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Professionals Call on the CDC to Address Misapplication of its Guideline on Opioids for Chronic Pain through Public Clarification and Impact Evaluation

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I. In 2016, the Centers for Disease Control and Prevention, CDC, issued a Guideline for Prescribing Opioids for Chronic Pain for primary care physicians. Its laudable goals were to improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy. The Guideline reflected the work of appointed experts who achieved consensus on the matter of opioid use in chronic pain.

Among its recommendations are that opioids should rarely be a first option for chronic pain, that clinicians must carefully weigh the risks and benefits of maintaining opioids in patients already on them, and that established or transferring patients should be offered the opportunity to re-evaluate their continued use at high dosages (i.e., > 90 MME, morphine milligram equivalents).

In light of evidence that prescribed dose may pose risks for adverse patient events, clinicians and patients may choose to consider dose reductions, when they can be accomplished without adverse effect, and with possible benefit, according to some trial data.

Nonetheless, it is imperative that healthcare professionals and administrators realize that the Guideline does not endorse mandated involuntary dose reduction or discontinuation, as data to support the efficacy and safety of this practice are lacking.

II. Within a year of Guideline publication, there was evidence of widespread misapplication of some of the Guideline recommendations. Notably, many doctors and regulators incorrectly believed that the CDC established a threshold of 90 MME as a de

facto daily dose limit. Soon, clinicians prescribing higher doses, pharmacists dispensing them, and patients taking them came under suspicion.

Actions that followed included payer-imposed payment barriers, pharmacy chain demands for the medical chart, or explicit taper plans as a precondition for filling prescriptions, high-stakes metrics imposed by quality agencies, and legal or professional risks for physicians, often based on invocation of the CDC's authority. Taken in combination, these actions have led many health care providers to perceive a significant category of vulnerable patients as institutional and professional liabilities to be contained or eliminated, rather than as people needing care.

III. Adverse experiences for these patients are documented predominantly in anecdotal form, but they are concerning. Patients with chronic pain, who are stable and, arguably, benefiting from long-term opioids, face draconian and often rapid involuntary dose reductions. Often, alternative pain care options are not offered, not covered by insurers, or not accessible. Others are pushed to undergo addiction treatment or invasive procedures (such as spinal injections), regardless of whether clinically appropriate.

Consequently, patients have endured not only unnecessary suffering, but some have turned to suicide or illicit substance use. Others have experienced preventable hospitalizations or medical deterioration in part because insurers, regulators and other parties have deployed the 90 MME threshold as a both a professional standard and a threshold for professional suspicion. Under such pressure, care decisions are not always based on the best interests of the patient.

lV. Action is Required: The 2016 Guideline specifically states, "the CDC is committed to evaluating the guideline to identify the impact of the recommendations on clinician and patient outcomes, both intended and unintended, and revising the recommendations in future updates when warranted". The CDC has a moral imperative to uphold its avowed goals and to protect patients.

Therefore, we call upon the CDC to take action:

- We urge the CDC to follow through with its commitment to evaluate the impact by consulting directly with a wide range of patients and caregivers, and by engaging epidemiologic experts to investigate reported suicides, increases in illicit opioid use and, to the extent possible, expressions of suicidal ideation following involuntary opioid taper or discontinuation.

- We urge the CDC to issue a bold clarification about the 2016 Guideline – what it says and what it does not say, particularly on the matters of opioid taper and discontinuation.

Signatories here represent their own views, and do not purport to reflect formal positions of their employing agencies, governmental or otherwise. *For questions please*

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