# Opinion: Putting patients first in prescription opioid regulation

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Keith Humphreys, PhD, the Esther Ting Memorial Professor in the Department of Psychiatry and Behavioral Sciences at Stanford Medicine, chairs the Stanford-Lancet Commission on the North American Opioid Crisis. Credit: Timothy

Archibald

When I agreed to lead the Stanford-*Lancet* Commission on the North American Opioid Crisis, I knew I was striding into a combat zone. For the past quarter century, the medical community—as well as the rest of the country—has formed competing camps that emphasize either the destructive power of opioids or their therapeutic usefulness.

Our commission's model estimated that if we don't change our current policies, over a million people will die of opioid overdoses in the United States this decade. The more the former camp highlights the potential of prescription opioids to cause addiction and overdose, the more the latter camp highlights how underprescribing opioids harms those suffering chronic pain.

These dynamics, to some extent, reflect shortcomings in how we judge risk and benefit. Psychologists, including Paul Slovic, Ph.D., a national expert on decision making and risk analysis, have shown that we tend to mentally outsource judgments that should involve complex reasoning about risks and benefits to simple emotional responses.

If we have a good feeling about the benefits of something (That car looks fun to drive!), we tend to minimize its risks (It has a terrible crash record). If we have a negative feeling about the risks, we tell ourselves the benefits are exaggerated.

In reality, high risk and high benefit can work together, as can low risk and low reward. I didn't want the commission recommendations to fall into this mental trap by painting opioids as either a menace or a panacea.

I've spent my career in the addiction field, where the harms of opioids

are very evident, but I've also spent a decade volunteering as a counselor in hospice, where the benefits of opioids are very evident.

A radio show producer who was arranging a panel on the opioid crisis asked me, "To ensure balance during the debate, I just have to ask if you are for or against opioids." I responded, "No." Needless to say, they found another guest.

I am proud of the justice done by commission members to addressing the complex nature of the opioid crisis—recommending policies to reduce corporate over-promotion of opioids, while recognizing the need for medical schools to teach students about the many effective uses of this class of medication.

How was this consensus achieved? And how can I promote a similarly nuanced stance in my teaching and interactions with policymakers? I haven't cracked the mystery, but I've learned something valuable.

The entire ecosystem around the opioid crisis separates people into competing factions. This includes formal structures, like journals and professional societies, and informal ones like Twitter. When a group interacts only with its own members, judgments and hostilities toward those in other groups tend to become more unbalanced and extreme.

The commission included people who wouldn't normally be in the same room: experts in addiction, pain medicine, law, and public policy, as well as people with lived experience of addiction and chronic pain. Yet they found a way to listen to each other. It was candidly hard work at times, certainly more so than if everyone had huddled only with their own.

It might take that combination of diverse perspectives and experiences, combined with an ethic of collegiality, to break out of our simplistic viewpoints about opioid use and addiction (and perhaps for many other

issues as well).

"We should not be pro-opioid or anti-opioid," said commission member Sean Mackey, MD, Ph.D., chief of the Division of Pain Medicine and the Redlich Professor at Stanford. "We should be pro-patient."

Provided by Stanford University