Managing risk, managing pain

August 30 2017

Credit: University of Manitoba

Oxycodone. Morphine. Fentanyl. They're some of the most effective drugs on the market for pain, but they're also some of the most addictive.

There's a place for these drugs, says Roger Suss, [MD/88]. But from what he's seen at his clinic in Winnipeg's inner city, a lot of the patients using them probably never should have been prescribed narcotics in the first place – either because another treatment would have been equally effective or they have medical contraindications that make narcotics a risky choice.

"A lot of patients come to us already on opioids," says Suss, a family physician at the Northern Connection Medical Centre (NCMC) and assistant professor, department of family medicine, Max Rady College of Medicine, Rady Faculty of Health Sciences. "We didn't prescribe them and we never would have chosen it for them."

And often, opioid overuse is not even their main problem, he adds. Many also have chronic health conditions that are compounded by social issues like poverty, inadequate housing, unemployment or other substance abuse.

Recent guidelines suggest that many patients should taper down until they're off narcotics altogether. The problem is, most don't want a smaller dose of pills. And they certainly don't want to hear 'no, you need to stop immediately.'

Suss says the key is finding common ground – a plan both the patient and physician can live with. And just as important, the patients need a clinic that will look after all of their medical problems, not just their opioid use.

Suss admits that better managing opiate use is also going to take some work on the clinic side. "A physician who is working with a patient to reduce their dose may feel undercut when the patient sees someone else and says, 'My pain was too bad so I had to use more' or 'My meds fell in the toilet.' If that colleague refills that prescription they may undermine

the plan," he says. "No one is ensuring that doesn't happen. And the patient isn't thinking long-term. They really do want to stop, sometime down the road. Just not now."

Suss and his team realized it was time for physicians to "get tough." But not with patients – with each other. That's when they created a tool that facilitates coordinated care for anyone receiving opioids for anyone visiting NCMC.

It's simple and it's clear. First, a primary physician is identified for each patient. Together, that physician and the patient will create a plan. It gets documented in a conspicuous place in the chart, so no matter who the patient sees next, the plan is easy to reference.

Naturally, there may be times when things aren't straightforward, the plan is unclear or there are issues around patient compliance. That's when the secondary physician connects back to his or her peer, making sure that the path forward is unambiguous. With regular oversight by the primary physician, there is always someone keeping an eye on the big picture.

Over the past four years, Suss has been reviewing the charts of about 40 patients who have been prescribed moderate or strong narcotics to track the tool's progress. "Our results suggest that we have been quite successful in reducing the opioid dosage for many of our patients, with minimal opioid use from other sources."

As expected, a certain number of patients leave when they are unable to find common ground with their primary physician. "We wish they had stayed, we wish we could provide them with medical care, but at least we are not part of the problem," says Suss. "Our findings are that you can help maybe half of them, without hurting the other half."

He considers this tool – unique amongst family medicine physicians in Canada – to be a promising step in the right direction. "It creates a strategy for family physicians everywhere for dealing with patients with chronic opioid use problems."

Provided by University of Manitoba

Citation: Managing risk, managing pain (2017, August 30) retrieved 7 August 2024 from https://medicalxpress.com/news/2017-08-pain.html

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