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ESSAY

The Perilous Blessing of Opioids

An injured bioethicist learned firsthand how desperately patients with severe pain need the relief of powerful drugs—and how little support they get to stop taking them.

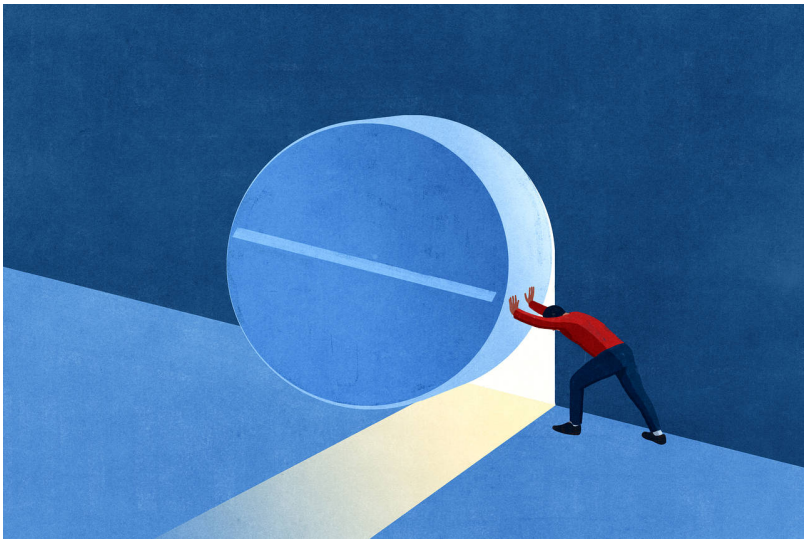


ILLUSTRATION: SHOUT

By Travis Rieder

June 14, 2019 5:30 a.m. ET

On a beautiful Memorial Day weekend four years ago, I left my home in Germantown, Md., on one of my rare motorcycle trips, but I did not get very far. A few blocks from the townhouse where I lived with my partner and our baby girl, a young man drove his large white van directly into the side of my bike. My left foot was crushed, and I was tossed to the ground.

That day radically changed my life, and not just because of the injury itself. As a bioethicist at Johns Hopkins University, part of my job is to think about the moral quandaries raised by the practice of medicine. Unexpectedly becoming a trauma patient can be a particularly good way to uncover such issues. My own experience exposed a pair of linked challenges for patients like

me and for our health care system: how to alleviate severe, debilitating pain while making sure that lives aren't destroyed by the opioids that remain, for now at least, an irreplaceable remedy.

I had five surgeries over the course of a month, at three different hospitals. There they gave me intravenous morphine, fentanyl and hydromorphone. They sent me home with powerful oxycodone pills. The drugs were a godsend for getting through my ordeal, but I soon faced the results of being on high and escalating dosages for too long. I had formed a profound dependence. When my orthopedic trauma surgeon finally told me, two months after the accident, that it was time to get off the meds, I was caught completely off-guard.

That's when my trip through hell really began. Following the spectacularly bad advice of the plastic surgeon who prescribed my pills, I set out to wean myself from my medication over the course of four weeks. That is far too aggressive a taper. I later learned that a standard recommendation is to reduce the dosage by no more than 10% a week and to pause or slow the tapering as needed. But that information wasn't, and isn't, common knowledge among prescribers.

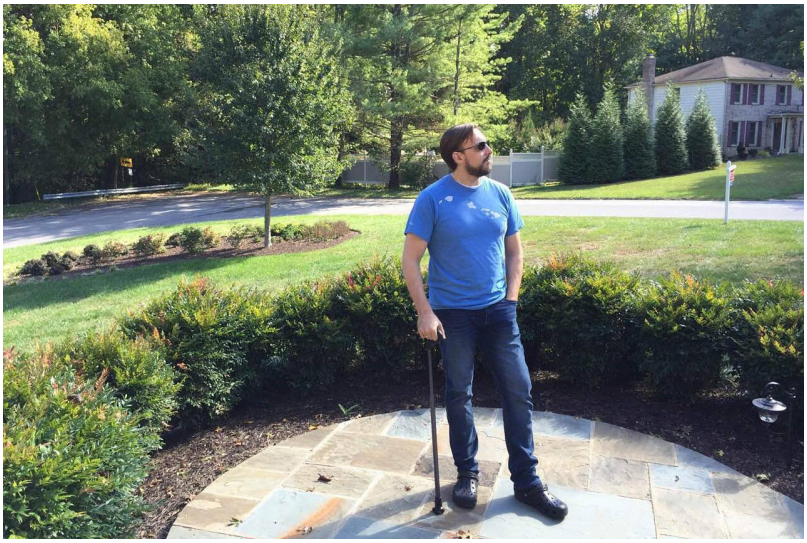
Perhaps the greatest challenge about opioids today is to resist the urge to be simplistic or reactionary.

The aggressive schedule launched me into withdrawal, and I learned viscerally, firsthand, what the absence of opioids can do to someone whose brain has become accustomed to them. Those symptoms include *increased* sensitivity to the very pain that the opioids counteract, as well as extreme flu-like symptoms, insomnia and crippling depression. I came to understand why people sometimes go back onto deadly dangerous drugs: because the alternative is such profound suffering that it makes you want to die.

I lived that lesson every moment of every day for four weeks, but I was incredibly fortunate. With the help of my family, I made it through the intense withdrawal and escaped the chemical hooks of the medication.

But no one in the health care system helped me through the weaning process—none of my prescribers, none of the pain-management doctors we consulted, nor any of the addiction medicine specialists we called. They all seemed to regard tapering as someone else's job, even though any patient on high enough doses of opioids for long enough will become physically dependent.

This all might make it sound like opioids are too dangerous to be permitted. Combine my experience with the more than 47,000 overdose deaths that involved an opioid in 2017 (the latest full year of data), and we might recoil from the drugs. But that peril is only half the story. Because for those weeks in the hospital and at home, nursing my mangled foot, the analgesic



The author in October 2015, about four months after his injury. PHOTO: COURTESY TRAVIS RIEDER

effects of opioids were all that made life worth living. Unmedicated pain was simply unbearable.

Opioids are not *only* dangerous; they also can be powerfully effective. Perhaps the greatest challenge about them today is to resist the urge to be simplistic or reactionary. America's current crisis of overuse has led some prescribers to avoid the drugs completely, and it has led politicians to occasionally consider ham-fisted policy solutions, like limiting the lengths or dosages of prescriptions regardless of any individual patient's needs. But when a medication has both risks and benefits, what we need isn't one-size-fits-all policies but nuance.

How do we get that? Though the picture is complicated, there are certainly some straightforward changes that we could make. For starters, clinicians need to reduce clearly inappropriate prescriptions. Moderately acute pain that can be effectively treated with acetaminophen and ibuprofen should not be treated with opioids, as has often happened in the past two decades for, say, routine pain from dental work or injury.

> **No one told me initially to worry about dependence or addiction, nor counseled me on what pain to expect.**

When opioids are appropriate—as in the case of severely acute pain—we need much better evidence-based guidelines for dosages, and we need doctors to follow them. Physicians have been aggressively prescribing opioids for decades without any data for guidance. The Michigan Opioid Prescribing Engagement Network (OPEN) is trying to rectify this situation, generating evidence and making recommendations regarding drugs and dosages for various surgeries. For instance, according to OPEN guidelines, while invasive, severely painful surgeries like a knee replacement could call for 50 tablets of 5mg oxycodone, a thyroidectomy should only yield a prescription for five of the pills. The battle now is to get clinicians across the country to use the guidelines, even if it means radically changing their practice.

Prescribing isn't the only relevant act when a patient is on opioid therapy. One of the most shocking features of my experience was that no one told me initially to worry about dependence or addiction, nor counseled me on what pain to expect or how to use the painkillers appropriately.

This kind of patient education is crucial. For other medical interventions we ask patients for their "informed consent," which is supposed to mean that they indicate their understanding and endorsement of a treatment plan. But none of my prescribers from three different hospitals thought that a similar level of understanding and consent was needed for the dangerous pain medications I was on.

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Doctors also must provide an exit strategy. In many instances, this would only require a plan for the number of days of use and a modest taper. But the longer a patient is exposed, the more complex the strategy may be. For every patient on opioid therapy, there must be a clinician who sees long-term management and tapering as their job. We cannot allow medical professionals to play hot potato with opioid patients, trying to toss them to someone else before the timer goes off.

Finally, physicians must compassionately engage with so-called "legacy" patients—those who, thanks to aggressive prescribing and overprescribing, have been on opioids for years or even decades. Taking the drugs away can send them into debilitating withdrawal, and the correct course of action isn't clear. The overdose crisis is no excuse to be callous about their suffering.

It would be nice if opioids were either just evil, dark magic or (better) the simple solution to all of our pain problems. Then we would know what to do. But they're neither of those things.

A nuanced approach to opioids will be difficult. Extracting the benefits from them while avoiding the harms requires clinicians who know how to use them; a system that rewards clinicians who engage in thoughtful, attentive pain therapy; and a population of patients willing to do the hard work alongside clinicians. All of this will take time and effort. But people are suffering, being badly medicated and dying every day. Inaction isn't an option.

—This essay is adapted from Dr. Rieder's new book, "In Pain: A Bioethicist's Personal Struggle with Opioids," published by Harper (which, like The Wall Street Journal, is owned by News Corp).