Halakhic Approaches to a Man-made Epidemic: Opioids and Narcan

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Opioids, a class of narcotics that includes oxycodone, heroin, and fentanyl, provide effective pain control but also present serious risks, including overdose, opioid use disorder, and addiction. In the late 1990s, Purdue Pharma released OxyContin,[1] saying that it was not addictive.[2] This claim

[1] OxyContin contains the same active ingredient as oxycodone. However, OxyContin releases oxycodone throughout the day whereas oxycodone pills release it immediately.

[2] In 1995, Purdue Pharma received FDA approval of OxyContin for pain management. Before this, doctors used opioids only for the treatment of extreme pain in emergency situations or for terminal cancer patients. Purdue Pharma marketed its product intensively, funding studies that downplayed the drug's addictive potential; supporting medical conferences and NGOs working to ease the suffering of chronic pain patients; disseminating medical propaganda; and rewarding physicians for prescribing OxyContin. Purdue Pharma provided financial support to the American Pain Society, the American Academy of Pain Medicine, the Federation of State Medical Boards, the Joint Commission, pain patient groups, and other organizations. It introduced a campaign entitled "Pain is the Fifth Vital Sign," encouraging physicians to use opioids aggressively to treat chronic non-cancer pain (Fauber J. 2012. "Painkiller boom fueled by networking: doctors, researchers with financial ties to drug makers set stage for surge in prescriptions," *Milwaukee Journal Sentinel*, Feb. 18, p. A1). The medical

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encourage healthcare providers to prescribe it freely. By the time the medical community recognized the medicine's addictive potential, opioid misuse had become widespread. A federal judge called it a man-made plague,[3] and Dr. David Kessler, former director of FDA, called it "one of the great mistakes of modern medicine."[4] In 2017, the US Department of Health and Human Services declared a public health emergency to combat opioid addiction,[5] proposing three strategies to reduce opioid use disorder and overdose: limiting opioid-prescribing practices; expanding use and distribution of Narcan, an antidote to opioid overdose; and the expansion of medication-assisted treatment.

This article explores how Jewish law approaches opioid use in the management of non-cancer, non-end-of-life pain, and the interventions to curtail this epidemic.[6] We will begin with some scientific background.

Opioids are highly addictive. Taking them for even five consecutive days increases the likelihood of long-term dependency, suggesting that addiction can develop with even brief use.[7][8] Americans consume approx-

community responded positively. However, in light of the opioid epidemic that ensued, the manufacturers and distributers of OxyContin now face massive lawsuits, amounting to billions of dollars, for these practices. The US has started taking steps to curb its use.

3 https://www.bloomberg.com/news/articles/2018-12-20/opioid-industry-claims-proceed-as-judge-cites-man-made-plague.

4 https://www.cbsnews.com/news/former-fda-head-doctor-david-kessler-opioid-epidemic-one-of-great-mistakes-of-modern-medicine/.

5 https://www.hhs.gov/opioids/about-the-epidemic/index.html.

6 Clinical Guidelines and the medical community distinguish between chronic non-cancer pain and pain from active cancer treatment, palliative care, and end-of-life care. This distinction reflects the unique therapeutic goals, ethical considerations, opportunities for medical supervision, and balance of risks and benefits with opioid therapy in each kind of care. In light of these differences, the distinct approach of medicine to cancer, palliative, and end-of-life pain, and how these differences might affect halakhic considerations, this article focuses primarily on issues related to non-cancer pain.
https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm#:~:text=The%20guideline%20is%20not%20intended,opioid%20therapy%20in%20such%20care.

7 Shah A, Hayes CJ, Martin BC, "Characteristics of Initial Prescription Episodes and Likelihood of Long-term Opioid Use - United States, 2006-2015," *MMWR*. 2017 Mar 17;66 (10):265-269.

8 https://www.cdc.gov/drugoverdose/pdf/patients/Get-the-Facts-a.pdf.

imately 80% of the world's opioids and 99% of its hydrocodone (the opioid component in Vicodin).[9,10] Twenty percent of the patients who visit a doctor for non-cancer pain receive an opioid prescription.[11] The rise in opioid consumption has contributed to a three-fold increase in opioid-related emergency department visits and a surge in misuse and addiction.[12] In 2020, more than 10 million Americans misused prescription pain relievers, which increase the risk of opioid dependence and Opioid Use Disorder (OUD); nearly 3 million people suffer from OUD.[13] Eighty percent of heroin users report that their initiation into opioid use came through prescription opioids. Nearly all heroin users who began opioid use with prescription opioids say that after becoming addicted to prescription pain medicines, they switched to heroin because prescription opioids were "more expensive and harder to obtain."[14] Opioid misuse has far-reaching and catastrophic effects on health and society, contributing to neonatal opioid withdrawal syndrome, foster care, a reduction in the workforce, an increase in heroin and fentanyl use, and injection-related infectious diseases.[15,16,17,18]

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9 https://painphysicianjournal.com/current/pdf?article=MTIxNg%3D%3D&journal=49.

10 Americans represent less than 5% of the world's population.

11 Daubresse M, Chang HY, Yu Y, et al., "Ambulatory Diagnosis and Treatment of Nonmalignant Pain in the United States, 2000-2010," *Med Care* 2013; 51:870–8. CrossRefexternal icon PubMedexternal icon.

12 https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/qdr-data-spotlight-opioids-edvisits-tx.pdf.

13 https://www.samhsa.gov/data/sites/default/files/reports/rpt35319/2020NSDUHFFR1PDFW102121.pdf.

14 Cicero TJ, Ellis MS, Surratt HL, Kurtz SP., "The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years," *JAMA Psychiatry* 2014;71: 821-26.

15 Lynch S, Sherman L, Snyder SM, Mattson M., "Trends in Infants Reported to Child Welfare with Neonatal Abstinence Syndrome (NAS)," *Child Youth Serv Rev.* 2018;86(c):135-141.

16 O'Donnell JK, Gladden RM, Seth P, "Trends in Deaths Involving Heroin and Synthetic Opioids Excluding Methadone, and Law Enforcement Drug Product Reports, By Census Region—United States, 2006-2015," *MMWR Morb Mortal Wkly Rep*, 2017;66(34):897-903.

17 Paquette CE, Pollini RA, "Injection Drug Use, HIV/HCV, and Related Services in Nonurban Areas of the United States: A Systematic Review," *Drug Alcohol Depend*, 2018; 188:239-250.

18 Krueger AB, "Where Have All the Workers Gone? An Inquiry into the Decline of the US Labor Force Participation Rate," *Brookings Papers on Economic Activity*

From 1997 to 2011, the number of individuals seeking treatment for addiction to opioids increased by 900%.[19] Between 1999 and 2019, nearly 500,000 Americans died from an opioid overdose,[20] a mortality rate that surpasses that of HIV/AIDS during the worst years of the HIV epidemic. In the 12-month period ending in April 2021, deaths from opioid overdose was over 75,000, a record high.[21] COVID-19 has exacerbated the opioid epidemic by increasing isolation, stress, and anxiety; disrupting drug supply chains; and complicating access to medical care.[22] The Stanford-Lancet Commission estimates that without policy reform and interventions, the death rate from opioids will double in the next decade, taking the lives of an additional 1.2 million North Americans.[23]

The Opioid Epidemic in the Religious World

Former FDA Director Dr. David Kessler labelled the opioid epidemic "an American condition" and "an American disease."[24] Is it a Jewish disease? Has the opioid epidemic infiltrated the Jewish world?

There is a pervasive myth that Orthodox Jews are immune to substance abuse and addiction.[25] Although there are few studies reporting the prevalence of substance abuse among American Jews,[26] anecdotal reports

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Conference, draft. https://www.brookings.edu/wp-content/uploads/2017/09/1_krueger.pdf. Published August 26, 2017. Accessed April 21, 2020.

19 SAMHSA (Subst. Abuse Ment. Health Serv. Adm.). 2010. Center for Behavioral Health Statistics and Quality. Treatment Episode Data Set (TEDS): 2007. Discharges from Substance Abuse Treatment Services. DASIS Ser.: S-51, HHS Publ. No. (SMA) 10-4479. Rockville, MD: SAMHSA.

20 US Centers for Disease Control and Prevention, "Multiple Causes of Death 1999–2020." 2021. http://wonder.cdc.gov/mcd-icd10.html (accessed Dec 29, 2021).

21 https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.

22 https://www.hsph.harvard.edu/news/features/a-crisis-on-top-of-a-crisis-covid-19-and-the-opioid-epidemic/.

23 https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)02252-2/fulltext. Lancet 2022; 399: 555–604 Published Online February 2, 2022 https://doi.org/10.1016/ S0140-6736(21)02252-2.

24 https://www.cbsnews.com/news/former-fda-head-doctor-david-kessler-opioid-epidemic-one-of-great-mistakes-of-modern-medicine/.

25 Carol Glass, "Addiction and Recovery through Jewish Eyes." Morgan O. J., Jordan M., editors. *Addiction and Spirituality: A Multidisciplinary Approach*, St. Louis, Mo, USA: Chalice Press; 1999.

26 Shulamis L.A. Strauser., *Ethnocultural Factors in Substance Abuse Treatment*. New York: Guilford Press, 2002, p. 447.

suggest that opioid misuse and abuse have infiltrated the American Jewish community. The Jewish Federation of Cleveland estimates that of the 820 people who died because of overdoses in Cuyahoga County in 2017, at least 50 were members of the Jewish community.[27] The Jewish United Fund estimates that 180,000 Jewish people are addicted to drugs (they do not estimate how many suffer specifically from opioid addiction).[28] In a survey that the Jewish Child and Family Services of Winnipeg conducted, 41.2% of respondents reported knowing someone currently struggling with addiction, and 23.5% disclosed a family history of alcohol or drug abuse.[29] A 2019 *Haaretz* article titled, "It's a Myth That Orthodox Jews Don't Get Addicted: The Opioid Epidemic in an Insular Community"[30] reported that over the last five years, Amudim, an organization that treats alcohol and drug addiction within the community, cared for 1,090 Jewish individuals in New York. According to the organization, addiction typically begins with prescription pain medications (opioids), and then progresses to heroin or cocaine.[31] These numbers probably underestimate the true extent of opioid abuse in the religious world, as many are reluctant to address the problem due to the fear that disclosure might taint the family, and damage its stature in the community, or marriage prospects.[32] In a UJA-Federation of New York survey of the impact of COVID-19 on

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27 https://www.news5cleveland.com/news/local-news/cleveland-metro/greater-cleveland-jewish-community-fights-back-against-opioid-crisis. Cleveland becomes first Jewish community in the country to break silence on deadly opioid addiction.

28 https://www.juf.org/news/local.aspx?id=445590.

29 Baruch M, Benarroch A, Rockman GE., "Alcohol and Substance Use in the Jewish Community: A Pilot Study," *J Addict*. 2015;2015:763930. doi: 10.1155/2015/763930. Epub 2015 Jun 16. PMID: 26161279; PMCID: PMC4487707.

30 https://www.haaretz.com/us-news/2019-11-25/ty-article/.premium/these-ny-orthodox-jews-are-fighting-the-stigma-of-opioid-addiction-in-the-community/0000017f-f003-d487-abff-f3ffa9680000?lts=1656324702824.

31 The article quotes Yaacov Behrman, the leader of a drug prevention program in Crown Heights, who personally recalled at least 10 cases of overdose death in the Orthodox community. In a July 2022 personal communication with one of the authors, Mr. Behrman indicated that the number of opioid overdose deaths has increased significantly since publication of the *Haaretz* article.

32 https://www.haaretz.com/us-news/2019-11-25/ty-article/.premium/these-ny-orthodox-jews-are-fighting-the-stigma-of-opioid-addiction-in-the-community/0000017f-f003-d487-abff-f3ffa9680000?lts=1656324702824.

Jews in the New York area, 10% of Jewish households reported a substance abuse problem. Nine out of ten of those are not seeking help.[33]

Opioid abuse has also reached Israel. Data from Israel reflect a 13% prevalence of illicit drug use; 1% of Israelis meet the diagnostic criteria for drug abuse/dependence, which is similar to the rate in the general US population.[34] One of ten members of the Clalit Health Fund, which insures nearly half of the Israeli population, received a prescription for opioids in 2018. Opioid use among Clalit patients more than doubled, and the use of fentanyl tripled in the decade ending in 2018.[35,36,37] Experts expect that one in six Israelis receiving long-term opioids will become addicted.[38] Although Israel has not yet compiled data on opioid use during the COVID-19 pandemic, professionals in the field report a 50–60% increase in use among teenagers from all segments of society.[39] An Israeli newspaper interpreted statements of charedi rabbis prohibiting recreational and medicinal marijuana as a clear indication that marijuana and other harder substances have infiltrated their community, and that the problem is so pervasive that it justifies public discourse.[40] David Papo, chairman of the Israel Pharmacists Association, stated, "We're in a war, so we need to take drastic measures."[41]

The consequences of denial and the failure to address substance abuse in the Jewish community are far-reaching and devastating. Deterring many from seeking help and preventing those who do so from integrating Judaism and Jewish values into their recovery, leads to unnecessary pain and alienation from Judaism.[42] Rabbi Abraham Twerski illustrates the true

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33 https://www.ujafedny.org/api/v2/assets/replaced-UJA-Covid19-Reports-ExecutiveSummary-2-0.pdf.

34 Religions 2014, 5, 972–984; doi:10.3390/rel5040972.

35 Miron O, Zeltzer D, Shir T*, et al*., "Rising Opioid Prescription Fulfillment among Non-Cancer and Non-Elderly Patients—Israel's Alarming Example," *Regional Anesthesia & Pain Medicine*. Published Online First: 19 November 2020. doi: 10.1136/rapm-2020-101924.

36 This study included patients with non-cancer pain as well as those with cancer, for whom opioid use is common and beneficial.

37 The largest increase in opioid consumption was among non-cancer patients aged under 65.

38 https://www.hashomrim.org/eng/381.

39 https://www.ynetnews.com/magazine/article/sjptellaf.

40 https://www.makorrishon.co.il/judaism/511017/.

41 https://www.hashomrim.org/eng/381.

42 Carol Glass, "Addiction and Recovery through Jewish Eyes," *Addiction and Spirituality: A Multidisciplinary Approach*, Oliver. J. Morgan and Merle Jordan, eds. Danvers, MA: Chalice Press, 1999, 235-247.

dangers of denial in the story of an alcoholic who sought help in the religious world, where she was shunned. She subsequently turned to a priest, who helped her recover. After becoming sober, she became a devout Catholic.[43]

In 2012, healthcare providers wrote 259 million prescriptions for opioid pain medication, enough for every adult in the United States to have a bottle of pills.[44] Dr. Gary Franklin, medical director of Washington State's Workers' Compensation program, describes the opioid epidemic as "the worst man-made epidemic in the history of modern medicine—and it's made by us, by physicians, by surrogates for the drug companies."[45] What is the role of physicians in fueling this epidemic and what steps must they take to halt it?

An opioid prescription introduces a patient to an addictive substance, creating the risk that he will develop Opioid Use Disorder. The vast number of these prescriptions has created a pill surplus that allows people to divert the opioids from their intended purpose. The majority of those who illicitly use prescription opioids obtain them not from drug dealers, but from a friend or relative with extra pills, or by prescription from a healthcare provider.[46] Many hold the misconception that opioids cannot be dangerous because they are sold by pharmacies and prescribed by physicians, not drug dealers.[47] But merely having an opioid prescription increases one's risk of overdose and opioid use disorder.[48] One study, which followed patients for up to 13 years after they received opioids for chronic, non-cancer pain, reported that one in 550 of them died from an opioid-related overdose at a median of 2.6 years from their first opioid

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43 *ibid.*

44 Paulozzi LJ, Mack KA, Hockenberry JM, "Vital Signs: Variation among States in Prescribing of Opioid Pain Relievers and Benzodiazepines—United States, 2012," *MMWR Morb Mortal Wkly Rep.* 2014;63:563–8. PubMedexternal icon.

45 https://www.npr.org/sections/health-shots/2022/04/09/1091689867/opioid-prescribing-guidelines-pain.

46 https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR2-2015/NSDUH-FFR2-2015.htm#tabb-13.

47 https://www.ynetnews.com/magazine/article/sjptellaf/.

48 Edlund MJ, et al., "The Role of Opioid Prescription in Incident Opioid Abuse and Dependence among Individuals with Chronic Noncancer Pain: The Role of Opioid Prescription," *Clin J Pain*, 2014;30:557–64. PubMedexternal icon.
Zedler B, et al., "Risk Factors for Serious Prescription Opioid-Related Toxicity or Overdose among Veterans Health Administration Patients." *Pain Med* 2014;15:1911–29. CrossRefexternal icon PubMedexternal icon.
Bohnert AS, et al., "Association between Opioid Prescribing Patterns and Opioid Overdose-Related Deaths," *JAMA* 2011;305:1315–21.

prescription, and that among those who received high-dose opioids, one in 32 patients died from an overdose.[49] Nearly 50% of new pain patients who took prescription opioids for more than 30 days in the first year continued to do so for three years or longer.[50]

Chronic pain affects 100 million Americans.[51] Nearly 50% of Americans suffer from it;[52] 11% of adults experience daily pain.[53] Chronic pain compromises complex activities, affects quality of life and work productivity, contributes to stigma, and has far-reaching clinical, psychological, and social consequences. All of this highlights the need for effective pain control.[54] While opioids can help treat and manage chronic pain, they might not be appropriate for many pain patients.[55,56,57] Surgeons overprescribe opioids for acute post-operative pain. In one study, they prescribed three times more prescription opioids than their patients used.[58] Although the risk of opioid misuse for acute post-surgical or post-procedural pain is low (0.6%), given the large number of procedures performed annually, approximately 160,000 patients annually risk developing dependence,

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49 Kaplovitch E, et al., "Sex Differences in Dose Escalation and Overdose Death during Chronic Opioid Therapy: A Population-Based Cohort Study," *PLoS One* 2015;10:e0134550.

50 https://www.nejm.org/doi/pdf/10.1056/NEJMra1507771.

51 https://nida.nih.gov/publications/improving-opioid-prescribing.

52 Tsang A, et al., "Common Chronic Pain Conditions in Developed and Developing Countries: Gender and Age Differences and Comorbidity with Depression-Anxiety Disorders," *J Pain* 2008;9:883–91. Corrected in: Demytteneare K. J Pain 2009;10:553.

53 Nahin RL, "Estimates of Pain Prevalence and Severity in Adults: United States, 2012." *J Pain* 2015;16:769–80.

54 "Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research," *Institute of Medicine*, Washington, DC: The National Academies Press; 2011.

55 https://nida.nih.gov/publications/improving-opioid-prescribing.

56 For example, pain from fibromyalgia and tension headaches responds better to anti-depressants and anti-convulsants than to opioids, and these medications lack the potential for addiction. Another problem is that chronic opioid use can lead to increased pain sensitivity, exacerbating pain. https://prevention.nih.gov/sites/default/files/documents/programs/p2p/ODPPainPanelStatementFinal_10-02-14.pdf.

57 https://www.painphysicianjournal.com/current/pdf?article=MTQ0Ng%3D%3D&journal=60.

58 Kim N, et al., "A Prospective Evaluation of Opioid Utilization After Upper-Extremity Surgical Procedures: Identifying Consumption Patterns and Determining Prescribing Guidelines," *J Bone Joint Surg Am*, 2016;98(20):e89.

abuse, or overdose from even a short course of opioids.[59,60] Emergency departments write only a fraction of all opioid prescriptions, yet these prescriptions account for about 45% of the opioids diverted for non-medical use;[61] while for acute pain, opioids may only provide 20–30% pain relief.[62,63,64,65]

Opioids are particularly dangerous when combined with benzodiazapines, alcohol, and muscle relaxants[66,67] or after a non-fatal overdose. But the percentage of prescriptions for concurrent opioids and benzodiazepines has increased dramatically.[68] Physicians consistently offer opioids to patients who have overdosed. Sixty-three percent of these patients continued to receive prescriptions for a high dose of opioids, and of them,

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59 Hall MJ, Schwartzman A, Zhang J, Liu X, "Ambulatory Surgery Data from Hospitals and Ambulatory Surgery Centers: United States, 2010," *Natl Health Stat Report*, 2017(102):1-15.

60 Shah A, Hayes CJ, Martin BC, "Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use - United States, 2006-2015," *MMWR*, 2017 Mar 17;66 (10):265-269.

61 Cheng D, Majlesi N, "Clinical Practice Statement: Emergency Department Opioid Prescribing Guidelines for the Treatment of Noncancer Related Pain," *American Academy of Emergency Medicine*, Milwaukee, WI: 2013.

62 Furlan AD, et al., "Opioids for Chronic Noncancer Pain: A Meta-analysis of Effectiveness and Side Effects," *CMAJ*, 2006;174: 1589-1594.

63 Teichman JM, "Clinical Practice. Acute Renal Colic from Ureteral Calculus," *N Engl J Med*, 2004; 350(7):684; Holdgate A, Pollock T, "Systematic Review of the Relative Efficacy of Non-steroidal Anti-inflammatory Drugs and Opioids in the Treatment of Acute Renal Colic." *BMJ*, 2004;328(7453):1401.

64 Friedman BW, et al., "Naproxen with Cyclobenzaprine, Oxycodone/Acetaminophen, or Placebo for Treating Acute Low Back Pain: A Randomized Clinical Trial," *JAMA*, 2015 Oct 20;314(15):1572-80.

65 Solomon DH, "Nonselective NSAIDs: Overview of Adverse Effects. UpToDate." Sep 20, 2016; Dodwell ER, et al., "NSAID Exposure and Risk of Nonunion: A Meta-Analysis of Case-Control and Cohort Studies," *Calcif Tissue Int*, 2010;87(3):193.

66 Tori ME, Larochelle MR, Naimi TS, "Alcohol or Benzodiazepine Co-involvement with Opioid Overdose Deaths in the United States, 1999-2017," *JAMA Netw Open*, 2020;3:e202361. [PMID: 32271389] doi: 10.1001/jamanetworkopen.2020.2361.

67 https://nida.nih.gov/research-topics/opioids/benzodiazepines-opioids#Reference.

68 Hwang CS, et al., "Trends in the Concomitant Prescribing of Opioids and Benzodiazepines, 2002-2014," *Am J Prev Med*, 2016;51:151-160. [PMID: 27079639] doi:10.1016/j.amepre.2016.02.014.

17% overdosed again over the next two years, further calling into question physicians' opioid prescription practices.[69]

Given the prevalence of over-prescription, its impact on the opioid epidemic, and physicians' unique role as gatekeepers of the supply of this potentially addictive medication, how does halakhah view the role of the physician in the opioid epidemic?[70] Does halakhah permit physicians to prescribe a drug with such a strong potential for addiction? If it allows these prescriptions, does it place any restrictions on the physician? What is the physician's responsibility for ending the opioid epidemic?

Halakhah emphasizes the importance of pain control. Rabbi JD Bleich believes that pain relief is part of the physician's obligation to heal the sick. He writes, "relief of pain should be aggressively pursued simply because it is the humane thing to do... the doctrine of *imitatio Dei* demands that a person act in a humane manner because in doing so he shares, at least in a miniscule fashion, in the divine attributes."[71] Halakhah approaches pain as a medical condition that one may treat like any other illness, despite the risks of treatment.[72] *Minḥat Shlomo* 2:82 permits administering pain medicine to a patient even if it will cause harm. He writes that because pain is difficult to tolerate, we must have mercy on the patient and ease his suffering. He points out that severe pain weakens the patient and may cause more harm than the medicine. He believes that providing pain relief is part of the mitzvah of "love thy neighbor." Citing *Sanhedrin* 84b, he points out that the only restriction that the Torah places on fulfilling this mitzvah is that one may not offer an option that one would not want for oneself. He reasons that any person would want to reduce pain, even if doing so leads to harm. The physician must therefore administer the medicine with the intent of calming the patient, despite the risk that it will hasten his death. Two halakhic principles justify administration of potentially harmful pain medicine: *pesiḳ reisha d'lo niḥa leh,* a permitted action that inevitably results in a prohibited action in which the

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69 Larochelle MR, et al., "Opioid Prescribing after Nonfatal Overdose and Association with Repeated Overdose: A Cohort Study," *Ann Intern Med*, 2016 Jan 5;164(1):1-9. doi: 10.7326/M15-0038. Epub 2015 Dec 29. PMID: 26720742.

70 For a discussion of how halakhah approaches addiction, please see our articles, https://hakirah.org/Vol30Galper.pdf and our forthcoming article Galper Grossman S and Grossman S, "Halakhah Examines the Nonmedical Use of Adderall," which will appear in a forthcoming issue of *Ḥakirah*.

71 Bleich JD, "Palliation of Pain," *Tradition*, 2002; 36:89–114.

72 Encyclopedia *Hilkhatit Refu'it*, vol. 4, *yissurim,* columns 9-14.

person has no interest,[73] and *shomer peta'im HaShem,* the principle that G-d watches over the simple.[74] Since it is usual for all patients to seek pain medicine, *shomer peta'im* will protect an individual from any harm that might arise from it.

Tzitz Eliezer 13:87 also permits pain medicine for a patient who suffers greatly from an incurable disease, although the medicine might hasten his death. He requires the physician to administer it only with the intent of easing suffering. He brings several sources to support his position. First, suffering harms the patient and might itself hasten his death. Second, he cites Ramban, *Torat HaAdam Sha'ar Sakanah*, that the Torah gave the physician permission to act because what harms one patient might heal another. Implicit in this permission is permission to administer potentially harmful medicine. Morphine offered to ease suffering is also *refuah,* healing, which is permitted even if it can hasten death.[75] He concludes by stating that intense pain is more difficult than *stam maḥalah,* a typical illness, and that the administration of pain medicine for pain relief is part of healing even though it does not heal the underlying illness. In *Tzitz*

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73 The halakhic principle, *pesik reisha*, appears in *Shabbat* 75a describing a situation where one wants to decapitate the head of a chicken for some purpose but has no intention to kill the chicken. Rambam, *Shabbat* 1:6, *Tosafot, Rosh Shabbat* 103a, and Ramban and Ran end of *Shabbat*, chapter 14, *Ritva, Sukkah* 33b, *Tur, Oraḥ Ḥayyim* 320, *Beit Yosef, Oraḥ Ḥayyim* 320, *Shulḥan Arukh, Oraḥ Ḥayyim* 320:18, *Mishnah Berurah* 320:52,55, and *Sha'ar Ha-tziyun* 320:53 rule that when one derives no benefit from the unintended consequence, *pesik reisha d-lo niḥa leh*, they have violated a rabbinic prohibition. A minority of Rishonim and *poskim* rule that one has not violated a prohibition (*Arukh*, cited in *Tosafot, Shabbat* 103a, *Ravyah* vol. 1, *Mesekhet Shabbat*, no. 194, Rabbeinu Yeruḥam, *Netiv* 12:14). Although we do not rule leniently based on this minority opinion alone, we take it into consideration with other factors that might support a more lenient approach.
https://www.etzion.org.il/en/halakha/orach-chaim/shabbat/pesik-reisha.

74 The principle *shomer peta'im HaShem* appears throughout Talmud. It permits one to engage in potentially dangerous activities that society has demonstrated a willingness to accept.

75 He argues that pain management plays a central role in Jewish law, citing Yavetz in *Mor Ukzia, Oraḥ Ḥayyim* 328, which permits an operation to remove stones from the gallbladder and kidney, dangerous surgeries at the time, performed exclusively to relieve suffering and not to prolong life. He also quotes *Ketuvot* 33b, which teaches that lashes are more severe than death, and *Beit Yosef, Yoreh Deah* 157, which discusses the permissibility of suicide to avoid enemy capture and the intense unendurable suffering that will result, suffering that could lead to psychological impairment.

Eliezer 14:103, Rav Waldenburg again permits the administration of narcotics to a patient with a dangerous illness for whom no other treatment, either to cure him or to relieve his pain, is available. He suggests that the medication will improve the patient's physical and mental condition, and perhaps even prolong his life, since pain is debilitating and pain relief will enable him to eat, drink, and strengthen his overall condition.

Hence, halakhah permits healthcare providers to prescribe opioids to relieve acute or chronic pain despite their addictive potential, because pain relief even without treatment of underlying disease qualifies as healing; *verapo ye-rape* permits prescribing potentially dangerous medicines for therapeutic benefit. The physician who administers the medication fulfills the mitzvah of love thy neighbor.

However, halakhah does not permit the unrestricted prescription of opioids. It requires that the physician who prescribes them adhere to accepted standards of medical care. Rav Auerbach invokes the halakhic principle *shomer peta'im* to permit narcotics despite their inherent danger because it is "the way of all patients to pursue and receive pain medicine." Some suggest that *shomer peta'im HaShem* is, in many ways, similar to the modern notion of "accepted medical practice," which attempts to justify the use of medications with potentially dangerous side effects, or non-evidence–based care.[76] *Avnei Nezer, Even HaEzer* 1 also suggests that *shomer peta'im HaShem* does not apply when physicians believe that a behavior is dangerous, suggesting that medical recommendation and guidance determine the application of this halakhic principle. *HaRefuah K-halakhah* lists several criteria for prescribing pain medicine, including a requirement that the prescribing physician have expertise in its administration and administers accepted dosages.[77] However, in the midst of the opioid epidemic and the dangerous culture of overprescribing, it is no longer "the way of all patients" suffering non-cancer, non-end of life, non-palliative care pain to receive opioids for all types of pain.

In 2016, after the State of Washington introduced voluntary opioid guidelines that reduced the incidence of opioid overdose death by 50%,[78] the CDC issued guidelines for the management of chronic non-cancer,

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76 Jotkowitz A, Zivotofsky AZ, "Love Your Neighbor Like Yourself: A Jewish Ethical Approach to the Use of Pain Medication with Potentially Dangerous Side Effects," *J Palliat Med*, 2010 Jan;13(1):67-71. doi: 10.1089/jpm.2009.0182. PMID: 19827965.

77 *HaRefuah K-Halakhah* 10:1:1:3 Note *LaMut* 5 *Shichuch Ke'evim*.

78 https://onlinelibrary.wiley.com/doi/epdf/10.1002/ajim.21998.

non-end of life, and non-palliative pain care.[79] The guidelines recommend initiating treatment of chronic pain with non-opioid therapies. When physicians do find it necessary to prescribe opioids, the guidelines suggest that they assess the risk of opioid-related harms, including substance use disorder; prescribe immediate-release instead of extended-release/long-acting opioids[80]; use the lowest possible dose; and reevaluate within the first weeks after initiation. The guidelines also recommend using a prescription drug monitoring program (PDMP) to determine concurrent opioid use.[81] For the management of acute pain, the guidelines suggest starting with other analgesics; reserving short-acting opioids for second-line treatment; and prescribing for no more than three days. They strongly discourage the replacement of lost, stolen, or destroyed opioid prescriptions.

The World Health Organization[82] and at least fifteen international medical organizations, including societies of pain specialists, state health departments, medical boards, and a professional society of neurologists, have released similar guidelines for managing chronic, non-cancer pain. Although these guidelines are not mandatory, they create a new standard of care that can be used in malpractice cases and in investigations by state licensing boards or the DEA. The consequences of a physician's failure to conform can be professionally devastating.[83] These guidelines also have halakhic ramifications.[84] Although halakhah permits physicians to prescribe opioids for non-cancer, non-end-of-life, non-palliative care pain,

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79 https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm.

80 Unintentional overdose is five times more likely with extended-release opioids than with immediate-release ones. Miller M, et al., "Prescription Opioid Duration of Action and the Risk of Unintentional Overdose among Patients Receiving Opioid Therapy," *JAMA Internal Medicine*, 2015;175(4):608-615.

81 PDMP, which is mandatory in some states, dramatically reduced the incidence of opioid overdose deaths in Florida and of prescriptions from multiple prescribers in New York and Tennessee. Delcher C, et al., "Abrupt Decline in Oxycodone-Caused Mortality after Implementation of Florida's Prescription Drug Monitoring Program," *Drug Alcohol Depend*, 2015 May 1;150:63-8. doi: 10.1016/j.drugalcdep.2015.02.010. Epub 2015 Feb 19. PMID: 25746236. https://nida.nih.gov/publications/improving-opioid-prescribing.

82 World Health Organization. WHO analgesic ladder. http://www.who.int/cancer/palliative/painladder/en/. Accessed October 29 2018.

83 https://www.medscape.com/viewarticle/842994_1.

84 In response to the 2016 CDC Guidelines, doctors have become wary of the criminal and civil consequences of offering opioids, making them reluctant to prescribe them. In 2020, The American Medical Association recommended that

they too must follow standard medical guidelines, which significantly restrict medical indications for opioid prescription.

Narcan Kits and Jewish Law

Opioid overdose can cause loss of consciousness, suppressed or arrested respiration leading to death or brain damage in minutes, cardiac arrest, and seizures. Narcan, also known as naloxone, is an antidote to opioids. It displaces them from brain receptors, blocking their effect. It restores breathing and consciousness, and reverses an overdose within three minutes.

The risks of Narcan use are minimal. Although only available by prescription, it is not a controlled substance or addictive. It only works if a person has opioids in their system; it has no effect on someone who did not use opioids. For someone who used opioids, it can cause withdrawal, which is uncomfortable but not fatal. It should be administered to anyone suspected of suffering an opioid overdose.[85]

Although emergency medicine physicians have administered Narcan to treat overdoses for decades, the medical community has only recently begun to supply Narcan to laypeople in an effort to stem the fatal consequences of the opioid epidemic. There are several justifications for providing Narcan kits to the lay community. First, they function like EpiPens for allergies; just as one would carry an EpiPen, one can carry a Narcan kit that could save someone's life. The kits are lightweight, easy

doctors immediately suspend the CDC's guidelines. CDC acknowledged that its suggestions had been misinterpreted and misused, and has revised these guidelines, which now suggest that physicians individualize their approach to pain management. While the new guidelines, which took effect in late 2022, remove a three-day limit for acute pain and a 90mg ceiling for morphine, they continue to recommend non-opioid therapies before initiating opioids. https://www.federalregister.gov/documents/2022/02/10/2022-02802/proposed-2022-cdc-clinical-practice-guideline-for-prescribing-opioids.

85 Belz, D., et al., "Naloxone Use in a Tiered-Response Emergency Medical Services System," *Prehospital Emergency Care*, 2006. 10(4): p. 468-471. Buajordet, I., et al., "Adverse Events after Naloxone Treatment of Episodes of Suspected Acute Opioid Overdose," *European Journal of Emergency Medicine*, 2004. 11(1): p. 19-23. Darke, S., R.P. Mattick, and L. Degenhardt, "The Ratio of Non-Fatal to Fatal Heroin Overdose," *Addiction*, 2003. 98(8): p. 1169-1171. Osterwalder, J.J., "Naloxone for Intoxications with Intravenous Heroin and Heroin Mixtures - Harmless or Hazardous? A Prospective Clinical Study," *Journal of Toxicology: Clinical Toxicology*, 1996. 34(4): p. 409-416. "Still Not Enough Naloxone Where It's Most Needed" CDCnews release, 2019; Available from: https://www.cdc.gov/media/releases/2019/p0806-naloxone.html.

to use,[86] cost roughly $25 per dose, and can reverse a potentially fatal event and stabilize a patient until emergency medical care arrives. However, one cannot self-administer Narcan. Eighty percent of overdose deaths occur at home,[87] while nearly 40% of overdoses occur in the presence of others. Narcan can save the life of a friend, loved one, or even a complete stranger. Just as one can detect a diabetic insulin reaction before the individual becomes comatose, it is possible to detect an overdose before it has lasting consequences.[88,89] A survey of 1,427 injection drug users regarding their attitude toward Narcan rescue kits, showed that nearly all had witnessed someone else overdose, but only half had called 911, because of concerns about police involvement. Virtually all had tried to administer lay remedies with no therapeutic benefit, indicating that they wanted to help save their peer but lacked the knowledge to do so. The majority wanted others to call 911 for them if they suffered an overdose, suggesting that an overdose would not be intentional or indicate a suicide attempt, and expressed interest in a Narcan training program.[90]

Similarly, in a survey of chronic pain patients receiving prescription opioids, nearly one in five had overdosed, and more than half had engaged in high-risk behaviors, including combining opioids with alcohol. Although nearly 40% of the study participants had witnessed an overdose, only 3% reported having a Narcan prescription or training in delivering it.[91] In a third study, 68% of participants recruited from syringe service,

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86 They can be administered intramuscularly, through clothing, intravenously, or intranasally.

87 https://www.cdc.gov/stopoverdose/naloxone/index.html.

88 Baca CT, Grant KJ, "What Heroin Users Tell Us about Overdose," *J Addict Dis,* 2007; 26:63–68.

89 O'Donnell J, et al., "Vital Signs: Characteristics of Drug Overdose Deaths Involving Opioids and Stimulants — 24 States and the District of Columbia, January–June 2019," *MMWR Morb Mortal Wkly Rep*, 2020;69:1189–1197. DOI: http://dx.doi.org/10.15585/mmwr.mm6935a1external icon.

90 Seal KH, et al., "Attitudes about Prescribing Take-Home Naloxone to Injection Drug Users for the Management of Heroin Overdose: A Survey of Street-Recruited Injectors in the San Francisco Bay Area," *J Urban Health*, 2003 Jun;80(2):291-301. doi: 10.1093/jurban/jtg032. PMID: 12791805; PMCID: PMC3456285.

91 Dunn, K.E., et al., "Opioid Overdose History, Risk Behaviors, and Knowledge in Patients Taking Prescribed Opioids for Chronic Pain," *Pain Medicine*, 2016: p. pnw228.

detox, or opioid treatment programs had witnessed an overdose, but only 17% had a Narcan kit at hand.[92]

Hypoxic brain injury is time-dependent, so the sooner hypoxia is reversed, the better.[93] Providing bystanders with Narcan kits and training them in its administration saves lives. Massachusetts implemented a Narcan distribution and training program, which reduced opioid overdose death by 11% without increasing opioid use, indicating that the kits did not encourage use.[94] Communities with high rates of Narcan distribution saw overdose deaths decline by 46%.[95,96] In Ohio, a program equipping police officers with Narcan and training them in its administration reduced opioid overdose mortality.[97] All fifty states and the District of Columbia have passed legislation to improve layperson Narcan access, and in most states, laypeople can get Narcan from a pharmacy without a prescription.[98] In states that enacted Narcan access laws, opioid overdose deaths decreased by 14%.[99] In Scotland, a national program to distribute Narcan to people discharged from prison reduced opioid overdose death by 36% in the first month after their release.[100] In Eastern Europe, the

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92 Dunn, K.E., et al., "Opioid Overdose Experience, Risk Behaviors, and Knowledge in Drug Users from a Rural Versus an Urban Setting," *Journal of Substance Abuse Treatment*, 2016. 71: p. 1-7.

93 Michiels C., "Physiological and Pathological Responses to Hypoxia," *Am J Pathol*, 2004; 164:1875–1882.

94 Walley, A.Y., et al., "Opioid Overdose Rates and Implementation of Overdose Education and Nasal Naloxone Distribution in Massachusetts: Interrupted Time Series Analysis," *BMJ*, 2013. 346(jan30 5): p. f174-f174.

95 Ibid.

96 https://journals.lww.com/journaladdictionmedicine/fulltext/2016/10000/prescribe_to_prevent__overdose_prevention_and.2.aspx.

97 Rando J, Broering D, Olson JE, Marco C, Evans SB, "Intranasal Naloxone Administration by Police First Responders Is Associated with Decreased Opioid Overdose Deaths," *Am J Emerg Med*, 2015 Sep;33(9):1201-4. doi: 10.1016/j.ajem.2015.05.022. Epub 2015 May 29. PMID: 26095132.

98 "Legal Efforts to Reduce Barriers to Accessing the Anti-overdose Medication Naloxone". NPHL, 2017; Available from: https://www.networkforphl.org/resources_collection/2017/08/29/921/legal_efforts_to_reduce_barriers_to_accessing_the_anti-overdose_medication_naloxone.

99 McClellan, C., et al., "Opioid-overdose Laws' Association with Opioid Use and Overdose Mortality," *Addictive Behaviors*, 2018. 86: pp. 90-95.

100 Bird SM, McAuley A, Perry S, Hunter C, "Effectiveness of Scotland's National Naloxone Programme for Reducing Opioid-related Deaths: A Before (2006-10) versus After (2011-13) Comparison," *Addiction*, 2016 May;111(5):883-91. doi: 10.1111/add.13265. Epub 2016 Feb 4. PMID: 26642424; PMCID: PMC4982071.

WHO launched an initiative to provide 40,000 Narcan kits, and trained more than 14,000 people in Kazakhstan, Kyrgyzstan, Tajikistan, and Ukraine. Ninety percent of the participants subsequently witnessed an overdose, and in virtually every case, the patient survived.[101] Although distribution to laypeople is cost-effective in instances of heroin overdose,[102] distribution to high schools is only cost-effective if overdoses happen at least once each year, in which case it would reduce opioid overdose mortality by at least 40%.[103]

Laypeople may obtain Narcan through community distribution initiatives or from physicians who co-prescribe it with opioids. The CDC recommends that clinicians co-prescribe Narcan to patients who are at high risk of overdose.[104] The Rhode Island Department of Health requires every emergency department (ED) and hospital in the state to prescribe Narcan for all patients who have had an opioid overdose, opioid use disorder, a prescription for high-dose opioids, or who have a prescription for both opioids and benzodiazapines.[105,106] Because those who overdose once are at the highest risk for subsequent overdoses, EDs have a unique opportunity to provide Narcan to those at highest risk of overdose. ED patients who use opioids tend to accept Narcan kits, especially if they have witnessed an overdose or believed that they were at high risk for one, suggesting that distribution in this setting reaches the targeted at-risk population. Prescribing Narcan to patients on opioid therapy for chronic pain decreases opioid-related emergency department visits, especially among

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101 https://www.who.int/news-room/fact-sheets/detail/opioid-overdose.

102 Coffin PO, Sullivan SD, "Cost-effectiveness of Distributing Naloxone to Heroin Users for Lay Overdose Reversal," *Ann Intern Med.* 2013;158(1):1–9. doi: 10.7326/0003-4819-158-1-201301010-00003.

103 Cipriano LE, Zaric GS, "Cost-effectiveness of Naloxone Kits in Secondary Schools," *Drug Alcohol Depend*, 2018 Nov 1;192:352-361. doi: 10.1016/j.drugalcdep.2018.08.003. Epub 2018 Sep 17. PMID: 30321745.

104 Centers for Disease Control and Prevention, "Vital Signs: Life-Saving Naloxone from Pharmacies," last modified Aug. 6, 2019, accessed Sept. 10, 2019, https://www.cdc.gov/vitalsigns/naloxone/index.html.

105 Rhode Island Department of Health and Department of Behavioral Healthcare and Hospitals Development Disabilities, "Levels of Care for Rhode Island Emergency Departments and Hospitals for Treating Overdose and Opioid Use Disorder" (2017).

106 "U.S. Surgeon General's Advisory on Naloxone and Opioid Overdose." HHS news release, 2018; Available from: https://www.hhs.gov/surgeongeneral/priorities/opioids-and-addiction/naloxone-advisory/index.html.

patients who receive high-dose opioids.[107] When physicians co-prescribe, the risk of opioid overdose decreases, even if the patient does not fill the Narcan prescription.[108]

Does Halakhah Require Physicians to Prescribe Narcan with Opioids?

Some states, such as Virginia and Florida, mandate that physicians co-prescribe Narcan for high-risk patients.[109,110] In these states, halakhah would require physicians to prescribe Narcan when they prescribe opiates, based on *dina de-malchuta dina,* the law of the land is the law.[111] Further, CDC guidelines recommending that doctors co-prescribe Narcan for high-risk patients[112] create a standard of care for the practice of medicine. The rabbinic authorities cited in the previous section require physicians to adhere to this standard, and might argue that *shomer peta'im HaShem* can only protect a physician from the dangers of prescribing opioids, and the

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107 Coffin, PO, et al., "Nonrandomized Intervention Study of Naloxone Co-prescription for Primary Care Patients Receiving Long-Term Opioid Therapy for Pain," *Annals of Internal Medicine*, 2016. 165(4): p. 245.

108 Dowell D, Haegerich,T, Chou R, "CDC Guideline for Prescribing Opioids for Chronic Pain - United States, 2016," *Morbidity and Mortality Weekly Report*, 2016. "Legal Interventions to Reduce Overdose Mortality: Naloxone Access and Overdose Good Samaritan Laws," *NPHL*, 2018; Available from: https://www.networkforphl.org/_asset/qz5pvn/network-naloxone-10-4.pdf. "Naloxone: The Opioid Reversal Drug that Saves Lives," *HHS*, 2018; Available from: https://www.hhs.gov/opioids/sites/default/files/2018-12/naloxone-coprescribing-guidance.pdf.

109 Virginia Department of Health Professions, Board of Medicine. Board of Medicine regulations on opioid prescribing and buprenorphine. https://www.dhp.virginia.gov/medicine/newsletters/OpioidPrescribing-Buprenorphine03142017.pdf.

110 https://www.amcp.org/sites/default/files/2019-03/Opioid%20Summary%20and%20Legislation_0.pdf.

111 For a more detailed discussion of *dina de-malchuta dina*, please see our article that will appear in a forthcoming edition of *Ḥakirah*, Galper Grossman S and Grossman S, "Halakhah Examines the Nonmedical Use of Adderall," forthcoming in *Ḥakirah* vol. 34.

112 https://www.medscape.com/viewarticle/842994_1.

patient who takes them, if the physician co-prescribes Narcan.[113,114] Implicit in physicians' license to heal is their responsibility to know current medical recommendations and implement them in clinical practice. Most states require physicians to participate in several hours of continuing medical education regarding opioid prescription and the management of opioid use disorder in order to renew their medical licenses. This training can include education regarding co-prescribing Narcan. Physicians seeking to renew their licenses in Florida must participate in a two-hour course on prescribing controlled substances, particularly opiates. It includes information about Narcan kits. Thus, in areas that mandate knowledge regarding the co-prescription of Narcan kits as part of their continuing medical education curriculum, halakhah would obligate physicians to participate in these learning initiatives and learn about co-prescribing.

Does Halakhah Consider Narcan Kits *Pikuaḥ Nefesh* If There Is No *Ḥoleh Lefanenu*?

Given the tremendous lifesaving benefits of Narcan kits, they would seem to have the halakhic status of *pikuaḥ nefesh*, with the same status as EpiPens or any other medical intervention with overwhelming life-prolonging potential. However, when asked about the permissibility of autopsies, *Noda b'Yehudah Yoreh Deah* 210 limited the application of *pikuaḥ nefesh* to situations when the sick person is *lefanenu* – standing before us.[115] Doctors who co-prescribe Narcan kits and opioids, do so in the hope of reversing an overdose that has not yet happened and might never occur. Similarly, the

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113 Letters of the Rambam to his student, Yosef ben Yehudah Even Vaknin, *Letters of the Rambam*, *mahadurah Kapaḥ*, p. 134. *Sefer Ḥasidim* 670 emphasizes the importance of reviewing medical data and literature, harshly criticizing someone who borrows a medical textbook from a physician leaving him without the tools to render proper care to future patients. Rambam writes that he devotes all of his free time to the study of medical textbooks so that he will never make a clinical recommendation without citing evidence to support it, its source, and its rationale. He complains that this review of the medical literature leaves him with little time to learn Torah. Rav Avraham Steinberg (*HaRefuah K-halakhah,* vol. 8 (8:1:4:1:11), p. 42) points out that Rambam put reviewing medical texts above learning Torah in his limited time for learning. Similarly, Rav Yitzchak Zilberstein requires physicians to update their knowledge.

114 *Shiurei Torah L-rofim* 1:6.

115 For a detailed discussion of the halakhic requirement of a *holeh lefanenu* to classify a situation as *pikuaḥ nefesh*, please see our article in *The Lehrhaus*, https://thelehrhaus.com/scholarship/sharpening-the-definition-of-holeh-lefanenu-the-diamond-princess-and-the-limits-of-quarantine/.

individual who purchases the kit has not yet and may never suffer an overdose. In *Binyan Tziyon* 137, R. Yaakov Ettlinger offers the following definition of and requirement for *pikuaḥ nefesh*, which further challenges the standing of Narcan kits as lifesaving interventions. "With respect to *pikuah nefesh*, we do not follow the majority,[116] this is only when there is a real and present danger to life. In such a case, we consider even a low likelihood of survival. But when there is no current *pikuaḥ nefesh*, but only fear regarding some future danger, then we follow the majority."[117] Following R. Ettlinger's logic, when someone receives a prescription for opioids, he is not in immediate danger of overdose, so perhaps we should follow the majority and not be concerned about a risk to a minority of those who use opioids.

How could purchasing a Narcan kit in anticipation of a future possible overdose be obligatory according to halakhah? After all, at the time when someone purchases the kit, the person using opioids is healthy and might never have an overdose. To discern whether *Noda be-Yehudah*'s requirement of *ḥoleh lefanenu* applies to Narcan kits, we need to define "a patient with a similar disease" more accurately. In *Iggerot Moshe, Yoreh Deah* 1:151, Rav Moshe Feinstein explains that the world has changed since Rav Yechezkel Landau wrote his *teshuvah* regarding autopsies. We live in a globalized society with sophisticated communication systems. One can quickly send relevant information gleaned from an autopsy to hospitals all over the world. Similarly, although we might not have personal knowledge of an opioid overdose, they occur almost daily in our midst. Walky-talkies and social media can quickly notify us of an emergency, and we can provide immediate assistance. Thus, overdoses by people whom we don't know take on the halakhic status of *ḥoleh lefanenu*.

Ḥazon Ish, Ohalot 22:32, suggests that the requirement for a *ḥoleh lefanenu*, as *Noda b-Yehudah* defines it, is inherently fraught with inaccuracy. We cannot determine whether the information gathered from an autopsy today will qualify as *pikuaḥ nefesh*, since it is possible that in the future a medical discovery might make that information superfluous. The requirement of a *ḥoleh lefanenu* for *pikuaḥ nefesh* does not depend on whether there is in fact a sick person before us but rather on probability. When a disease is uncommon, we are not concerned about its future spread. However, for common illnesses when the disease is *matzui,* likely to occur based on the current circumstances of danger, the danger is already present and

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116 Rav Ettinger suggests that we worry about a risk to the minority of individuals when the danger is certain.

117 We follow likelihood ratios. If there is a high risk of danger, then the situation is *pikuaḥ nefesh*. But low levels of risk would not qualify as *pikuaḥ nefesh*.

pikuaḥ nefesh is already *lefanenu*. Rav Shlomo Zalman Auerbach, cited in *Nishmat Avraham, Yoreh Deah* 349:2, explains that in the Ḥazon Ish's opinion, the requirement that the patient who might benefit from the autopsy be present only applies to situations where the disease in question is rare. However, for a disease that is prevalent—and certainly for a disease that is rampant—a similar patient most certainly is present somewhere and can be considered *lefanenu*, even if he is not actually with us. With nearly 50,000 deaths per year, opioid overdose is common. Thus, even though an opioid overdose victim does not appear before us, these patients exist elsewhere and have the halakhic status of *lefanenu*. In *Iggerot Moshe, Orah Hayyim* 4:80, Rav Moshe Feinstein suggests that in a large population with a high probability of life-threatening danger, a potential, future event qualifies as *ḥoleh lefanenu*. He permits the violation of a biblical prohibition on Shabbat to return oxygen tanks to a large population of currently healthy individuals who might require them over Shabbat. Although no one is sick right now, it is likely that someone will need oxygen over the course of Shabbat.[118,119]

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[118] In *Amud Ha-Yemini* 17, Rav Shaul Yisraeli writes, "We learn from here the rule that even *pikuaḥ nefesh* that is not before us, neither at this moment nor afterwards, but it is clear to us that it will arrive at some point in the future — we view it as if it were already before us. For even if there is only a one-in-a-thousand chance of it occurring, the saving of one life at some time in the future suffices to allow and to obligate performing these actions."

[119] We do not classify every remote danger as *pikuaḥ nefesh*. *Shomer petaim HaShem* applies when the risk is "far removed and occurs in the minority of minority cases" (Achiezer 1:23). Rabbi Akiva Eiger suggests that a one-in-a-thousand risk is *pikuaḥ nefesh*, suggesting that the term does not apply to dangers with a lesser risk (*Shu"t Rabbi Akiva Eiger* 60). Although it is difficult to estimate the risk of opioid overdose fully, it accounts for more than 1,000 daily emergency department visits (https://www.ncbi.nlm.nih.gov/books/NBK470415/). The 142,000,000 million prescriptions for opioids in 2020 led to nearly 80,000 overdose deaths (https://www.cdc.gov/drugoverdose/rxrate-maps/index. html. Thus, the risk of dying of an opioid overdose is less than 1 in 1,000. Given this relatively low prevalence, how can the distribution of Narcan kits qualify as *pikuaḥ nefesh*? *Shomer Peta'im* applies to behaviors that society considers safe. In 1981, Rav Eliezer Waldenburg ruled that *shomer peta'im HaShem* could not apply to cigarettes, since it is only relevant when the dangers of a behavior are unknown and many people engage in it without harm (*Tzitz Eliezer* 15:39). However, since then, governmental statements and the US Surgeon General's warning against the dangers of smoking indicate that society now recognizes, and refuses to accept, the dangers of smoking, which invalidates the claims that *shomer peta'im HaShem* applies to this behavior. Although the risk of opioid overdose is low, legislation in some states requiring physicians to prescribe naloxone with opioids, the Surgeon General's calls to increase distribution of Narcan, and

Conclusion

The opioid epidemic has caused over half a million overdose deaths in the last two decades, and the number is rising each year. In the US, more people die annually of opioid overdose than from motor vehicle accidents.[120] Limiting inappropriate use of opioids and implementing interventions that reduce their harm can help halt this epidemic.

Jewish law highly values pain control, and mandates physicians to treat pain. While this may require prescribing opioids to manage non-cancer, non-end of life, non-palliative pain, it concomitantly requires the prescriber to follow current clinical guidelines and practice, which restrict opioid prescription to very specific scenarios with intense physician oversight. Halakhah views Narcan rescue kits, which can quickly reverse an opioid overdose and save lives, as *pikuaḥ nefesh*, so requires physicians to co-prescribe them to those at high risk of overdose.

After all, if we can save one life, we can save a world. ☙

CDC guidelines recommending Narcan for high-risk individuals and their families indicate that society considers opioid use in the absence of Narcan a risk that we must avoid.

120 Injuryfacts.nsc.org/all-injuries/preventable-death-overview/odds-of-dying/data-details/#_ga=2.138738224.249024422.1659435855-1519271280.1659435855.