What the Opioid Crisis Took From People in Pain

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Credit...Walter Zerla, via Getty Images

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Doctors didn't think Brent Slone would survive his gruesome 2011 car crash. His car flipped after he swerved to avoid a stalled vehicle. His spinal cord was compressed. He broke several ribs, a shoulder and a knee. One lung collapsed. A shattered pelvic bone ruptured his bladder and seriously damaged his spleen, kidney and colon.

Miraculously, Mr. Slone avoided brain injury. However, he was paralyzed from the waist down. After months of painful physical rehabilitation, he went home to his wife, Sonya Slone, and their 6-year-old daughter. When he had appropriate pain care, Mrs. Slone said, he was able to be a loving and involved father.

But in 2017, the clinic he attended cut his pain medications by more than half overnight. He tried to remedy the prescription by calling and even showing up in his wheelchair. Still, he was told he wouldn't receive any refills until an appointment six days away. In agony, he texted Sonya: "they denied script im done love you." He died by suicide in a local park.

Mr. Slone is just one of many thousands who have been harmed by ongoing reductions in opioid prescriptions, which are used for chronic pain by an estimated five million to eight million Americans. These cuts by doctors and pain clinics, intended to fight overdose and addiction, have hurt patients. But Mr. Slone's story is unique in an

important way: the Slone family won a nearly $7 million malpractice judgment against his doctors and the clinic. “Had his pain physicians treated Brent with the care and compassion he deserved, he would still be here,” she said. This is believed to be the first such victory in a malpractice case related to opioid cutbacks.

Image

Brent Slone in 2017 at the La Jolla Cove Rehabilitation center.Credit...Sonya Slone

Though even some doctors are confused on this issue, addiction and physical dependence are not the same thing. Addiction, according to the National Institute on Drug Abuse, is compulsive drug seeking and use that occurs despite negative consequences. But pain patients like Mr. Slone are not considered addicted when medication improves their quality of life and the risks of side effects like withdrawal are outweighed by the relief medication offers.

For people with chronic pain, research is only beginning to show how widespread the damage from opioid prescription cuts is. One study examined the medical records of nearly 15,000 Medicaid patients in Oregon who were taking long-term, high doses of opioids. Those whose medications were stopped were three and a half to four and a half times as likely to die by suicide compared to those whose doses were stable or increased. Another study, which included the medical records of over 100,000 people, found that drastically reducing a patient's opioid dosage increased the risk of overdose by 28 percent and increased the risk of mental health crisis requiring hospitalization by 78 percent.

Many opioid prescribing cuts were made under the auspices of guidelines published by the Centers for Disease Control and Prevention in 2016 to fight the overdose crisis. These guidelines recommend avoiding opioid prescriptions if at all possible and, when prescribing them for chronic pain, generally keeping the dosage below 90 morphine milligram equivalents, or M.M.E., per day — a measure calculated by comparing other opioids to the strength of morphine. Lawyers for Mr. Slone's doctors argued in court that the agency's guidelines justified their clients' actions because his dosage was far higher than that.

The C.D.C. is now updating those recommendations, admitting that the result has too often been unsafe changes in care. The agency opened a comment period for the newly revised guidelines in February, and the public has through April 11 to respond. The final version must be recalibrated to stop tragedies like what happened to Mr. Slone.

The original guidelines were intended mainly for primary care providers, and the idea behind the recommendations was to stop communities from being flooded with painkillers. However, the guidance has been misapplied as a mandate, and all types of doctors, including pain specialists, have reduced or eliminated prescriptions.

By 2019, the authors of the original guidelines warned in The New England Journal of Medicine that they were being misused, saying, "Unfortunately, some policies and practices purportedly derived from the guideline have in fact been inconsistent with, and often go beyond, its recommendations." That year, the Food and Drug Administration cautioned that it had "received reports of serious harm," including suicides, associated with patients who suddenly had their medication discontinued or abruptly reduced.

But by then, states had passed legislation giving some of the recommendations the force of law. The National Committee for Quality Assurance, which provides standards for insurers, government agencies and medical organizations, made keeping doses within

the guidelines into a metric — incentivizing doctors to taper or stop seeing high-dose patients. Insurers, pharmacy chains and government agencies also use the guidelines to inform restrictions, and law enforcement uses them when prosecuting physicians for running "pill mills."

If these policies had reduced the death toll, some might argue that they are warranted. But they have not. Measured by the number of prescriptions written per capita, medical opioid use rates in 2020 were down to levels last seen in 1993, before OxyContin marketing helped spark the crisis. However, overdose deaths are still increasing dramatically, driven by illegally manufactured synthetic opioids and many who formerly got pharmaceuticals from doctors and now resort to dealers.

Even people the C.D.C. exempted from the guidelines seem to have been hurt. A 2022 study found that opioid use among patients with cancer fell between 2013 and 2018, with the steepest decline occurring after the guidelines were introduced.

"We normally don't mandate or incentivize actions in health care where lots of papers say it could do harm and a few say it might be helpful," said Stefan Kertesz, a professor of medicine and public health at the University of Alabama at Birmingham. "And we certainly wouldn't mandate that those actions be done on a patient who has not consented."

To ensure that people in pain stop becoming collateral damage in the drug war, the C.D.C. and other policymakers must change course. The revisions posted for comment make some critical concessions. Importantly, they eliminate the 90 M.M.E. per day recommended dosage cap. This is crucial not only because some people need much higher dosages but also because the method of calculating it is imprecise.

The authors of the revisions also warn against the misuse of the guidelines by groups such as health systems and lawmakers, stressing that they "should not be applied as inflexible standards of care." They emphasize individualized treatment, writing that these recommendations are meant "to support, not supplant, clinical judgment." Finally, they strongly advise against rapid dose cuts like the one that led to Mr. Slone's death.

But these changes may not be enough. While the guidelines explicitly reject dosage caps, they continue to warn doctors to be wary of dosing over 50 M.M.E. per day, which could still be misread as a rule. Moreover, these revisions by themselves can't undo all the laws, metrics and regulations that codified the old guidelines.

If policymakers really want to prevent suicides like Mr. Slone's as well as overdose deaths, addiction and pain must be treated with compassion and science, and the assumption that we can solve either problem merely by slashing the medical supply must end.