagency Pain Research Coordinating Committee, a former member of the CDC Opioid Workgroup (2020-2021), and a current member of the pain advisory group of the American Psychological Association. Steinberg reported being employed by the US Pain Foundation and being policy chair for the Massachusetts Pain Initiative, a volunteer position. No other disclosures were reported.

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