

**CASE AND COMMENTARY**

**Is Nonconsensual Tapering of High-Dose Opioid Therapy Justifiable?**

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**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.

## Commentary

In the wake of America's opioid crisis, clinicians across the country are feeling pressured to prescribe fewer opioids, as scholars have claimed repeatedly that they are at least partially to blame for the broader drug overdose epidemic.<sup>1,2,3,4</sup> Guidelines like the one published by the Centers for Disease Control and Prevention (CDC) urge caution when initiating or escalating opioid prescriptions but leave unclear how such reductions are to be achieved.<sup>5</sup> The CDC guideline, however, has been widely misinterpreted as a mandate to deprescribe for existing patients<sup>6</sup>—in particular, for *legacy patients*, so-called because their **long-term use** of often high-dose opioid therapy is a legacy of past, more aggressive prescribing practices. Although some patients likely achieved this status due to their physicians failing to respect prescribing norms, many did not; long-term opioid therapy was simply seen as acceptable—sometimes even obligatory—during the late 1990s and early 2000s when pain was taken to be the “fifth vital sign” and opioids were sold to clinicians by pharmaceutical companies as safe and effective.<sup>7</sup>

Mr T is likely one such patient, and he represents one of the most difficult challenges of current pain management practice: because he has taken opioids for so long, he is physically dependent on a high dose and scared of his supply being discontinued. Such cases need to be approached with excessive caution. When a patient's physical dependence is induced by past poor prescribing and clinical management, the *ethical structure* of current prescribing decisions changes—and should change. In particular, clinicians must consider both patient autonomy and their obligation not to compound iatrogenic harms to vulnerable patients. I argue in what follows that these considerations suggest that it is impermissible to taper patients like Mr T without their consent.

### Morally Relevant Features of Legacy Cases

Physicians in Dr G's position might believe that the only ethically relevant question of the case is whether chronic opioid therapy is evidence-based practice. It is now well accepted that **overprescribing** contributed to America's opioid crisis,<sup>7</sup> and, as a result, the CDC guideline recommends a cautious approach that closely attends to physicians' past prescribing of opioids for chronic, noncancer pain.<sup>5</sup> This sort of mindset is revealed in Dr G's initial response to the dose: “You've grown to tolerate this amount of this drug over time, but that's not good for you; it's not safe.” Physicians like Dr G presumably believe that high-dose opioid therapy carries significant risks and thus that reducing or eliminating opioid use is indicated. Although the evidence is not actually clear on this point,<sup>8</sup> I will assume that Dr G is correct that a reduced dose might be better for Mr T from a clinical standpoint for the sake of exploring whether nonconsensually reducing Mr T's dose is ethically justifiable.

*Initiation vs continuation.* The most important lesson for responsible opioid prescribing in cases like Mr T's is that the presumption of a duty to taper as following from evidence-based medicine fails to acknowledge the difference between *initiating* patients on opioid therapy and *continuing* patients on opioid therapy.<sup>6</sup> This distinction is morally relevant for at least 2 reasons: first, because long-term opioid therapy patients can have profound physical dependence; and second, because what patients are entitled to can be affected by how they have been treated by the health care system in the past. I'll address each of these points briefly in turn.

*Risk-benefit profile.* The fact of physical dependence changes the risk-benefit profile of opioid therapy.<sup>8</sup> Mr T fears the withdrawal symptoms that come with discontinuing opioids, and this fear is a perfectly reasonable one: withdrawal can be far more than

unpleasant or painful; it can be an absolute nightmare.<sup>9</sup> And because a patient who has been on chronic opioid therapy might know the symptoms of withdrawal well, the prospect of withdrawal itself can cause significant anxiety. (As Mr T states in the case, “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.”) Indeed, withdrawal can be so devastating that patients who have their opioid therapy discontinued abruptly or are tapered too quickly have been reported to commit suicide.<sup>10</sup>

Dr G likely believes that she can mitigate some of this suffering with a careful taper, but she cannot promise that tapering will be symptom free, or even that it won’t be miserable. What little data we have about tapering in the most ideal circumstances do not provide much reason for optimism. In one study, practiced experts attempted to carefully taper patients to below 90 MME or to transition those unable to taper onto buprenorphine. Despite the resources of a specialty clinic conducting slow, careful tapers, more than a third of the patients dropped out of the study; among those who successfully completed the taper, more than half reported increased pain.<sup>11</sup> In a separate study under essentially ideal conditions, in which patients volunteered for tapering interventions and investigators were national experts on the topic, results were heterogeneous. Many patients were able to achieve moderate dose reductions, but others required *increased* doses. Some experienced decreases in pain while others experienced increases in pain.<sup>12</sup> Slow, careful tapers, even for patients with access to far more professional expertise and resources than average patients, do not necessarily make patients more comfortable. Indeed, even ideal tapering regimens can lead to an increase in pain, with no certainty that patients will be able to eventually complete the taper. It is also important to note that the slower the taper—even when offered with the intention of helping mitigate suffering from withdrawal symptoms—the longer (possibly months or years) the withdrawal process is drawn out. This possible prolongation of withdrawal is an important ethical consideration when deciding how to help a patient who has become iatrogenically physically dependent on opioids.

*Iatrogenesis.* Additionally, legacy patients are owed a certain amount of deference in choosing their treatment as a result of the situation in which the medical community has placed them. In general, we don’t think that patients are owed some particular medication or service. Patients aren’t allowed to “order” a drug from a physician. Rather, physicians are stewards of potent substances, and it is their job to decide whether it is appropriate to use a medication in any particular case. High-dose legacy patients are different, however, because they’ve suffered iatrogenic harm from poor prescribing and poor medical management. If Dr G is correct that chronic opioid therapy isn’t good for Mr T, then Mr T has already been wronged by being given an inappropriate treatment—perhaps by an unskilled prescriber or perhaps simply because norms concerning prescribing have changed. Now, he’s being pushed or required to go through withdrawal in the hope—but with no guarantee—that he won’t be in worse pain at the end of the whole ordeal.<sup>12</sup>

In a case like Mr T’s, it seems reasonable to say that Mr T’s preferences should play a role in decision sharing about treatment. It might well be the case that there is something clinically and ethically wrong about continuing to prescribe high-dose opioids for some patients’ chronic, noncancer pain. But there is also something clinically and ethically wrong about forcing patients to endure exacerbated, protracted iatrogenic suffering. There is no morally pure choice here, but ensuring that patients play a central role in **sharing decisions** with their physician about therapy can mitigate the badness of

the situation; it can allow the exercise of autonomy that has been threatened by patients being put on a medication, long-term, with no plan for when or how to get off.

To be clear, the argument of this section does not justify the conclusion that a physician ought to write whatever prescription a patient wants, nor does it tell us what Dr G ought to do. Rather, it introduces a key distinction (between initiating and continuing opioids) and shows how the presence of physical dependence is ethically relevant for determining the appropriateness of continuing to prescribe opioids. In particular, physical dependence changes the risk-benefit profile of opioid prescribing due to the threat of withdrawal if the prescription is discontinued; and the patient, having already suffered an iatrogenic harm, should be given a voice in determining how best to mitigate that harm. These considerations suggest that there are reasons to continue a prescription even when initiating opioid therapy wasn't appropriate.

### **Prescribing for Legacy Patients Is Not Always “Misprescribing”**

Some prescribers might object that continuing to prescribe opioids for Mr T would be wrong if Dr G believes opioids are no longer treating the original pain. After all, most physicians are now acutely aware of legal and professional risks of prescribing opioids to satisfy a patient's addiction under the guise of pain medicine.<sup>13</sup> What's important to recognize, however, is that Dr G has no evidence that Mr T has an addiction, which is characterized by cravings and compulsive behavior even in the face of adverse consequences, such as job loss, relationship deterioration, or overdose.<sup>14</sup> Rather, Mr T is physically dependent on opioids, and dependence is characterized by withdrawal symptoms when a medication is abruptly discontinued.<sup>14</sup> Dependence does not, by itself, entail addiction.

Although continuing to prescribe to a patient one suspects of suffering from addiction is clearly taken by medicine and the law to be a case of misprescribing, according to the Harrison Act of 1914,<sup>13</sup> there is no clear ethical or legal requirement to discontinue prescribing for a patient physically dependent on opioids. Indeed, there could not be, since dependence forms as a matter of course for many medications, including opioids, benzodiazepines, and selective serotonin reuptake inhibitors. So, how should physicians decide whether a given instance of prescribing constitutes a case of misprescribing? Kelly Dineen has shown that there is virtually no concrete guidance on this topic.<sup>13</sup> In the absence of concrete guidance, physicians must ask in each case whether the benefits of opioid therapy outweigh the risks.<sup>15</sup> Accordingly, physicians must consider in each case not only the risks of chronic opioid therapy but also the risks of deprescribing. Forcibly tapering a patient, even when that patient does not suffer from addiction, can expose him to some harms of addiction. Withdrawal symptoms and pain are not only harms in themselves but also can destabilize a previously stable patient. A patient who is cut off from his source of opioid medication might seek other sources to self-medicate<sup>6</sup> or suffer medical or functional deterioration.<sup>16</sup>

In the public health world, a number of harm reduction strategies are endorsed for curbing opioid overdose. These include interventions like syringe-exchange programs,<sup>17</sup> naloxone distribution,<sup>18</sup> and safe consumption sites.<sup>19</sup> Outside the United States, there is even support for providing persons with opioid use disorder with a safe supply of opioids so that they don't have to turn to markets that offer potentially contaminated sources of heroin.<sup>20</sup> The philosophy behind such interventions is that preventing people from using opioids is not what's important; preventing harms of opioid use—specifically, physical dependence, addiction, and death by overdose—is what's important. Forcibly tapering otherwise stable patients off high-dose, chronic opioid therapy reveals that this

practice might have an effect that is the opposite of what public health is calling for: it may be a *harm expanding* intervention, exposing those who have long received opioid medications variously to worsened pain, withdrawal, social instability amidst untreated dependence, or loss of medical care relationships.<sup>21</sup> Taking such risks into account, continuing to prescribe high-dose opioid therapy for a legacy patient does not clearly constitute ethical or legal misprescribing. In light of both clinical goals for an individual patient and public health goals for communities, the risks of long-term opioid therapy must also be weighed, in each patient's case, against the risks of *not* prescribing.

### **What Should a Physician Do?**

If Dr G is correct that Mr T's current dose is dangerous, then an ideal outcome would be one in which Mr T feels comfortable working with Dr G to slowly taper to a safer opioid dose, while simultaneously receiving multimodal pain therapies to treat his underlying pain. But Mr T does not seem ready for tapering yet, which means that Dr G has more to consider in counseling Mr T and sharing decisions with him.

Dr G is obligated to counsel Mr T about potential clinical and public health benefits of tapering: minimizing or eliminating risks and side effects of opioid use, potentially decreasing his pain over time (if Mr T is experiencing opioid-induced hyperalgesia), and reducing the number of pills in his medicine cabinet that are potentially available for diversion. Dr G's goal should be to establish a supportive relationship with Mr T in which both can agree upon and implement a careful tapering strategy.<sup>22</sup> In the meantime, Dr G should continue prescribing at current levels, while counseling and partnering with Mr T to help him achieve a better quality of life and reduced pain.

We must, however, acknowledge that Mr T might never be convinced that the benefits of tapering outweigh its risks. Were this the case, as I've argued, it would still not be ethically permissible for Dr G to unilaterally taper or discontinue prescribing opioids for Mr T. As time goes on, Dr G could offer alternative strategies: in particular, Dr G might suggest transitioning Mr T to buprenorphine, as this opioid is a safer alternative to oxycodone, thanks to its ceiling effect on respiratory depression.<sup>23</sup> And if, over time, Mr T's pain worsens or he shows symptoms of opioid use disorder, Mr T might no longer be a *stable* legacy patient, and thus the risks of continued opioid prescribing might start to outweigh the benefits, even accounting for the risks of deprescribing. If either of these cases were to occur, Dr G should partner with a pain or addiction specialist to manage Mr T's care and evaluate how to best mitigate emerging risks.

The view that it is ethically impermissible to nonconsensually taper stable legacy patients, even when not tapering means prescribing some form of opioid therapy indefinitely, might surprise some. But this view accords with recommendations offered in the US Department of Health and Human Services' 2019 Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics,<sup>23</sup> which advises clinicians not to taper patients prior to their consent to a plan. This guide suggests monitoring physically dependent patients, mitigating their risk of overdosing by providing overdose education and coprescribing naloxone, and periodically "encourag[ing] movement toward appropriate therapeutic changes."<sup>23</sup> These tasks depend on developing deep familiarity with patients' experience and life history, earning their trust, partnering, and sharing decisions.

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#### Editor's Note

The case to which this commentary is a response was developed by the editorial staff.

#### Citation

*AMA J Ethics*. 2020;22(8):E651-657.

#### DOI

10.1001/amajethics.2020.651.

#### Acknowledgements

The author would like to thank Stefan Kertesz, MD, MSc, for reading an early draft of this manuscript and providing insightful commentary and Kelly Dineen, RN, JD, PhD, for offering insights into the legal restrictions surrounding opioid prescribing.

#### Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

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ISSN 2376-6980