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Dear Dr. Dowell:

On behalf of the American Medical Association (AMA) and our physician and medical student members, I am writing to thank you for your recent Viewpoint piece in the Journal of the American Medical Association (JAMA), "Patient-Centered Reduction or Discontinuation of Long-term Opioid Analgesics." The AMA appreciates that the Centers for Disease Control and Prevention (CDC), National Institute on Drug Abuse (NIDA) and U.S. Department of Health and Human Services (HHS) continue to recognize that patients in pain require individualized care and that the CDC's 2016 guidelines on opioids have been widely misapplied. As you point out in the recent JAMA Viewpoint, the CDC guidelines have been treated as hard and fast rules, leaving physicians unable to offer the best care for their patients. Your public pronouncements of this are an important course correction. At the same time, there are additional areas that we would like to offer for your consideration and our continued collaboration to end the opioid epidemic and improve patient care.

First, we once again appreciate your clarity that patients with acute or chronic pain can benefit from taking prescription opioid analgesics at doses that may be greater than arbitrary thresholds. We recommend, however, even stronger direction to specifically urge state governments, federal agencies health insurance companies, pharmacy chains, pharmacy benefit management companies (PBMs) and other advisory or regulatory bodies to rescind any hard threshold policies based on the misinterpretation of the CDC guidelines.

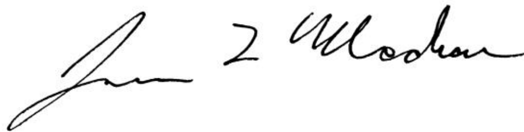
Second, we also appreciate the new guidance on tapering and will share it with our members. It is a reality, however, that physicians are often caught between two difficult, and often impossible, choices. If they prescribe opioid analgesics at doses or quantities above the strict thresholds that we all agree are being misapplied, those physicians have become subject to law enforcement and medical board investigations. On the other hand, because of the fear of prosecution, as you note, some physicians have chosen to no longer prescribe opioid analgesics, which can leave patients in a bind if no one is willing to take on a new patient already receiving high doses of opioid analgesics. Tapering, while laudable when clinically indicated, does not help physicians in either of the above scenarios. We urge your help to mitigate this medical Catch-22.

Third, the AMA strongly agrees with you that non-opioid pain care alternatives can help alleviate the reliance on opioid therapy. Physicians have responded by reducing opioid prescriptions by 33 percent between 2013 and 2018. Unfortunately, payers and PBMs have not demonstrated similar progress in

increasing access to low-cost non-opioid pharmacologic options or reducing barriers to non-pharmacologic options such as interventional or restorative therapies, physical therapy, cognitive/behavioral therapy or other options spelled out in the HHS Interagency Pain Care Task Force report. It is challenging for physicians to be directed by the federal government to increase access to non-opioid pain care options when payers and PBMs make that difficult, to impossible, to achieve. Your support to rectify this situation would be greatly appreciated.

Thank you again for your continued leadership. To discuss ways in which we can work together on these areas, please contact Margaret Garikes, Vice President, Federal Affairs, at 202-789-7409 or margaret.garikes@ama-assn.org.

Sincerely,



James L. Madara, MD

cc: Wilson M. Compton, MD, MPE (National Institute on Drug Abuse)
Admiral Brett P. Giroir, MD (Office of the Assistant Secretary for Health)