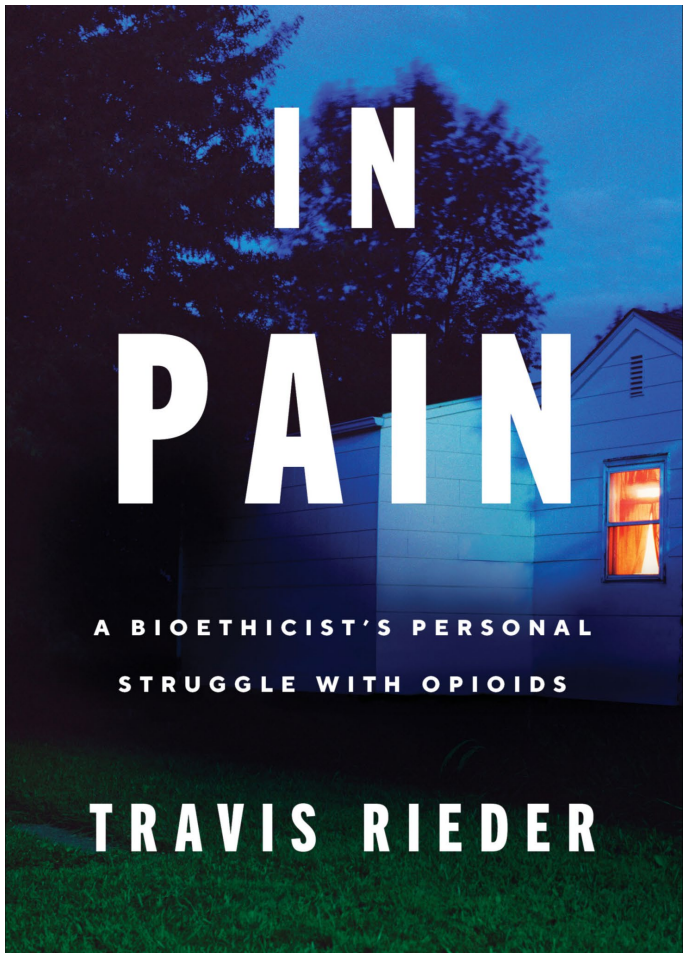

EASTERN PAIN ASSOCIATION
Half & Half Mid-Year Meeting
June 11, 2022

Travis N. Rieder, PhD
Berman Institute of Bioethics
Johns Hopkins University
trieder@jhu.edu
@TNREthx

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PART I:
A PERSONAL CASE STUDY

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MAY 23, 2015

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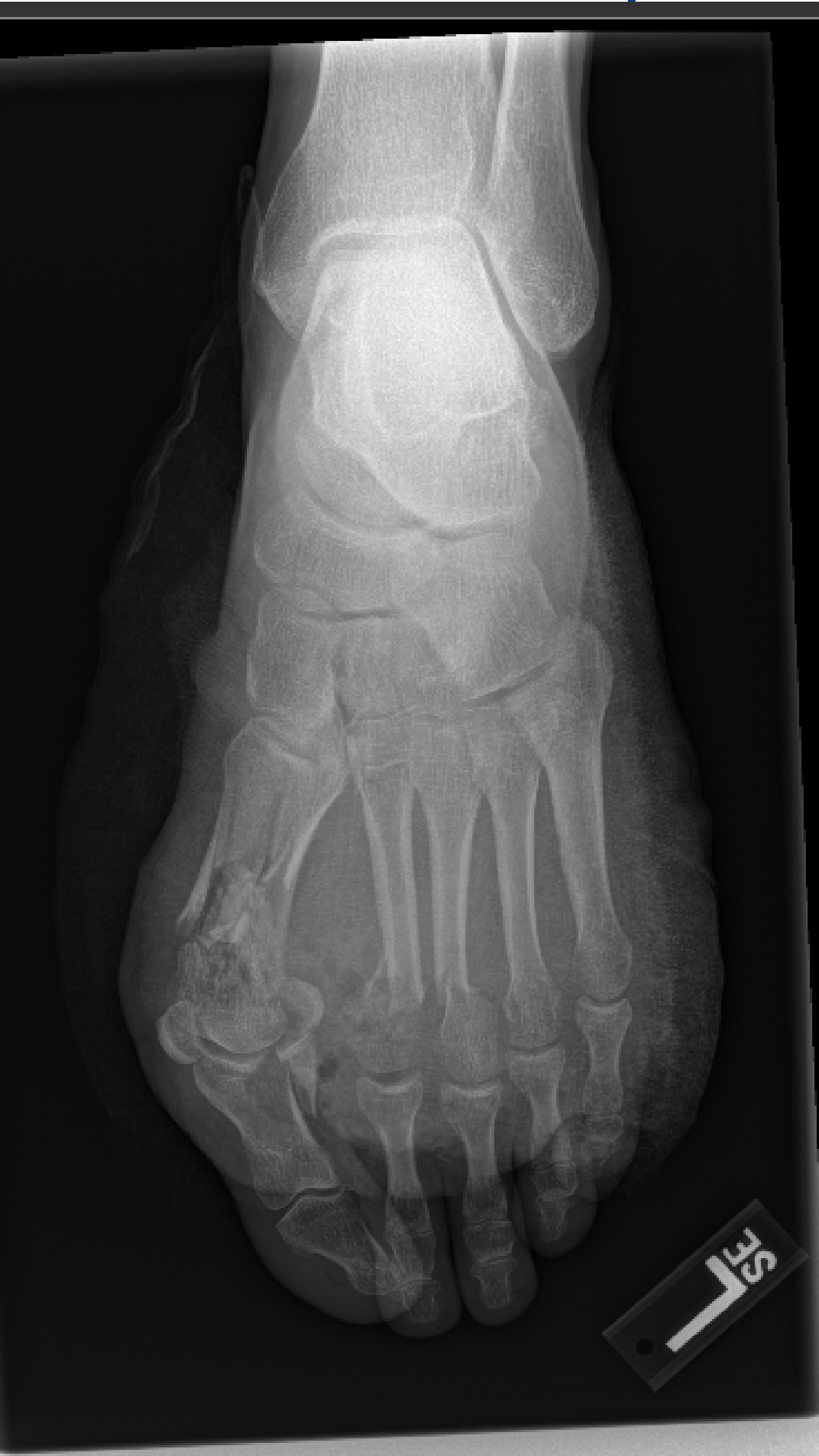
SHOEI
SHIFT



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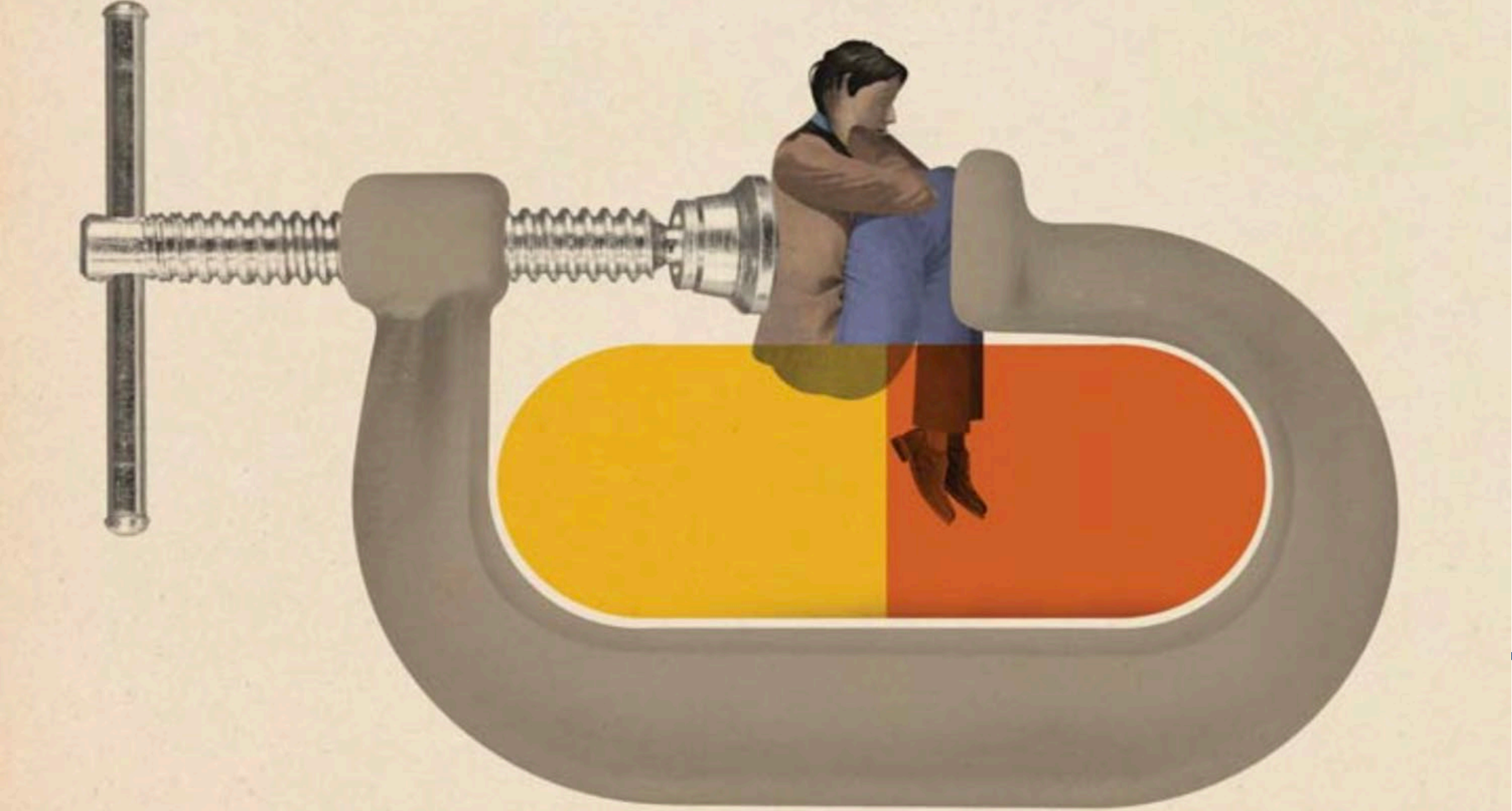
Travis Rieder | TEDxMidAtlantic

The agony of opioid withdrawal — and what doctors should tell patients about it



Travis N. Rieder. 2017. In Opioid Withdrawal, with No Help in Sight. *Health Affairs* 36(1).

PART II:
WHY COULDN'T I FIND HELP?

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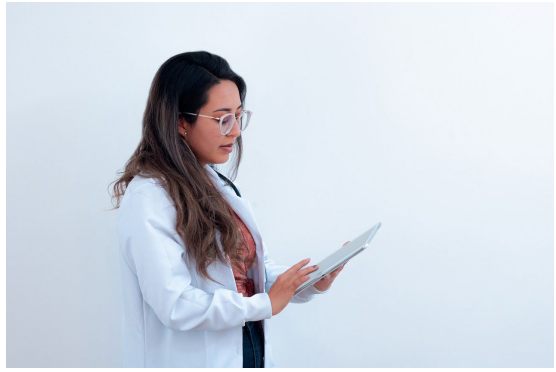
NOBODY OWNS ROUTINE WITHDRAWAL CARE



WHAT WE MISS:
DEPENDENCE =/= ADDICTION

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DISTINGUISH: DEPENDENCE & ADDICTION

PHYSICAL DEPENDENCE

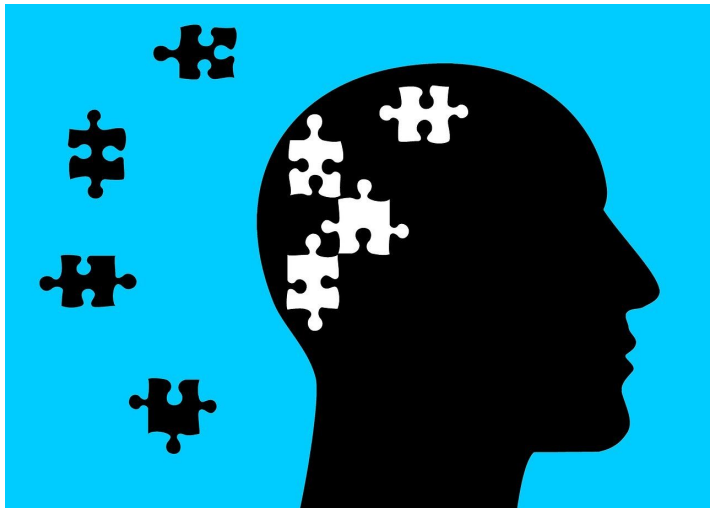
- Withdrawal following discontinuation
- Just how brains work
- Occurs in 100% of individuals on high doses, long-term, around the clock

ADDICTION

- Cravings
- Continued use despite negative consequences
- Occurs in a vast minority of those exposed

DISTINGUISH: DEPENDENCE & ADDICTION

Will cause dependence but no addiction



Will cause dependence and can lead to addiction

Can lead to addiction but no dependence

THE LESSON:

Dependence happens, so it must be someone's job to treat it.

PART III:
AN ETHICS FRAMEWORK

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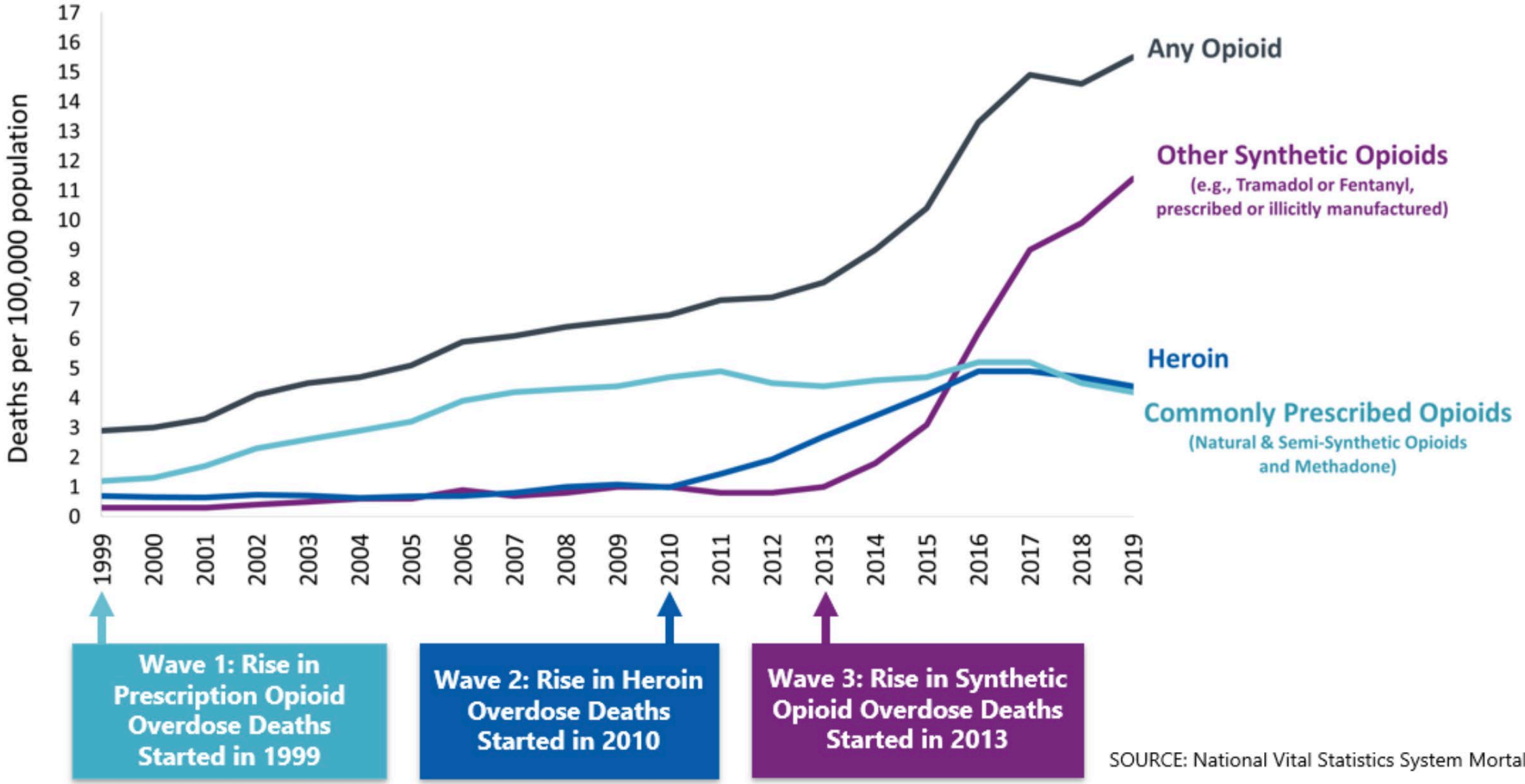
Three Waves of the Rise in Opioid Overdose Deaths



SOURCE: National Vital Statistics System Mortality File.


Restrictionist
WHERE WE NEED TO BE
Drugs for everyone
ATTITUDE TOWARD OPIOIDS

WHAT DOES THAT LOOK LIKE?

RESPONSIBLE PRESCRIBING:

1. Appropriate initiation
2. Appropriate management
3. Appropriate discontinuation

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RESPONSIBLE PRESCRIBING:

1. Appropriate initiation

2. Appropriate management

3. Appropriate discontinuation

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RESPONSIBLE PRESCRIBING:

1. Appropriate initiation
2. **Appropriate management**
3. Appropriate discontinuation

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RESPONSIBLE PRESCRIBING:

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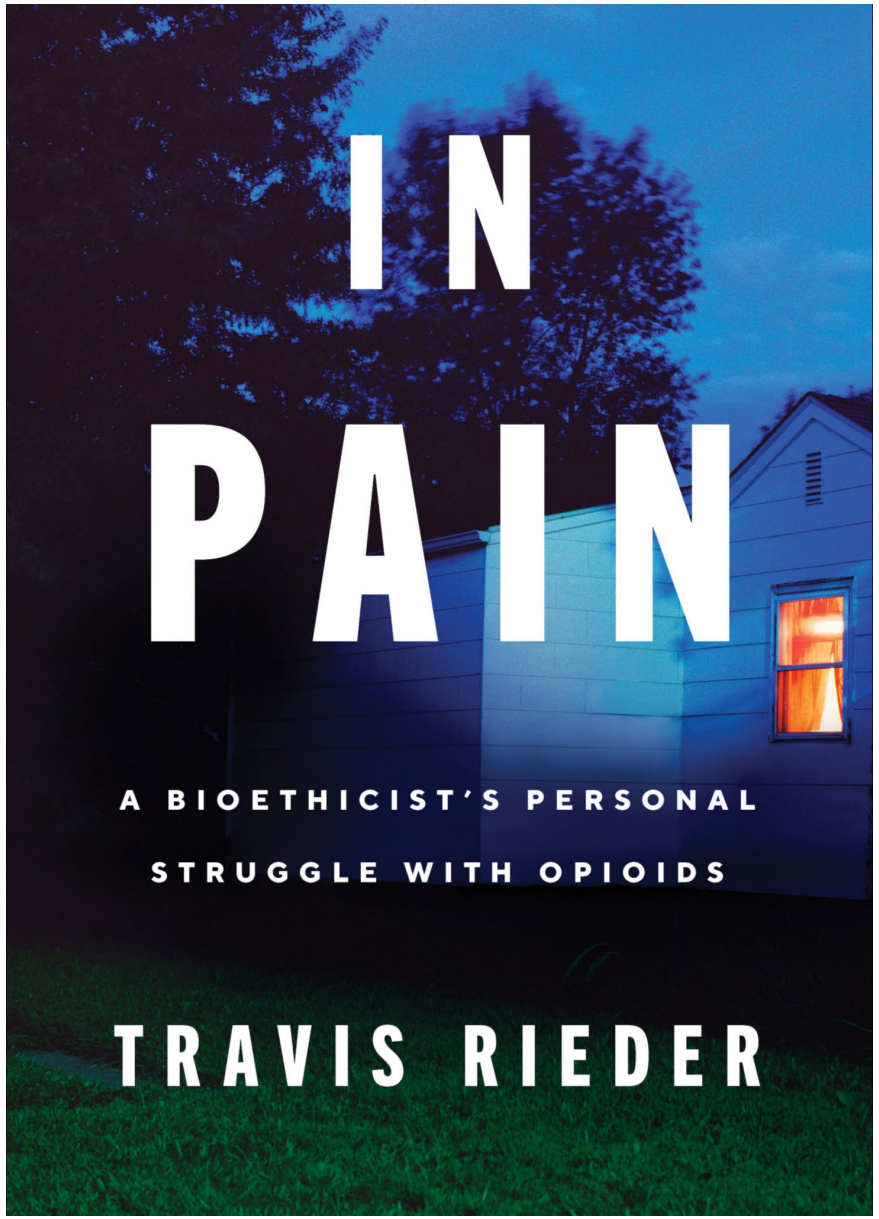
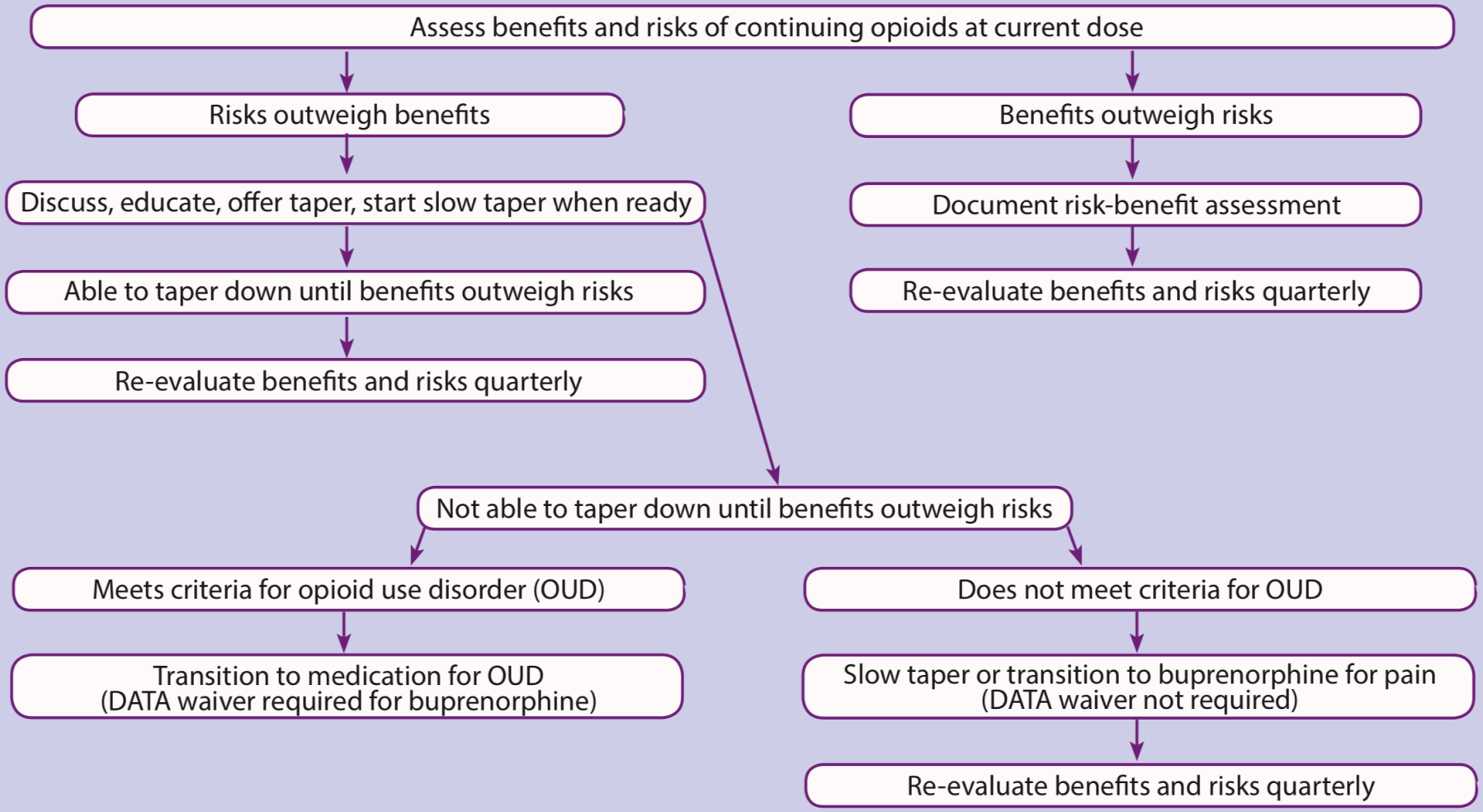

IN
PAIN
A BIOETHICIST'S PERSONAL
STRUGGLE WITH OPIOIDS
TRAVIS RIEDER

THANK YOU.

Opioid Tapering Flowchart

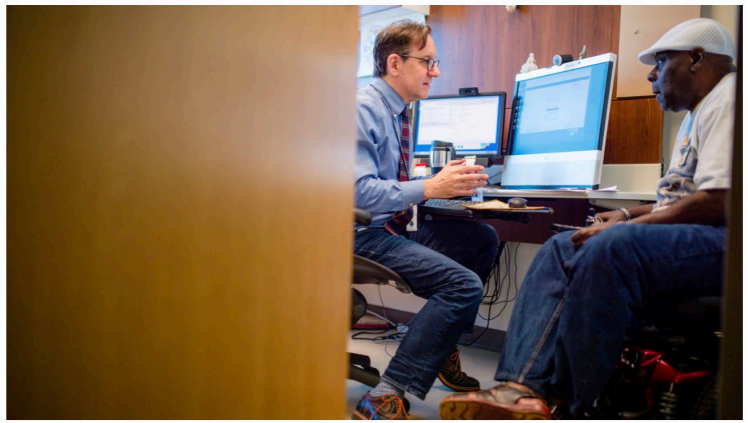


Adapted from Oregon Pain Guidance. Tapering – Guidance & Tools. Available at https://www.oregonpainguidance.org/guideline/tapering/.

HEALTH

The chronic-pain quandary: Amid a reckoning over opioids, a doctor crusades for caution in cutting back

By Andrew Joseph May 30, 2019 Reprints



Dr. Stefan Kertesz talks with Danny Jefferson, 66, one of his primary care patients.
TAMIKA MOORE FOR STAT

BIRMINGHAM, Ala. — About four years ago, Dr. Stefan Kertesz started hearing that patients who had been taking opioid painkillers for years were being taken off their medications. Sometimes it was an aggressive reduction they weren't on board with, sometimes it was all at once. Clinicians told patients they no longer felt comfortable treating them.

Kertesz, a primary care physician who also specializes in addiction medicine, had not spent his career investigating long-term opioid use or chronic pain. But he grew concerned by the medical community's efforts to regain control over prescribing patterns after years of lax distribution. Limiting prescriptions for new patients had clear benefits, he thought, but he wondered about the results of reductions among "legacy patients." Their outcomes weren't being tracked.

Perspective

No Shortcuts to Safer Opioid Prescribing

Deborah Dowell, M.D., M.P.H., Tamara Haegerich, Ph.D., and Roger Chou, M.D.

Article Figures/Media Metrics

5 References 118 Citing Articles 6 Comments

Audio Interview

Interview with Dr. Deborah Dowell on concerns about misimplementation and misapplication of the CDC's opioid-prescribing guideline. (08:46)
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SINCE THE Centers for Disease Control and Prevention (CDC) released its Guideline for Prescribing Opioids for Chronic Pain in 2016,[1] the medical and health policy communities have largely embraced its recommendations. A majority of state Medicaid agencies reported having implemented the guideline in fee-for-service programs by 2018, and several states passed legislation to increase access to nonopioid pain treatments.[2] Although outpatient opioid prescribing had been declining since 2012, accelerated decreases — including in high-risk prescribing — followed the guideline's release.[2,3] Indeed, guideline uptake has been rapid. Difficulties faced by clinicians in prescribing opioids safely and effectively, growing awareness of opioid-associated risks, and a public health imperative to address opioid overdose underscored the need for guidance and probably facilitated uptake. Furthermore, the guideline was rated as high quality by the ECRI Guidelines Trust Scorecard. In addition, the CDC (including the authors of this Perspective, who were also authors of the Guideline) engaged clinicians, health systems leaders, payers, and other decision makers in discussions of the guideline's intent and provided clinical tools, including a mobile application and training, to facilitate appropriate implementation.[4]

Efforts to implement prescribing recommendations to reduce opioid-related harms are laudable. Unfortunately, some policies and practices purportedly derived from the guideline have in fact been inconsistent with, and often go beyond, its recommendations. A consensus panel has highlighted these inconsistencies,[5] which include inflexible application of recommended dosage and duration thresholds and policies that encourage hard limits and abrupt tapering of drug dosages, resulting in sudden opioid discontinuation or dismissal of patients from a physician's practice. The panel also noted the potential

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CASE AND COMMENTARY

Is Nonconsensual Tapering of High-Dose Opioid Therapy Justifiable?

Travis N. Rieder, PhD

Abstract
This case considers a so-called legacy patient, one whose behaviors and symptoms express a legacy of past, aggressive opioid prescribing by a clinician. Some prescribers might feel pressured to taper doses of opioids for such patients, but this article argues that nonconsensual dose reductions for stable opioid therapy patients is impermissible because it both puts a patient at risk and wrongs an individual in a misdirected attempt to ameliorate a systemic wrong. Although perhaps surprising, this argument is supported by current evidence and recommendations for patient-centered pain care.

Case

Dr G is a family medicine physician seeing a new patient, Mr T, whose physician of many years, Dr A, recently retired. Mr T is 58 years old and takes 170 morphine milligram equivalents (MME) of oxycodone by mouth each day to treat chronic pancreatitis pain. Dr G is shocked by this large dose and asks Mr T about it. Mr T explains, "I've been at this dose for a while now. Dr A used to have folks from this drug's company who would visit his clinic, so he knew what he was doing."

Dr G sits and responds, "Well, that might be true, but I can't prescribe that amount. You've grown to tolerate this amount of this drug over time, but that's not good for you; it's not safe. I'm going to help you taper down, to gradually get used to lower doses. We'll make this change together over time."

Mr T looks terrified. "Look, I've run out of pills before. When that happened, I've never been so sick and miserable in my life. I didn't want to live." Becoming exasperated and starting to panic, Mr T insists, "I need to keep doing what's working for me now! Are you saying Dr A has been wrong all this time? You say, 'We'll make this change together over time.' What does that mean? How long will this take?"

Dr G suspects that the opioid therapy is primarily treating the physical dependence caused by the medication rather than the original pain. Based on recent guidelines, she also doesn't think chronic opioid therapy was likely a good strategy for Mr T. She wonders whether to say this explicitly to Mr T and what to do next.

Opioid overdose: A bioethicist explains why restricting supply may not be the right solution

January 25, 2022 8.25am EST

Author

Travis N. Rieder
Director of the Master of Bioethics degree program at the Berman Institute of Bioethics, Johns Hopkins University

Disclosure statement

Travis N. Rieder does not work for, consult, own shares in or receive funding from any company or organization that would benefit from this article, and has disclosed no relevant affiliations beyond their academic appointment.

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