The False Dichotomy of Pain and Opioid Use Disorder
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On March 3, 2022, the Sackler family agreed to a settlement of up to $6 billion on behalf of Purdue Pharma in response to litigation that alleged that the company promoted OxyContin—an early driver of the opioid crisis—while knowing it was resulting in significant opioid harms. But it will take more than money to ensure that people suffering from pain and opioid use disorder (OUD) receive appropriate care. A new paradigm to undergird US policies and practices is needed, one that aligns the need for safe and equitable opioid access for people with both pain and OUD.

To see the flaws in the current US system, one needs to look no further than cancer. More than half of patients with cancer experience moderate to severe pain and many require opioid management even after the completion of cancer therapies. Although the opioid-centric approach to cancer pain management and the exemption of cancer pain from such national pain guidelines as those from the US Centers for Disease Control and Prevention seem to assume that people with cancer are not at risk for OUD and other opioid harms, people with cancer have a higher prevalence of substance use disorders compared with people without cancer. Despite this risk, most cancer centers do not offer addiction services and less than 15% of palliative care clinicians possess the required X waiver to prescribe buprenorphine for OUD.

People with pain and OUD have limited care options because of existing policies that isolate addiction treatment from the rest of health care. Methadone and buprenorphine are opioid analgesics approved by the US Food and Drug Administration and are gold standard medications for treating OUD, but divergent regulations make them challenging to access for either indication and nearly impossible for a dual indication of pain and OUD. Any licensed clinician certified by the Drug Enforcement Agency can prescribe opioids for pain, but when treating OUD, methadone is limited to federally regulated opioid treatment programs and buprenorphine is limited to clinicians who possess the X waiver.

Failed Policies
Existing policies force clinicians to assign people with pain to one group and people with OUD to another, thereby driving value-laden judgments about the legitimacy of opioids for a given person and condition—judgments associated with racial, ethnic, and socioeconomic inequities. Racial disparities in access to pain management and opioids are well documented. For example, buprenorphine is less likely to be available through health care facilities in Black communities than in White communities. Methadone, sometimes referred to as “liquid handcuffs,” is the dominant medication prescribed for OUD disorder in Black patients and can only be dispensed in federally licensed opioid treatment programs.

The assessment and treatment of pain and OUD, including the regulation of buprenorphine and methadone, is based on a false dichotomy. Approximately 10% of individuals prescribed opioids for pain will develop an OUD, and about 25% will manifest concerning behaviors that may indicate a “subclinical” OUD. Buprenorphine and methadone are important tools in cancer pain management and they can significantly decrease mortality and improve quality of life for people with OUD. In palliative care, methadone and buprenorphine are regularly used as analgesics; however, OUD treatment without an X waiver or outside a methadone treatment program is illegal. The lack of integration of OUD in specialties such as oncology has also led to therapeutic nihilism, and the view
that people with OUD do not get better perpetuates stigma rather than emphasizing the barriers to obtaining life-saving treatment.

Currently, there are limited options for people with OUD who develop cancer or other conditions associated with painful sequelae despite undertreated pain and serious illness being powerful triggers for a return to nonmedical opioid use.4 If a patient with OUD is treated with methadone then develops cancer, it is difficult to address pain with methadone as a dual treatment without violating federal regulations or state-based policies. Sometimes clinicians in cancer care circumvent the system and take over methadone prescribing, but this a precarious situation that violates federal policy and has few safeguards to optimize patient safety.5

Fear and scrutiny around opioid prescribing have dire consequences for people with opioids prescribed for pain, with forced opioid tapers resulting in increased risk of opioid overdose and reduced access to primary care. Even among people with cancer, a condition for which opioid use is consistent with guidelines, more than half of patients experience stigma associated with their opioid prescriptions, including strained relationships with clinicians and difficulty filling an opioid prescription.

Policy Solutions

The X waiver is a barrier to accessing appropriate treatment of both pain and OUD. Since 2021, buprenorphine guidelines from the US Department of Health and Human Services have allowed clinicians to treat 30 patients with buprenorphine for OUD without the additional education requirement. A better solution is to eliminate the X waiver altogether and have all Drug Enforcement Agency–certified clinicians become familiar with buprenorphine prescribing.7

In 2019, a report by the National Academies of Science, Engineering, and Medicine concluded that current regulations around methadone and buprenorphine are not empirically based and impose substantial restrictions on life-saving medications. A recent workshop to inform the work of the Office of National Drug Control Policy included evidence obtained during the SARS-CoV-2 pandemic, when flexible methadone policies permitted take-home doses. This change did not increase overdose rates, prompting advocacy for methadone programs to permanently decrease attendance requirements and in-person dosing. Flexibility in where methadone can be dispensed is needed. Concurrent care models to deliver medication for OUD within cancer centers would decrease barriers for people with cancer and provide greater opportunity for flexible dosing for cancer-related pain and OUD, and pharmacy-based dispensing, which has been widely adopted in other countries, could also be helpful. Methadone clinics are an anachronism of a 50-year-old federal policy for which innovation is sorely needed.

Concurrent management of pain and OUD can be reimagined with the increased use of telehealth, with early evidence suggesting equivalent care. Although less than 1% of OUD care was delivered via telehealth before the SARS-CoV-2 pandemic, since March 2020, clinicians have been allowed to initiate and manage buprenorphine over the phone. Likewise, telehealth could significantly improve interdisciplinary collaboration on multimodal approaches for addressing the high rates of opioid prescribing, substance use, and chronic pain associated with cancer, as the Veterans Administration health care system has done with noncancer pain.

More research is needed on how OUD and pain conditions interact as well as best practices in prescribing for both. As states and the federal government gain access to funding from opioid settlements, patients and clinicians alike could benefit from a national research agenda that can inform how to transform US mental and behavioral health services.

Discomfort and stigma in treating OUD and pain require shifting societal attitudes and disseminating evidence. The opioid settlement funding should build on existing public education campaigns to counter stigma and highlight the voices of people with lived experience of pain and OUD. These campaigns need to reach policy makers and clinicians as well.
All communities and patients should have access to clinicians with the authority to prescribe the appropriate medication for the treatment of OUD, pain, or both conditions. But it will require policymakers to develop more flexible policies that address the needs of patients with pain and OUD and clinicians to implement these policies in ways that end OUD-associated stigma.

REFERENCES


