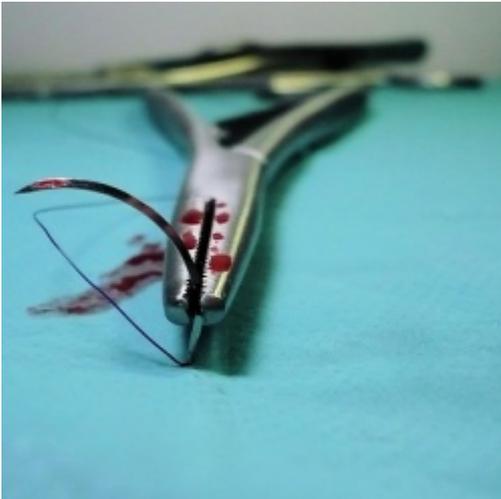


# Surgeons Finally Speak Up On Their Opioid Prescribing



By *Chuck Dinerstein* — September 26, 2018



Courtesy of Max Pixel [1]

Surgeons never let the skin come between them and a problem – it is a fundamental feature of our DNA. And after more than a year of blaming physicians, among others, for our opioid crisis, more and more practitioners, those actually writing the prescriptions, have something to say. A new article in the *Journal of the American College of Surgeons* [1] provides practical guidelines based on a consensus of both physicians and patients.

The study begins by pointing out that surgery is often the first exposure of an individual to opioids. And quite frankly, surgeons have been remiss in their prescriptions for pain in this acute setting, with large variations in the number of pills prescribed; in 45% of cases, patients were given prescriptions for opioids even though they had stopped using them during hospitalization.

The actual research involved developing a consensus among surgeons, nurse practitioners, surgical residents, pain specialists, pharmacists, and patients. These patients had undergone one of the procedures under consideration and were “health literate” volunteers. The consensus was achieved by modifying an initial draft of perioperative pain management written by the pain specialists over three cycles; based upon group discussion and literature reviews. The finalized third-round review is the substance of the report.

- Prescriptions should take into account the patient’s wishes and their response to pain medications. An important nod to both shared decision making and patient feedback on what works for their pain needs.
- Non-narcotic pain medications [2] should be maximized and given on a schedule to pre-empt the onset of pain. Pain is easier to manage before it becomes a problem.

- Opioid prescription, like all medical prescribing, should be tailored to patients' body, contraindications, the response to pain therapy, and addiction potential of both patient and medication.
- Patients with terminal diseases should be treated as special cases, e.g., addiction potential is not a concern.

The consensus was that most surgeries required few if any opioids and those were predominantly operations involving the bones where pain management is more often difficult. [3] Patients, in general, wanted fewer pain medications than the surgeons; perhaps a result of physicians' concern about the impact of patient satisfaction scores to their practice.

The authors explain how surgeons have found themselves overprescribing and as always, it is a constellation of factors. Their narrative resonates with my experience. Physicians are taught to prescribe medications from their more slightly advanced peers; it is not a rigid set of principles taught in medical school. This experiential training was compounded by the mistaken belief that opioids were rarely addictive and that pain was the fifth vital sign, requiring particular concern. The increasing power of health systems and physician as employees rather than as autonomous agents made pain scores and patient satisfaction rating a financial incentive, one that was frequently misaligned with proper care.

When faced with a health problem, physicians, in this case, surgeons, respond. We are here to help, not addict. The study has simple, practical suggestions – recommendations we can bring to bear today. Let physicians practice medicine, the state legislature and Congress has no expertise, and we cannot allow them to continue practicing medicine without a license.

[1] In keeping with concerns regarding a conflict of interest let me say that I have been a proud member of the American College of Surgeons since completing my training.

[2] Ibuprofen and acetaminophen

[3]

- Three procedures require no opioids – vaginal delivery, a cochlear implant and cardiac catheterization (presumably, along with any other percutaneous procedures)
- Eleven operations require 1-15 tablets – hernia repair, removal of a gall bladder, thyroid, prostate or portion of a breast, C-section, minimally invasive removal of the uterus and arthroscopic partial meniscectomy (a knee joint component)
- The remaining procedures required 16-20 tablets – orthopedic procedures and traditional (big scar) removal of the uterus.

Source: Opioid-Prescribing Guidelines for Common Surgical Procedures: An Expert Panel Consensus

**Source URL:** <https://www.acsh.org/news/2018/09/26/surgeons-finally-speak-their-opioid-prescribing-13445>

**Links**

[1] <https://www.maxpixel.net/Needle-Surgery-Tools-Blood-Iglotrzymacz-Vice-1662206>