Hospitalists are physicians whose practice consists of caring for patients during their hospitalization and then returning their care upon discharge to the patient’s primary care provider. They are the group, along with surgeons, most responsible for prescribing pain medications for hospitalized patients and they released a new consensus to reduce opioid exposure and improve/standardize care. The recommendations are limited to adults with acute pain, not chronic pain, not patients with cancer and not children. The recommendations are broken down into three categories, deciding to use opioids, using them during hospitalization and prescribing at time of discharge.

**Deciding to use opioids**

1. Only for patients with moderate to severe pain who have not responded to nonopioid alternatives.
2. Consider patient-specific risks with opioids, e.g., medical conditions like sleep apnea or a compromised metabolism as well as a history of substance abuse.
3. Review prescription drug monitoring program database to fully inform your decision.
4. Educate patient and families about risks and side effects in addition to benefits.

As a surgeon, I would summarize all of these recommendations as obtaining consent, identifying the appropriate reason for the treatment, identifying reasons the patient should not be given this treatment and informing them of the risks and benefits. I think this is a significant advance in physician thinking after all medicine is therapy, why does surgical treatment require written consent and medical therapy nothing at all.
Using opioids during hospitalization

1. Use the lowest dose for the shortest period
2. Use immediate release formulations rather than long-acting ones
3. Use oral agents rather than intravenous agents whenever possible
4. Understand the dosage you are using so that when changing from intravenous to oral or from one medication to another you are consistent
5. Pair opioids with giving non-opioids at the same time – make use of synergistic effects
6. Simultaneously provide medication to reduce opioid-induced constipation
7. Limit opioid use when other central nervous system depressants are also being used
8. Work with patients and family to establish realistic goals and expectations for opioid treatment
9. Monitor the response to opioids including functional changes and development of adverse effects.

All practical suggestions, intervene the least, understand the medications well-enough to get the right amount at the right time in the right form, prevent and watch for known adverse effects (surgeons label these complications); and most importantly, make sure the treatment is effective and that the risk-benefit balance remains benefit.

Prescribing opioids at discharge

1. Ask patients about opioids they have at home when writing new prescriptions
2. Prescribe the minimum quantity anticipated to treat the pain symptoms after release from the hospital
3. Teach the patient and family how to use these agents at home properly, use, storage, protecting against diversion (that is the term being used when someone else is using your medications), not to mix opioids with sleep meds or alcohol, no driving and call if you are having a problem.

Again, practical, easily implemented guidelines.

What I find most interesting is the process leading to this consensus statement. The authors spoke to practicing physicians, engage experts in usage patterns and clinical outcomes, reviewed the literature and then wrote initial guidance. Those guidelines were then reviewed and commented upon by multiple practicing hospitalists, patients and their families. After taking all these views into account, the recommendations went through a Delphi type review. For those unfamiliar with this technique, the individuals writing the consensus do it in a structured way, beginning with an initial statement, all members of the group proposing revisions, rewriting, re-proposing – it is a form of conversation and debate.

I did find this one comment of greatest concern.

“The greatest limitation of this Consensus Statement is the lack of high-quality studies informing most of the recommendations in the guidelines upon which our Consensus Statement was based. The majority of recommendations in the existing
This is scientism, cloaking practice in a science of numbers. Perhaps rather than rely on quantitation which will take years to do we should employ the “wisdom of the crowd.” In this case, the crowd is practicing physicians, not just academics or thought leaders; but physicians who treat patients and prescribe opioids every day of their working lives. These clinicians can look at a problem and identify sensible, workable solutions. It doesn’t require Congressional inquiries, onerous regulations or mandated retraining. It only requires that we let physicians known there may be a problem and then let them do what they are trained to do – find appropriate medical solutions.

Source: Improving the Safety of Opioid Use for Acute Noncancer Pain in Hospitalized Adults: A Consensus Statement From the Society of Hospital Medicine  DOI:10.12788/jhm.2980

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