Centering the Pendulum: The Evolution of Emergency Medicine Opioid Prescribing Guidelines

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On January 10, 2013, New York City mayor Michael Bloomberg announced, in a press conference that garnered national attention, a new initiative to curb the rapid increase of emergency department (ED) visits and overdoses related to opioid pain medications.[1] The intent of the new guidelines was to center the pendulum, which many believe has swung to the extreme of overprescribing by health care providers and become a significant public health threat.

Some of the media and the responding public interpreted the guidelines as governmental interference with physician autonomy and alleged that many public hospital patients would not be able to receive adequate pain relief for their acute or chronic pain.[2] Coming on the heels of controversial efforts in New York City to restrict availability of *trans* fats and supersized sodas, the perceived encroachment on the therapeutic relationship between patient and physician was not welcome.

Fortunately for emergency physicians and patients, the media depiction is not accurate. The guidelines were created by emergency physicians with the intent of improving patient safety. Emergency physicians are among the most frequent prescribers of opioid analgesics nationally,[3] although it is not known how much this prescribing behavior contributes to the epidemic. However, opioid analgesic prescribing is challenging, given the limited continuity of care and lack of medical history about ED patients. As a means of balance, 3 of the main tenets of the guidelines are to prescribe no more than 3 days' worth of opioid medications, to prevent the initiation of long-acting opioid pain relievers, and to suggest that "lost" prescriptions not be readily refilled (Figure).

The New York City opioid prescribing guidelines are recommendations and not mandates. The guidelines provide significant room for clinicians to prescribe in any way they deem appropriate for an individual patient. The use of similar prescribing guidelines has precedence. Washington State implemented a comparable plan in 2011, as have other jurisdictions, to address increasing opioid abuse and deaths in their regions.[4] In October 2012, the American College of Emergency Physicians provided evidence-based guidance about several related issues vexing emergency physicians. Among the recommendations were that opioid use should be carefully considered, individualized, and time limited; that opioids are best reserved for patients with severe or refractory pain; and that exacerbations of chronic pain preferably be treated without additional opioid analgesics.[5]

In our view, prescription opioids are overprescribed, which contributes to their abuse. Opioid prescriptions nationwide increased by a factor of 10 between 1990 and 2007, and abuse and overdose deaths increased in parallel.[6,7] Nonmedical prescription opioid use had increased by 40% in New York City in just 6 years, and 4% of New Yorkers aged 12 and older reported misusing. The rate of opioid-related ED visits doubled in that period, and deaths caused by opioid pain relievers increased 20% from 2005.[8]

One explanation for the massive increase in prescribing of prescription opioids is the enhanced focus on managing pain that evolved from misguided incentives during the past decade. In response to perceived undertreatment of pain, The Joint Commission in 2001 placed the pain score on par with the blood pressure (the fifth vital sign), and physician competency and compensation began to be assessed through patient satisfaction with their ED pain control.[9] To some clinicians, the threat of being accused of "oligoanalgesia" may be so unacceptable that they endorse liberal prescribing despite the risks. The New York City opioid prescribing guidelines are intended to advocate an approach that balances pain relief with the sequelae of opioid overuse: addiction, abuse, and unintentional overdose (in addition to intentional self-harm and pediatric exposures). Eliminating pain is a laudable goal, but it raises the question of how many patients will actually be exposed to the irresistible euphoria of these addictive drugs[10,11] or experience respiratory depression in the pursuit of a pain score near zero.

The medical profession has been led to believe that all pain must be eliminated. In a recent article about the paucity of data to support accusations of oligoanalgesia, Green[12] described what many of us have witnessed: some patients with pain decline opioid analgesia. These patients want to remain alert, avoid adverse effects, and understand the cause of their condition instead of simply obtaining relief of pain. Have we been incorrect about aggressive opioid analgesia because we were led to believe that this is what our patients wanted? Educated patients in the ED, compared with those with less education, receive fewer opioid analgesics after a motor vehicle crash.[13] Perhaps they better understand the risks of addiction or overdose than our less-educated patients. Regardless, this

Note: These guidelines do not replace clinical judgment in the appropriate care of patients nor are they intended to provide guidance on the management of patients while they are in the ED.

In the management of patients with acute or chronic non-cancer pain discharged from an emergency department,

1. Consider short-acting opioid analgesics for the treatment of acute pain only when the severity of the pain is reasonably assumed to warrant their use.

2. Start with the lowest possible effective dose if opioid analgesics are considered for the management of pain.

3. Prescribe no more than a short course of opioid analgesics for acute pain . Most patients require no more than three days.

4. To assess for opioid misuse or addiction, use targeted history or validated screening tools. Prescribers can also access the New York State Controlled Substance Information (CSI) on Dispensed Prescriptions Program for information on patients' controlled substance prescription history.

5. Avoid initiating treatment with long-acting or extended-release opioid analgesics.

6. Address exacerbations of chronic or recurrent pain conditions with non-opioid analgesics, non-pharmacological therapies, and/or referral to specialists for follow-up, all as clinically appropriate.

7. Avoid when possible prescribing opioid analgesics to patients currently taking benzodiazepines and/or other opioids. Consider other risk factors for consequential respiratory depression.

8. Attempt to confirm with the treating physician the validity of lost, stolen, or destroyed prescriptions. If considered appropriate, replace the prescription only with a one- to two-day supply.

9. Provide information about opioid analgesics to patients receiving a prescription, such as the risks of overdose and dependence/addiction, as well as safe storage and proper disposal of unused medications.

Figure. New York City Emergency Department Discharge Opioid Prescribing Guidelines. These ED Opioid Prescribing guidelines were created by the New York City Health Department and were endorsed by the New York City Health and Hospitals Corporation, several non-public medical centers, and the New York State Chapter of the American College of Emergency Physicians. Only the front sheet is included. The full guideline with supportive documentation can be found at: hp://www.nyc.gov/html/doh/downloads/pdf/basas/opioid-prescribing-guidelines.pdf.

finding hints that physicians' biggest shortcoming in pain management may be our inability to impart to our patients the true benefits and risks of opioid analgesics administered in the ED or at discharge.

Emergency physicians can improve our prescribing of prescription analgesics. Fox et al[14] in this issue of *Annals* have made an attempt to improve the opioid analgesic prescribing practices of emergency physicians in their institution. By moving away from the dictums of the past decade, these authors working in the rural community ED setting in a state with a substantial opioid misuse problem developed and implemented a guideline for the management of dental pain. The reduction in prescribed opioid was 17%. The modest decrease provides indirect support that the targeted intervention was not draconian. Of course, reduced prescribing is only a surrogate for the real outcomes of interest: reduced abuse, addiction, and death. Despite these and other limitations (eg, we don't know which patients received pain medicine appropriately), they made a practice change and measured the implementation. The dental community has recently addressed this same challenge through its "opioid sparing" stepwise guideline in acute pain management.[15]

The ED is a safety net for the most complicated public health problems; the issue of prescription drug abuse is no exception. Emergency physicians may not have created the problem but are now compelled to be a part of the solution. Guidelines such as those in rural Maine and New York City might just be the beginning. We must recognize that the focus on aggressive pain relief with opioid analgesics may be harmful. We need to reset our patients' and our own expectations for the degree and duration of subjectively defined pain relief that we can safely provide. Most practically, we may need to include a detailed conversation about the risks of opioids and help the patient make an educated choice between opioid, nonopioid (eg, acetaminophen, ibuprofen), and nonpharmacologic (eg, cold, heat) forms of pain relief.

Although we do not assume that the New York City guidelines, nor those in Maine, Ohio, Washington, and elsewhere, will alone rapidly and consequentially reduce opioid misuse, we hope that this will produce a net benefit[16] and raise awareness of the challenges of these patient care issues. Enhancement and expansion of state-based prescription drug monitoring programs with Web-based, real-time search functions showing patient medication histories could help prevent inadvertent ED prescription diversion and misuse.[17] A multidisciplinary approach including other prescribers, pharmacists, industry, regulators, and patients will shape our efforts. Unintended consequences will occur, and unless we work collaboratively with other specialties to augment their safe prescribing practices, the initiative may fail. A well-intentioned though fragmented regional approach may be less optimal than a consensus-driven, nationally implemented, evidence-based effort. To prevent prescription opioid decisionmaking from going the way of *trans* fats, emergency physicians need to recognize the substantial threat and act proactively in the best interests of both ED patients and the public health.

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