Reference number: 202412-0920-006

The CDC, by issuing the 2016 and 2022 Opioid Prescribing Guidelines, has played a major role in the destruction of US pain medicine and the ongoing suffering of both chronic and acute pain patients. These guidelines have resulted in widespread untreated and undertreated pain, worsened outcomes, psychological distress, overdose through substitution of illegal drugs, and suicidal ideation/behavior while NOT having the intended effect of reducing addiction rates or fatal drug overdoses. It will literally require years to correct the mess that CDC has made by adhering to an ineffective and largely political agenda, to the exclusion of well-established science. An entire generation of medical practitioners hesitate to prescribe (or, in the case of pharmacists, fill) adequate levels of opioid medication in fear of losing their licenses and criminal prosecution.

Nearly all states have designed and implemented new laws, regulations, and policies based on the CDC recommendations with the laudable goal of decreasing the rate of opioid overdose. Many states' Medicaid programs, insurers, pharmacy benefit managers, and pharmacies also used the CDC guidelines to create opioid prescribing limits. After studies and further research demonstrated that legally prescribed opioid medication was not the driving force behind this so-called epidemic and that the chances of developing an addiction after an initial legal prescription are less than one percent, the CDC, and therefore all entities noted above, continued enforcing limitations on prescription opioids at the expense of pain patients everywhere.

Millions of patients have been dropped due to their clinicians' fear of sanctions or persecution by State Medical Boards, insurance companies, or law enforcement on fallacious grounds derived from the CDC guidelines. This remains true although the CDC published warnings against misuse of the guidelines. An example is the popular seven-day restriction of opioid medication post-surgery, even though studies have shown that chronic pain is much more likely to develop if acute pain is not adequately treated (and every patient is different!). These ripple effects extend out to the supply chain as well – shortages of commonly used opioid medications have been reported nationwide.

In summation, the CDC guidelines are scientifically inaccurate, ineffective, injurious, and should be completely rescinded. They did not include input from pain management physicians or patients, but rather were written by addiction specialists using cherry-picked data to push their own agenda working with those who wanted to appear to be mitigating the overdose crisis, whether or not the strategies actually worked.

There are numerous errors, including:
* a gross over-emphasis on the risks of opioid prescribing while deliberately and inappropriately ignoring the impact and side effects of alternate therapies (such as NSAIDs or steroid injections);
* continued over-emphasis on tapering legacy patients to levels that are inadequate to control their pain, regardless of the presence of a well-established, responsibly maintained clinical record and the negative impacts of tapering;
* never addressing polymorphism (i.e. some patients process medication faster than others, therefore needing higher doses to achieve the same effect);
* continually using MME units as cutoff points when this measurement lacks any scientific proof of its validity; and
* continually recommending “non-opioid" therapies over opioid therapy despite a lack of published clinical trials demonstrating any validity, whereas opioids have a long history as safe and effective medications.

Perhaps this will change in the future, but at the moment, opioids remain the most effective medication to relieve pain. They have no parallel. To deny this treatment to patients in need is not only irresponsible, but actively cruel. The CDC acted on the admirable goal of preventing drug addiction and overdose, but the guidelines as written have caused immeasurable damage.

To add a few affirmative suggestions for actually reducing overdose/addiction rates and encouraging educated as well as effective pain treatment:
* continue expanding the distribution and availability of Narcan;
* continue expanding Medication Addiction Treatment (Suboxone, methadone, etc,), including in prisons;
* follow the harm reduction model of creating safe injection sites;
* drastically increase insurance coverage for and the number of rehab beds (people should be able to be admitted within 24 hours);
* address the underlying causes such as homelessness, poverty, untreated mental illness, and trauma (aligning with the results of the Rat Park study);
* legalize medical marijuana and encourage companies to not prohibit its use while employed;
* require much more than the current average of nine hours of pain education in medical school;
* improve insurance coverage of adjunctive therapies (e.g. acupuncture, physical therapy, medical devices) as well as longer appointments for pain management; and
* publicly combat the puritanical narrative that pain is something to push through, value as character-building, a sign of weakness, or can be cured with positive thinking alone.