## The Medical Journal of Australia • MJA MEDIA RELEASE

## EDUCATION FOR JUNIOR DOCTORS MAY DECREASE OPIOID PRESCRIBING AT HOSPITAL DISCHARGE

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DELIVERY of a brief education module to junior doctors and pharmacists has been associated with a significant reduction in opioid prescribing for surgical patients at hospital discharge, according to research published online today by the *Medical Journal of Australia*.

In Australia, deaths caused by opioids such as oxycodone, morphine and codeine increased 102% during 2006–2017, and deaths involving fentanyl, pethidine and tramadol increased 1000%. It has been reported that patients prescribed opioids on discharge from surgical care are 44% more likely to be taking opioids one year later than those discharged without opioids. The likelihood of long-term opioid use after minor and major operations is similar.

Researchers from the Centre for Medicine Use and Safety and the School of Public Health and Preventative Medicine at Monash University, and Alfred Health, analysed data from opioid-naïve patients discharged from The Alfred Hospital's 13 surgical units after a stay of at least 24 hours. Surgical units were randomised to the intervention or control arms. Interns, residents, and clinical pharmacists assigned to intervention arm units attended education sessions, presented by the hospital analgesic stewardship pharmacist, about appropriate analgesic prescribing for patients in hospital surgical units.

"During the baseline period, 1369 intervention unit admissions and 1014 control unit admissions were included; during the evaluation period, 973 intervention unit episodes and 706 control unit episodes were included," wrote the authors, led by Ria Hopkins, a Research Fellow at the Centre for Medicine Use and Safety and Alfred Health.

"After adjusting for age, length of stay, pain score, acute pain service involvement, and use of immediate release opioids prior to admission, patients in the intervention group were prescribed slow release opioids at discharge less frequently than patients in the control group and were more frequently discharged without any prescribed opioids following the intervention.

"Providing de-escalation plans was more frequent for intervention than control group patients prescribed slow release opioids on discharge post-intervention."

Hopkins and colleagues said other factors that may have decreased prescribing, aside from their intervention, were increased awareness of the harms associated with opioids and institutional strategies which may have generally reduced opioid prescribing at the Alfred Hospital.

"The hospital did not introduce specific policy changes during the study period, but the publication by the Australian and New Zealand College of Anaesthetists of their *Position statement on the use of slow release opioid preparations in the treatment of acute pain* in March 2018 may have influenced prescribing," they wrote.

"Nevertheless, we found that educational interventions can have a significant effect even when baseline opioid prescribing rates and quantities are low."

Hopkins and colleagues concluded that "providing brief education sessions for junior clinicians and clinical pharmacists was followed by significantly reduced opioid prescribing at discharge for opioid-naïve surgical

patients, suggesting that education is an effective evidence-based strategy for optimising opioid prescribing in acute care".

"However, junior medical officers in teaching hospitals frequently rotate between specialties, and the value of the education module would depend on its regular delivery, which is time-consuming and often unsustainable.

"Possible solutions include incorporating the module into orientation programs and offering it online. Future iterations of the intervention could include post-education assessment and personalised feedback.

"Longer term evaluation of outcomes is required, as is evaluation of the impact of the intervention on prescribing appropriateness."

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