

Improving Opioid Prescribing

The New York City Recommendations

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ON JANUARY 10, 2013, NEW YORK CITY MAYOR Michael Bloomberg announced new guidelines for the prescribing of opioid analgesics to patients being discharged from the city's emergency departments. The guidelines were developed by a panel of emergency physicians and are intended to reduce opioid addiction and overdose deaths while preserving access to opioids for patients in whom the benefits are expected to exceed the harms. Because most opioids are prescribed by primary care physicians, the introduction of these guidelines alone is unlikely to effect a large decrease in opioid-related harm. Nevertheless, it is worth considering why such guidelines are necessary and what complementary actions physicians, patients, and health authorities should take to address the increasing problem of opioid-related harm.

The 9 New York recommendations¹ are modeled after similar initiatives in Washington State and elsewhere. Emergency physicians are encouraged to use low doses of short-acting opioids for a few days at most, rather than long-acting or extended-release products. The guidelines also suggest that physicians exercise caution when prescribing opioids to patients taking benzodiazepines, that they inform patients about the risks of opioid dependence and overdose, and that they consult the state's prescription drug monitoring program to ascertain details of previous prescriptions. The latter will soon become a statewide requirement for prescription durations of 5 days or longer.

However, the guidelines are optional and do not restrict physicians from providing the care they consider to be in a patient's best interest. That such guidelines are even necessary is a testament to the magnitude of the problem. From 2004 to 2009, the number of emergency department visits in New York City related to the misuse and abuse of opioid analgesics more than doubled (from 4456 to 9254), and non-medical use of opioids (ie, use without a prescription or use with a prescription but in a manner other than prescribed) increased by roughly 40%.² Approximately 4% of the city's population 12 years or older—estimated at more than a quarter of a million New Yorkers—have reported opioid misuse.² Although emergency departments are generally not

where these problems originate, they often are key to perpetuating misuse.

The problem of opioid-related harm is neither limited to emergency departments nor unique to New York City. It is estimated that more than 200 million opioid prescriptions are issued nationwide each year, and approximately 16 000 people die annually from prescription opioid overdose.³ For every opioid-related death, many more individuals experience opioid addiction. This morbidity and mortality evolved over 2 decades from the complex interplay of several factors, including well-meaning physicians with few other drug therapies for patients with pain and a uniquely successful but often misleading (and sometimes illegal) promotional effort centering on assessing pain and prescribing opioids for analgesia—an effort that heightened expectations of patients and physicians while minimizing concerns about opioid use. The key factor, however, has been the pleasurable effects imparted by prescription opioids, many of which are chemically similar to heroin.

Underlying the recommendations outlined in the guidelines are several underappreciated facts. First, despite the widely held perception that opioids are the most potent medications available for the treatment of pain, for most conditions there is little evidence that opioids are more effective than other therapies.⁴ Most of the available prescription opioid products have gained regulatory approval largely on the basis of studies in which they were compared with placebo—a treatment no clinician would contemplate for pain. Second, the risks of opioid dependence and addiction are far greater than generally appreciated—up to one-third of patients receiving chronic opioid therapy meet criteria for an opioid use disorder.⁵ Third, physicians often issue prescriptions for a larger supply of opioids than necessary and sometimes initiate therapy with extended-release formulations in situations in which short-acting preparations would be preferred (eg, for acute pain). Although this may reflect a desire for compassionate care, it is worth emphasizing that every individual who spirals into addiction or dies from an

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overdose of prescription opioids has an initial exposure and that this initial exposure typically involves opioids obtained via prescription rather than theft from a manufacturer, distributor, or pharmacy.

Some may argue that the New York City guidelines will lead to undertreatment of pain. Moreover, physicians may resent what they perceive to be bureaucratic meddling or interference with their professional judgment, although the voluntary nature of the guidelines should dispel this concern. Like most clinical practice guidelines, excessively rigid application may have unintended consequences. For example, patients who rely on emergency departments for primary care could be adversely affected if the guidelines are misinterpreted as policy.

There also may be repercussions involving patient satisfaction. Two decades of marketing and advocacy have led some patients to perceive that they have an entitlement to pain control with opioid analgesics. In fact, they have an entitlement to good care; these are not synonymous.⁶ Dissatisfaction with the type or duration of analgesic prescribed in an emergency department may undermine the response to treatment, spur complaints against physicians, or have financial implications if satisfaction measures are a determinant of physician income. This could be mitigated by the development of more robust patient experience metrics and by recognizing that a discussion about the causes of pain and the risks of available treatment options may result in an informed decision not to treat with opioids.

Another concern is that the guidelines alone will be insufficient. Evidence from other areas of medicine suggests that the passive dissemination of guidelines, or even the use of more intensive techniques such as “audit and feedback,” have only a modest effect on practice.⁷ For this reason, some jurisdictions and payers have tied the introduction of guidelines to regulations that mandate certain practices. For example, physicians in Washington State who care for patients with chronic pain are required to use treatment agreements when prescribing opioids to patients with a history of substance abuse or psychiatric illness and to seek specialist consultation when prescribing doses greater than 120 mg of morphine (or equivalent) daily. In Ontario, Canada, the Workplace Safety Insurance Board will only pay for short-acting opioids for the first 12 weeks following an injury. A few health systems have also launched large-scale initiatives to improve the safety and effectiveness of opioid prescribing—for example, Group Health in Washington State has implemented a multifaceted strategy including individualized treatment plans, urine drug screens, and decision support using electronic health records.⁸

Many physicians and patients have had unreasonable expectations of opioids and have seriously underestimated their risks. It is time to collectively lower expectations and pre-

scribe these drugs less readily, to fewer patients, at lower doses, and for shorter periods. The New York City guidelines align with this view and are simple, sensible, and easy to follow. The next steps should be to monitor for intended and unintended consequences and to develop similar guidelines for other specialties, understanding that such measures may encounter resistance. As with impaired driving, meaningful change in the prescribing of opioids may require legislative action.⁹ Any such measures must ensure that patients with chronic pain or opioid addiction are not abandoned.

Emergency department prescribing of opioid medications is not the cause of the opioid epidemic, but these guidelines and others¹⁰ are important first steps toward addressing this public health problem. Other specialties should follow this lead. Only by changing how opioids are prescribed can the toll of addiction and death from these drugs be reduced.

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