The Truth about Painkillers

Sally Satel

In October 2003, the Orlando Sentinel published “OxyContin under Fire,” a five-part series that profiled several “accidental addicts” — individuals who were treated for pain and wound up addicted to opioids. They “put their faith in their doctors and ended up dead, or broken” the Sentinel wrote of these victims. Among them were a 36-year-old computer-company executive from Tampa and a 39-year-old Kissimmee handyman and father of three — the latter of whom died of an overdose.

The Sentinel series helped set the template for what was to become the customary narrative for reporting on the opioid crisis. Social worker Brooke Feldman called attention to the prototype in 2017:

Hannah was a good kid…. Straight A student…. Bright future. If it weren’t for her doctor irresponsibly prescribing painkillers for a soccer injury and those damn pharmaceutical companies getting rich off of it, she never would have wound up using heroin.

Feldman, who has written and spoken openly about her own drug problem, knows firsthand of the deception embedded in the accidental-addict story. She received her first Percocet from a friend years after she’d been a serious consumer of marijuana, alcohol, benzodiazepines, PCP, and cocaine.

Indeed, four months after the original “OxyContin under Fire” story ran, the paper issued a correction: Both the handyman and the executive were heavily involved with drugs before their doctors ever prescribed OxyContin. Like Feldman, neither man was an accidental addict.

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Yet one cannot overstate the media’s continued devotion to the narrative, as Temple University journalism professor Jillian Bauer-Reese can attest. Soon after she created an online repository of opioid recovery stories, reporters began calling her, making very specific requests. “They were looking for people who had started on a prescription from a doctor or a dentist,” she told the Columbia Journalism Review. “They had essentially identified a story that they wanted to tell and were looking for a character who could tell that story.”

The story, of course, was the one about the accidental addict. But to what purpose?

Some reporters, no doubt, simply hoped to call attention to the opioid epidemic by showcasing sympathetic and relatable individuals—victims who started out as people like you and me. It wouldn’t be surprising if drug users or their loved ones, aware that a victim-infused narrative would dilute the stigma that comes with addiction, had handed reporters a contrived plotline themselves.

Another theory—perhaps too cynical, perhaps not cynical enough—is that the accidental-addict trope was irresistible to journalists in an elite media generally unfriendly to Big Pharma. Predisposed to casting drug companies as the sole villain in the opioid epidemic, they seized on the story of the accidental addict as an object lesson in what happens when greedy companies push a product that is so supremely addictive, it can hook anyone it’s prescribed to.

Whatever the media’s motives, the narrative does not fit with what we’ve learned over two decades since the opioid crisis began. We know now that the vast majority of patients who take pain relievers like oxycodone and hydrocodone never get addicted. We also know that people who develop problems are very likely to have struggled with addiction, or to be suffering from psychological trouble, prior to receiving opioids. Furthermore, we know that individuals who regularly misuse pain relievers are far more likely to keep obtaining them from illicit sources rather than from their own doctors.

In short, although accidental addiction can happen, otherwise happy lives rarely come undone after a trip to the dental surgeon. And yet the exaggerated risk from prescription opioids—disseminated in the media but also advanced by some vocal physicians—led to an overzealous regime of pill control that has upended the lives of those suffering from real pain.
To be sure, some restrictions were warranted. Too many doctors had prescribed opioids far too liberally for far too long. But tackling the problem required a scalpel, not the machete that health authorities, lawmakers, health-care systems, and insurers ultimately wielded, barely distinguishing between patients who needed opioids for deliverance from disabling pain and those who sought pills for recreation or profit, or to maintain a drug habit.

The parable of the accidental addict has resulted in consequences that, though unintended, have been remarkably destructive. Fortunately, a peaceable co-existence between judicious pain treatment, the curbing of pill diversion, and the protection of vulnerable patients against abuse and addiction is possible, as long as policymakers, physicians, and other authorities are willing to take the necessary steps.

**The Reality of Opioid Addiction**

Between September 2018 and September 2019, I worked at a local clinic in Ironton, Ohio, an Appalachian Rust Belt town of 10,000 that had been pummeled by the opioid crisis. On Tuesday nights, I co-led group therapy with John Hurley, a seasoned social worker and twinkly eyed Santa Claus of a man. Every so often, a patient would complain that he was a victim of a doctor who prescribed OxyContin. This would prompt Hurley to reply with a wink, “oh, I see, so the directions on the prescription said ‘chop and snort two times a day,’ did they?” The patients sitting in the circle of plastic chairs would chuckle knowingly after Hurley’s comeback. Mostly in their 20s, 30s, and 40s, all were well acquainted with intoxicants before prescription opioids became part of their repertoire.

Our small therapy group mirrored the wider universe of pill abuse. According to an analysis of 2014 data from the Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Survey on Drug Use and Health (NSDUH), more than three-quarters of non-medical users of prescription opioids—those who use prescription drugs they were not prescribed or take them for reasons other than pain relief—had at least tried non-prescribed benzodiazepines, such as Valium or Xanax, or inhalants before turning to prescription opioids. Similarly, a Washington University review of almost 5,000 people who sought treatment for pain-reliever addiction found that 70% had prior experience with cocaine, methamphetamine, hallucinogens,
or benzodiazepines. Other data from the same researchers show that over 90% of patients admitted to treatment programs for opioid-use disorders had used at least one additional addictive substance in the preceding month. These findings are consistent with data from the Centers for Disease Control and Prevention (CDC) showing that four in five individuals who die from overdoses associated with prescription opioids have at least one other drug present in their systems at death.

Patients’ first opioid medication could have come from a doctor, but subsequent supplies were obtained elsewhere. According to a 2014 survey by SAMHSA, only 22% of a national sample of people who misused prescription opioids within the past year obtained their most recent supply from a single doctor. Meanwhile, half of the sample reported having obtained pills from a friend or relative—usually older relatives with cancer or a terminal illness. Others stole or bought the pills from someone they knew, procured them online, or purchased them from a dealer. The latter’s supply might have come from warehouse or pharmacy robberies, or from stops along delivery routes to pharmacies and hospitals where, again, inventory is subject to theft. Some “doctor-shopped” (obtained multiple prescriptions from multiple doctors), forged prescriptions, or patronized “pill mills” (doctors’ “offices” that are largely pills-for-cash outfits).

At the same time, studies of patients taking prescribed opioids for any reason routinely reveal that the vast majority take them without incident. The NSDUH reports that among the 91.8 million adults who took pain relievers in 2015, 1.9 million, or 0.8%, qualified for a prescription-opioid-use disorder at some point during the year. Another representative study, this one from a research team at Harvard University in 2018, discerned signs of opioid abuse and addiction in only 0.6% of over half a million privately insured patients prescribed opioids for post-surgical or acute pain. And in a 2016 Washington University survey of almost 700,000 patients, 0.3% abused or developed an addiction to opioids within a year after receiving at least one prescription.

Even among patients undergoing treatment for chronic pain, only a small percentage are at risk of abusing or developing an addiction to opioids. A team led by a scholar at the Research Triangle Institute, for instance, found that 0.12% to 6.1% of half a million chronic-pain patients abused or developed an addiction to opioids within 18 months of starting treatment. The Cochrane Library, a respected independent
collection of databases, found that in a combined sample of 2,600 patients drawn from nine separate studies, only 0.27% developed signs of opioid addiction. Another review, co-authored by the director of the National Institute on Drug Abuse and published in the *New England Journal of Medicine*, found “[r]ates of carefully diagnosed addiction [averaging] less than 8 percent” in chronic-pain patients.

Why do estimates of opiate abuse and addiction range from under 1% to 8% of these patients? Researchers from the University of Miami shed valuable light on the question when, in a review of 24 studies on patients prescribed opioids, they distinguished between patients experiencing pain with a history of substance abuse or addiction and those without. They found that an average rate of new-onset drug abuse or addiction for pain patients overall was 3.27%. But when they examined the four studies that had deliberately excluded patients with a history of substance abuse or addiction, the rates shrunken to 0.19%.

These findings are consistent with abundant evidence confirming that patients with mental-health conditions (particularly depression) and those who report taking extra medication to manage stress are more likely to progress to abuse or addiction than those who do not fit these criteria. For example, an analysis of the National Epidemiologic Survey on Alcohol and Related Conditions — a survey of over 36,000 people — found significantly increased odds of abusing or developing an addiction to pain relievers in those who reported traumatic experiences, as well as those who had been diagnosed with a psychiatric condition. In the Washington University survey mentioned above, roughly two-thirds of the participants — all of whom sought treatment for pain-reliever addiction — confirmed that they had been diagnosed with and treated for a psychiatric disorder. A similar proportion of subjects reported they had used prescription opioids “to self-treat psychological issues,” while 80% indicated they did so “to ‘escape’ from daily stressors, past trauma, [or other] issues going on in their lives.”

The fact that the vast majority of patients take opioids like Percocet, Vicodin, and OxyContin without incident significantly undermines the popularity of the accidental-addict narrative. At the same time, we know that prescription pain relievers helped set the current crisis in motion. How can both of these statements be true?

Part of the paradox can be explained by the fact that, for decades, otherwise responsible physicians routinely failed to identify patients at
higher risk of becoming addicted when prescribing pain relievers. At the same time, many doctors were also overprescribing opioids—either by prescribing them in cases where other pain relievers might have sufficed or by giving patients too many doses. In fact, one representative study published in the *Journal of Joint and Bone Surgery* in 2016 found that patients prescribed pain relievers typically reported using only about one-third of their supply. Their surplus pills spilled out of unattended medicine chests and into the gray market, where ensuing transactions helped stoke the opioid crisis.

**How we got here**

So why were otherwise responsible physicians prescribing so many opioids in the first place? The reasons can be traced back to the second half of the 1880s, when opium and morphine flowed more or less freely in America.

Between the 1870s and 1880s, Americans’ per-capita consumption of these substances roughly tripled. Opiates were available in opium dens for recreational users, sold as patent medications, and prescribed in great volumes by physicians and pharmacists—some of whom offered their patients heroin. In the words of historian David Courtwright, “[t]he worst offenders” of the era’s opiate rush were doctors.

By the early 1900s, however, most physicians had become aware of the hazards associated with opioid pain relievers. As local and state authorities awakened to this reality, they enacted laws to control sales to patients. Congress followed suit in 1914, passing the Harrison Anti-Narcotic Act to target profit-hungry doctors and pharmacists who prescribed or sold opioids too freely. Then in 1932, the powerful Federal Bureau of Narcotics began its nearly four-decade crackdown on their use and prescription.

Led by the infamous drug-war hawk and moral crusader Harry Anslinger, the bureau heavily regulated pharmaceutical opioids while its agents kept an iron grip on physicians prescribing suspicious amounts through in-person audits. It also distributed newsletters warning doctors that they would be held liable if their patients used pain medication to get high.

As physicians prescribed fewer and fewer opioids, patients who truly needed them to manage debilitating pain began to suffer. The cycle of inexperience reinforced itself: The less physicians prescribed opioids to
patients, the less able they were to learn how to properly and cautiously use opioids to treat pain.

Fear of addicting their patients hung over medical-care providers for much of the 20th century. Except for acute trauma and post-surgical care, doctors deployed prescription opioids sparingly. In 1985 John Morgan, a physician and pharmacologist at the City University of New York, observed that “American physicians markedly undertreat severe pain based on an irrational and undocumented fear that appropriate use will lead patients to become addicts.” He coined the term “opiophobia” to describe the phenomenon.

The needless anguish endured by these patients spurred physicians to launch a national movement to treat pain more assertively. Concerned oncologists and pain specialists—then the dominant prescribers of pain relievers for chronic use—teamed up with their counterparts at the World Health Organization to initiate a campaign to persuade non-specialists to take pain seriously in patients with terminal illnesses. Eventually, they extended this imperative to patients with the kind of long-term, unremitting pain that accompanies severe neurological illness, musculoskeletal problems, and inflammatory conditions.

Lawmakers also began to take note. In 1984, New Jersey became the first state to enact an intractable-pain law, which protected doctors from liability for prescribing opioids. Several other states followed suit. In 1998, the Federation of State Medical Boards (FSMB) published its “Model Guidelines for the Use of Controlled Substances for the Treatment of Pain,” asserting that while doctors should seek to minimize abuse, prescribing opioids may be necessary in some circumstances.

The campaign gained further momentum in 1999 when the U.S. Department of Veterans Affairs designated pain the “fifth vital sign,” meaning that pain was to be taken as seriously as the traditional quartet of pulse, blood pressure, respiration, and temperature. A year later, Congress passed a bill declaring the first 10 years of the 2000s a “Decade of Pain Control and Research,” while the influential Joint Commission on Accreditation of Healthcare Organizations established standards for pain management. In 2004, the FSMB called on state medical boards to make under-treatment of pain punishable by law. Finally, in 2005, Medicare and Medicaid began linking the results of patient-satisfaction surveys to hospital reimbursement. Knowing they were being rated on how well they relieved patients’ reported pain, many physicians felt
obligated to prescribe opioids when patients asked for them or asked for higher amounts, even if doing so went against their better judgment.

The drive to expand pain treatment overshot its mark. Between 1991 and 2009, prescriptions for opioids nearly tripled, with overdoses mounting in parallel. Too often, doctors reflexively prescribed a month’s worth of pills for acute pain from a tooth extraction or fractured wrist when only several days’ worth—or even just a heating pad and Tylenol—were needed. As a result, researchers at Johns Hopkins found that almost 60% of Americans prescribed opioid pain relievers reported storing unused pills in the home. The more these painkillers circulated among the public, the more opportunities arose for non-patients to obtain them, abuse them, become addicted, and possibly die.

**THE NEW OPIOPHOBIA**

By the early 2010s, several factors converged to suppress opioid prescribing and diversion—which occurs when medications initially prescribed by doctors to their patients end up in the hands of third parties. States began cracking down on pill mills and tightening their prescription-monitoring programs in an effort to detect patients who doctor-shopped. Many limited the number of days for which pain relievers could be prescribed. At the same time, the makers of OxyContin reformulated the product to make it more difficult to crush and thus abuse.

These changes appear to have helped, as a dwindling number of opioid-related deaths since 2011 have been linked to prescription opioids. A CDC study of 11 states participating in the agency’s Enhanced State Opioid Overdose Surveillance program, for example, found that only 17.4% of those states’ opioid-related deaths between July 2016 and June 2017 involved prescription opioids alone.

Over the same period, deaths related to illicit opioids climbed dramatically. In January 2015, the CDC reported that 5,766 drug-overdose deaths involving synthetic opioids—mostly fentanyl, an opioid between 50 and 100 times more potent than morphine—had occurred during the preceding 12 months. In January 2017, the 12-month total was 20,932—a jump of nearly 400%. July 2020’s report more than doubled the 2017 number, reaching 48,729. These numbers suggest that the very efforts to curb abuse of prescription pain relievers pushed opioid abusers to more potent and inherently riskier drugs that are now cheaper and more abundant than prescription pain relievers.
Many physicians also began refusing to prescribe opioids and withdrawing patients from their stable opioid regimens around 2011—approximately the same time as states launched their reform efforts. Reports of pharmacies declining to fill prescriptions—even for patients with terminal illness, cancer pain, or acute post-surgical pain—started surfacing. At that point, 10 million Americans were suffering “high impact pain,” with four in five being unable to work and a third no longer able to perform basic self-care tasks such as washing themselves and getting dressed.

Their prospects grew even more tenuous with the release of the CDC’s “Guideline for Prescribing Opioids for Chronic Pain” in 2016. The guideline, which was labeled non-binding, offered reasonable advice to primary-care doctors—for example, it recommended going slow when initiating doses and advised weighing the harms and benefits of opioids. It also imposed no cap on dosage, instead advising prescribers to “avoid increasing dosage to ≥90 MME per day.” (An MME, or morphine milligram equivalent, is a basic measure of opioid potency relative to morphine: A 15 mg tablet of morphine equals 15 MMEs; 15 mg of oxycodone converts to about 25 mg morphine.)

Yet almost overnight, the CDC guideline became a new justification for dose control, with the 90 MME threshold taking on the power of an enforceable national standard. Policymakers, insurers, health-care systems, quality-assurance agencies, pharmacies, Department of Veterans Affairs medical centers, contractors for the U.S. Centers for Medicare and Medicaid Services, and state health authorities alike employed 90 MME as either a strict daily limit or a soft goal—the latter indicating that although exceptions were possible, they could be made only after much paperwork and delay.

As a result, prescribing fell even more sharply, in terms of both dosages per capita and numbers of prescriptions written. A 2019 Quest Diagnostics survey of 500 primary-care physicians found that over 80% were reluctant to accept patients who were taking prescription opioids, while a 2018 survey of 219 primary-care clinics in Michigan found that 41% of physicians would not prescribe opioids for patients who weren’t already receiving them. Pain specialists, too, were cutting back: According to a 2019 survey conducted by the American Board of Pain Medicine, 72% said they or their patients had been required to reduce the quantity or dose of medication. In the words of Dr. Sean Mackey,
director of Stanford University’s pain-management program, “[t]here’s almost a McCarthyism on this, that’s silencing so many [health professionals] who are simply scared.”

**Doctors Pressured, Patients Suffer**

The consequences of this new opiophobia have fallen on the shoulders of patients experiencing acute or chronic pain, many of whom have found themselves abandoned by health-care providers in the name of preventing opioid abuse and addiction.

Dose tapering of chronic-pain patients with commercial health insurance and Medicare Advantage has increased substantially in recent years, and a quarter of those patients have had their doses tapered more quickly than medically recommended, according to a 2019 study by researchers at the University of California, Davis. In 2017, a survey of 3,100 chronic-pain patients by the non-profit Pain News Network revealed that 71% could no longer obtain necessary opioid medication from a doctor or had to settle for a lower dose. Eight out of ten said their pain and quality of life had worsened, and more than 40% said they had considered suicide as a way to end their suffering. Even some patients with sickle cell disease and terminal cancer—subgroups that the CDC explicitly excluded from the reach of the guideline—were not immune from painful dose reductions or complete cutoffs.

Many of these abandoned patients have become “pain refugees,” a tragic cadre of individuals who chase the dwindling numbers of physicians still willing to prescribe even modest doses of opioids. Traveling hundreds of miles every few months to obtain care in another city or state, they often drain their limited incomes on the odyssey. Those who remain with their local physicians often try to supplement their reduced doses by adding alcohol or benzodiazepines for pain relief, thereby inadvertently enhancing the odds of an overdose. (In fact, the lethality of such combinations has created an exaggerated sense of the inherent lethality of opioid pain relievers which, on a population level, are rarely the sole cause of a fatal overdose.)

Other pain patients who’ve had their doses tapered or cut off have replaced opioids with large amounts of non-steroidal anti-inflammatory agents such as Advil, acetaminophen, or aspirin, which puts them at increased risk of liver injury, renal damage, and bleeding from the upper gastrointestinal tract. Still others report being required to undergo
invasive procedures, such as implantation of medication pumps, in order to manage their pain.

Some patients have become so desperate for relief that they’ve moved to inherently riskier drugs after losing access to prescription opioids. “The VA cut my pain meds cold turkey after over 25 years,” a veteran told Fox News. “I now buy heroin on the street.” Though the percentage of such patients is small (perhaps 5% over five years, according to estimates from SAMHSA), turning to street pills has proven dangerous. The Drug Enforcement Administration warns that sales of counterfeit pills—consisting of fentanyl pressed into pill shapes with familiar tablet markings—have been linked to overdose deaths nationwide.

Suicide is perhaps the most devastating consequence of the crackdown on opioid prescriptions. Case studies documented by physicians and personal tragedies memorialized on social media give the strong impression that poorly treated pain has pushed some patients into taking their own lives. Since 2011 Anne Fuqua, a retired nurse and chronic-pain patient, and Terri Lewis, a doctor of rehabilitation medicine with Southern Illinois University, have maintained a registry of people who took their own lives following physician-initiated changes or cuts in their doses. To date, they have confirmed 584 suicides, the majority of which included people under age 59. About half were women, and almost all were white. Self-inflicted gunshot wounds were the most common cause of death, followed by hanging, carbon-monoxide poisoning, and jumping off a bridge. One veteran in New Jersey set himself on fire.

After 2016, advocacy organizations such as Human Rights Watch and the American Cancer Society called on the CDC to revise its recommendations. To the agency’s credit, it responded. In 2019, the centers issued a press release and published an article in the *New England Journal of Medicine* stating that their guideline had been sorely misinterpreted as a federal mandate to reduce patients to 90 MME. The Food and Drug Administration followed suit. Citing reports of “serious withdrawal symptoms, uncontrolled pain, psychological distress, and suicide” among patients inappropriately cut off from pain relievers, the agency issued a memo requiring changes to opioid labels so that they specifically warn of the risks of sudden and involuntary dose tapering. HHS also produced a guide on careful tapering practices.

Unfortunately, the corrected record has not had much impact. “The clarification did not filter down,” observes Kate Nicholson, a
Denver-based civil-rights attorney. “Patients are still being forced to have doses reduced or discontinued, and are experiencing outright abandonment by their clinicians. And doctors still fear law enforcement.”

**Policy and Practice Prescriptions**

Up to 18 million Americans who rely on prescription opioids are now caught in the debate over the proper limits of treatment. “I am heartbroken for anyone who may have overdosed on opioids or lost someone who did,” Texas-based pain advocate Andrea Anderson told me, “but as someone who has helped hundreds of people suffering chronic pain in the last four years, withholding opioid medications from them just doesn’t make sense.”

So how do we inject more sense into prescription-opioid policy and practice?

First, like old generals, we must stop fighting the last war. Opioid prescribing peaked in 2010 and 2011, and has since been in long-term decline—decreasing by 40% between 2011 and the end of 2020, according to the IQVIA Institute for Human Data Science. The total amount of opioids dispensed as measured in MMEs fell by 60% over the same period, with fewer pills being dispensed per person.

Meanwhile, opioid-related deaths began to surge in 2013—several years after physicians began their sustained cutback on pain-reliever prescriptions. These crisscrossing trends suggest that the opioid crisis of the last decade has not been driven by prescription medications, but predominately by illicit heroin and fentanyl, which have been involved in over 62,000 deaths as of July 2020. Wholesale restrictions on prescription opioids will thus do little to combat the nation’s opioid-overdose problem.

Second, the CDC must rewrite its guideline to counteract the overzealous application of the 2016 version. In summing up the guideline’s impact, the American Medical Association wrote, “[b]y placing so much emphasis on reducing opioid prescribing, the CDC has caused considerable fear in the patient and medical community that opioid therapy for pain will automatically cause opioid-use disorder, overdose, and death.” The agency’s attempts to clarify its guideline in 2019 did not do enough to assuage this fear; it’s now time for a more authoritative directive.

In a promising move last summer, the CDC appointed a new slate of outside experts, including critics of the earlier guideline, to craft a new
version. The rewritten guidelines should give primacy to the idea that all pain care must be individualized and that, so long as the benefits of opioid medication exceed the risks, doctors should not be pressured by hard thresholds for chronic and short-term prescriptions.

Third, physicians need better training in treating patients who are experiencing chronic pain. Their education should cover opioid prescribing, pain management, screening for psychiatric conditions and problematic treatment with opioids in the past (excellent patient-assessment questionnaires now exist), and screening for past substance abuse or addiction. Doctors needn’t avoid using opioids in patients who appear vulnerable to addiction, but they must prepare for the possibility of having to monitor these patients more closely. They should also be trained to detect new-onset opioid abuse and addiction that occurs during the course of care, as well as how to manage these problems or refer patients to specialized care.

Fourth, patients’ well-being must take precedence over pill counts. States, health plans, pharmacy chains, and insurers must therefore avoid imposing rigid standards on permissible dosing. Likewise, they should deem unethical forced dose tapering of patients who are benefiting from opioids and taking them responsibly. As one protocol out of the Stanford University School of Medicine advises, “the focus should never be solely on opioid reduction.” Instead, “pain treatment should be applied to facilitate not only goals for pain and opioid reduction but improved function and quality of life.”

Fifth, health-care systems should revitalize interdisciplinary pain-management programs. In 2019, HHS called for the revival of such programs, which offer an array of medical, physical, and psychological therapies for pain in one location. Interdisciplinary clinics had flourished in the 1970s but were replaced with scattered, “carved out” services by the late 1990s as a cost-containment strategy.

Even if revived, the benefits of these programs will be thwarted unless insurers cover needed services. Examples of such services include physical therapy, occupational therapy, behavioral therapy, therapeutic exercise, procedures like steroid injections or surgically implanted spinal stimulators, and medications—including non-opioid pain relievers, anti-convulsants, anti-depressants, and musculoskeletal agents, in addition to opioids.
A time to prescribe

The truth about prescription pain relievers is that only a minority of patients are at risk of becoming addicted to them. As Ironton social worker John Hurley well knew, the typical person who abuses painkillers or becomes addicted to them is not naive to the practice of altering their mood or consciousness with substances.

Unfortunately, for years, many well-meaning physicians did not do enough to protect patients who were at heightened risk of abusing or becoming addicted to opioids. At the same time, many journalists and some physicians promoted a narrative that did not reflect the reality of opioid abuse and addiction, resulting in greater confusion among lawmakers and the public.

For people in pain, it is true that some number of them — no one truly knows how many — might have avoided treatment with opioids, or at least opioids at high doses, had their doctors initially treated them with non-opioid medications, steroid injections, or surgically implanted devices, among other interventions. Still, many patients do not turn to opioids until all else has failed. When that occurs, opioids can be excellent pain relievers — a truth first confirmed by the ancient Sumerians who discovered the palliative virtues of the opium poppy around 3400 B.C.

Fortunately, prudent policy and practice can accommodate the dual imperatives of protection from addiction and treatment of pain. Four realities have made this compromise more likely: the dawning realization that prescription opioids pose little risk to most patients, the recognition that physicians need to appraise addiction risk factors with greater vigilance, the growing acknowledgement of the obvious harm to chronic-pain patients caused by draconian limits on dosing, and the fact that we now know prescription opioids contribute only modestly to today’s pressing overdose problem.

With the per-capita use of prescription opioids projected to drop back to levels not seen since 2000 sometime this year, one might suggest that we have made significant progress in pill control. This progress, however, must come with a bold caveat — that while we must maintain vigilance against needless or excessive prescribing, depriving chronic-pain patients of the blessed relief that opioids can deliver should never be part of a rational abuse-reduction strategy.
Today, every opioid prescription in America is tracked by multiple sources. Patients are graded by insurers’ proprietary algorithms and ranked according to risk of abusing or becoming addicted. Medicare and Medicaid are required to report aggregate trends and identify outlier prescribers, and medical students are now receiving long-overdue basic training in both pain care and addiction diagnosis and treatment. The hardest-won lesson of the past two decades may be the realization that we are on the threshold of what is likely to be the safest time to prescribe opioids in their history.