OPIOID PRESCRIPTIONS IN A NEW CARE RELATIONSHIP: CHALLENGES FACING DOCTORS AND PATIENTS

By: Augusta Stobbe

Home for the Summer Program, July 16-27th, 2018

Stonewall, MB

Supervisor: Dr. Greg Pinniger

Title: Opioid prescriptions in a new care relationship: challenges facing doctors and patients.

Opioids are used to manage both acute and chronic pain. Compared to other countries, Canadian doctors have prescribed opioids liberally in the past; we are currently the 2nd largest prescriber of opioids in the world.(1) Until recently, prescriptions have increased steadily, with a 23% rise in dispensing rates from 2006-2011.(2) However, while opioids are useful for acute, post-surgical and cancer pain, their benefits are more controversial for chronic, non-cancer pain management.(1) Long term use can lead to dependence, addiction, and other opioid-related adverse events, particularly when combined with benzodiazepines. (1,2) In light of the growing debate over the safety and efficacy of opioid use for chronic, non-cancer pain, the Canadian National Pain Centre released new opioid use guidelines in 2017.(1) These guidelines recommended limiting new opioid prescriptions, and lowering doses on current prescriptions. They also addressed identifying risk factors for addiction in patients before making prescription decisions.(1)

Following the release of the national guidelines, the College of Physicians and Surgeons of Manitoba (CPSM) has begun a consultation and research process to develop standards of practice for opioid use in chronic, non-cancer pain for doctors in Manitoba. The currently available draft standard lays out expectations regarding prescriptions in various scenarios.(3) This report will consider the currently drafted standards for opioid prescription for patients new to a doctor who are already using opioids for chronic, non-cancer pain. Each aspect of the standard will be discussed regarding its benefits and challenges for both the prescriber and the patient. A case will be used to introduce and frame this discussion.

Case:

Joe* presented as a new patient to Stonewall Medical Group. He was in his early 30s, and had been a prescription opioid user for chronic, non-cancer pain for almost a decade. In his early twenties he had sustained musculoskeletal injuries that required surgical intervention. Joe was seeking both a family doctor and a new hydromorphone prescription, as his current one was going to run out within a few days. Joe was from almost an hour away from Stonewall, but had made the trip because he was having trouble finding a doctor who was accepting patients in his home town. In order to facilitate the process, Joe had brought a copy of the radiologist's report on his leg x-ray, the contact information for his recent opioid prescriber, and a printed out copy of his DPIN obtained from the pharmacist. While discussing his medical history, Joe related that he had previously used Oxycontin and OxyNeo. He also indicated that he had struggled with addiction to these drugs in the past, and had tapered his dose and then been off of opioids for four months before beginning his current course of hydromorphone.

Joe's daily dose seemed relatively high, and he was vague about exactly how much he needed to use for pain relief. Dr. Pinniger called the pharmacist to confirm the currently prescribed levels of hydromorphone. In addition to providing this information, the pharmacist expressed concern over the potential for opioid abuse. He explained that Joe had initially been on 2 pills/day, and that his dose had increased to 4 pills/day within only four months. Further, Joe had requested early dispensing on a few occasions. Dr. Pinniger explained to Joe that he could provide hydromorphone for him, but that he would do so on the expectation that they

* Name changed to ensure anonymity.

would begin to taper the dose over time and eventually try to discontinue it. He stated that he was concerned about Joe's safety on the current doses, and that hydromorphone at those levels was related to a higher danger of addiction or adverse events. Joe agreed that the potential for addiction was real, but did not comment on whether or not he agreed with the long term plan of tapering the drug.

Once Dr. Pinniger had agreed to provide a temporary prescription to provide for Joe until their next appointment, Joe mentioned something new. He said that he had a weeklong trip coming up and so he needed an early release on his new prescription. Dr. Pinniger phoned the pharmacy back, and it became clear that Joe was ahead by about a day and a half on his current prescription. Given the fact that Joe was an unknown patient, and that the pharmacist had expressed concerns, Dr. Pinniger decided to give him the prescription with a weekly pick-up but no early release. Joe was quite upset, but eventually decided to take the prescription that Dr. Pinniger was offering and forego his trip. He indicated that finding a new family doctor was his main goal, and that if he had to cancel a trip to ensure that Dr. Pinniger would agree to prescribe hydromorphone, then he would do so.

Discussion:

The CPSMs draft standard of practice for prescriptions for new patients currently using opioids lays out various requirements during first time visits. These requirements are aimed at a reduction in opioid prescription and prevention of opioid misuse. While these goals are important for the health and safety of Canadians, they can present challenges to the patient and prescriber. Each aspect of the proposed standard has strengths and weaknesses. The following excerpts are from the new draft standard:

*For patients who are new to a member's practice and who have been taking opioids for a significant period of time already the member **shall**:*

(a) Maintain vigilance for potential diversion and other substances of concern by verifying the current opioid prescription by:

i. Obtaining collateral information from both the previous prescriber(s) and dispensing pharmacy(ies) confirming the clinical indication and current opioid dosage,

ii. Reviewing the patient's current and past medications utilizing DPIN. If DPIN access is unavailable, consult with a pharmacist to obtain DPIN, and

iii. Ordering an initial urine drug screen.

Benefits and Challenges for Prescribers:

These requirements are important because they establish continuity of care for the patient, and work to ensure that the narcotics are being used correctly. By contacting the previous prescriber, the doctor can get valuable insight into the patient's history from another healthcare professional.

A pharmacist can give accurate information on current and previous prescriptions. The DPIN and the urine test can help confirm that the patient is not struggling with an addiction and trying to access more opioids through various sources.

However, while these requirements are valuable, they can also be challenging to enact. Calling the pharmacy, former prescriber, and accessing the DPIN all take time. Often, call backs are necessary as some former caregivers are not available to talk at the moment. When a patient comes in for a standard length of appointment without indicating that they are new and looking to start up a care relationship that involves opioid prescription there is not enough built in time to do all these calls. If the patient's prescription has refills left, this is no problem. However, if the prescription is near to expiry, then it can be challenging to make the calls and then fit in another appointment to prescribe the opioids after this is completed. This can leave a patient without the drugs that their body needs. One risk with refusing opioid prescriptions is that patients whose bodies are dependent on the narcotic will look elsewhere.(2) This could lead to sources that are illicit, which can be dangerous for the patient.

Benefits and Challenges for Patients:

As well as benefitting the doctor, these standards also benefit the patient by ensuring continuity of care. When there is a discussion surrounding the transfer of care, the patient will have an informed family doctor who can provide better, more appropriate, care. However, even though this transfer of information is important, it could also make the patient feel like their doctor does not trust them. If a patient does not trust their care provider, there is a greater risk that they may distort or alter their answers to try and ensure that they receive the care they want. This could make the development of provider-patient trust more challenging and interfere with the provision of good quality care.

(b) Conduct and document a comprehensive history and physical examination, including,

i. pain condition, general medical condition, current medication, opioid use history, psychiatric status, substance abuse history, trauma, and psychosocial history,

ii. assessing the patient's risk for opioid misuse, abuse, or diversion and consider appropriate screening tools to determine the patient's risk for addiction to opioids, and

iii. obtaining (photo)identification from patient, unless unavailable.

Benefits and Challenges for Prescribers:

A comprehensive history and physical is important when meeting a new patient. It allows a provider to make informed recommendations for care. In addition, knowing the potential for opioid misuse can help the provider make a plan for pain control that is suited to their patient.

However, while these requirements are useful, they can also be challenging. A thorough history and physical of this nature requires a substantial amount of time. As discussed above, if the patient has requested a regular appointment, there may not be adequate time for a discussion and examination that goes to enough depth. With the fact that some patients (such as Joe) are travelling far to find a doctor, it can be difficult to make another appointment in a timely manner.

Another challenge will be eliciting very personal information such as trauma and psychosocial history. Trust and its resulting vulnerabilities are often developed over time, and asking for this information on the first appointment may yield few, obscure answers that are not useful for making prescription decisions.

Benefits and Challenges for Patients:

These requirements, like the ones discussed above, are designed to benefit patients by preventing abuse. However, they have the potential to become a barrier to care. Firstly, doctors often find complex, potentially-addicted opiate-using patients very challenging to deal with, and sometimes would rather not accept them as new patients. While doctors are not allowed to discriminate on this basis, there are still some who will find other reasons to turn the patient away or make them feel unwelcome. Some doctors address this issue by refusing to provide any patients with opioids, but this also serves to leave patients with legitimate pain (and appropriate opioid use) in a vulnerable position where they have even more difficulty finding a provider than the average Manitoban.

Another challenge lies in the establishment of a new relationship. Having a doctor who knows very little of a patient's history advise them to cut down their opioid dose may feel like a judgement to patients. They may feel isolated and search elsewhere for care, bouncing from doctor to doctor.(4) The patient may also be less inclined to follow advice from a new doctor than they would from one whom they know and trust. It may be that a care relationship must be established before suggestions of tapering are useful.

A final issue lies in patient honesty. In order to receive the best care, a patient must feel safe and comfortable being honest with their care provider. However, if a patient who needs opioids to live pain-fee feels that revealing past drug use, mental health struggles, or psychiatric diagnoses will hamper their ability to get an opioid prescription they may choose to leave important information out of their history. It's already challenging to be honest about these subjects due to social stigma, let alone when it changes your ability to access needed medications. This obscuring of the facts could lead to poor care provision in later encounters due to the provider's ignorance.

(c) Always prescribe the lowest effective dosage of opioid medication. Titrate the dosage gradually, with frequent tolerance checks and clinical reassessment. Monitor opioid effectiveness until optimal dosage is attained, subject to the following:

*i. Doses greater than **50 milligrams** morphine equivalents per day require careful reassessment of the dosage and patient response.*

*ii. If the patient is on **90 milligrams** morphine equivalents per day or less, and there is documented benefit to the patient, then continue the treatment.*

*iii. If the patient is on more than **90 milligrams** morphine equivalents per day, careful reassessment of the dose is required including discussion and documentation of specific and realistic goals of reduced pain severity (not elimination of pain), improved physical, psychological, and social functioning. To determine the lowest effective dose of opioid needed to achieve and/or*

maintain these goals, a trial of slow tapering of the opioids shall be started. If the patient has a substantial increase in pain or decrease in function that persists more than one month after a dose reduction, tapering may be paused or potentially abandoned in such patients.

iv. Prescriptions may be written for a maximum of up to three months, but never authorize the dispensing of more than a one-month supply of any opioid.

All dosages must be recorded clearly in the medical record.

Benefits and Challenges for Prescribers:

Having clear guidelines for appropriate dosing is useful for doctors who do not have extra training in pain management. It is also helpful for a doctor who is starting a current patient on an opioid trial. However, it can be more challenging if the patient is already a chronic user and new to the practice. Once a patient is dependent on the opioid, monitoring pain levels and dose response can be complicated by increased tolerance levels or withdrawal symptoms. Furthermore, if the patient is new it can be difficult to ascertain current pain levels and dose effectiveness without the baselines provided by past discussions and medical records.

Benefits and Challenges for Patients:

Building a trusting relationship with a new provider takes time, and limiting opioid prescriptions to a three month maximum can make the transition to a new provider trying. The patient may experience difficulty convincing a new care provider that their current opioid use works well for them, particularly with the new pressures on doctors from the media and the new Canadian guidelines that emphasize dose tapering and discontinuation if possible. While some patients may benefit from dose tapering, for others it may be painful and ultimately useless if their dose is already optimized or stable.

Another hazard may be in the patient's perception of the risk involved with prescription opioid use. Patients who have had various, short-term care providers may not have had thorough discussions surrounding the risks of chronic, high-level, opioid use. In addition, the internet often does not provide accurate information for those who do not have experience critically evaluating sources. This can lead to inaccurate expectations for pain management, and a dangerous ignorance of the potential risks of opioid use.

(d) Taper benzodiazepine(s) slowly to the lowest functional dose, or zero if possible, if a patient on existing long-term prescribed benzodiazepine(s) is concurrently taking long- term opiates. Excluding acute and time-limited indications, do not initiate a new benzodiazepine(s) prescription in combination with long-term opioids.

Benefits and Challenges for Providers/Patients:

This requirement is beneficial because it will increase the safety of opioid use. However, benzodiazepines are addictive as well, and so it will be difficult to taper them.(5) The doctor may

want to lead a discussion regarding which drug is more critical to the patient's ability to function on a daily basis.

(e) Consult with an appropriate specialist and/or multidisciplinary program (including these possibilities: pain clinic, psychiatry, psychology, pharmacist, addiction specialist, physical therapist, kinesiologist, chiropractor, practice colleague, if available) when the patient receives a ***90 milligrams*** *morphine equivalents dose daily for longer than 90 days or the patient experiences serious challenges in tapering off opioids or if opiate use disorder is suspected.*

Benefits and Challenges for Providers/Patients:

This requirement provides a distinct benefit to patient care, as it brings in a wider, more diverse team that can address unique needs of the patient. The problem is that these consultations and referrals can take time. By the time a referral is completed, the patient's condition may have worsened. In addition, appointments with specialists are primarily in Winnipeg, which is a barrier to many rural patients. Taking time off of work and paying for the travel can be prohibitive to some people.

Conclusion:

Canada is the 2nd highest opioid prescriber in the world, and health care providers are seeking to change this. With the new debate around opioid prescriptions, and the release of the Canadian guidelines, opioid prescription rates in Manitoba are slowly beginning to decrease. This is good, as for many people the risks of using opioids outweigh the benefits. However, as the CPSM works to create new standards, it is important to critically engage with the challenges of providing good quality care.

The benefits and challenges of opioid prescription that are identified in this report are not new. They are part of the reason that Manitoba is currently creating new standards of practice in this area. Some doctors may respond to these challenges by refusing to prescribe any opioids whatsoever. This protects them from potential lawsuits around the matter, but it also makes it difficult for patients to find supportive care and a possible eventual tapering of the narcotics. While making decisions on opioid prescription, whether at a College or individual level, it is important to critically engage with the challenges discussed above. We need to regularly examine them from both provider and patient perspective in order to continue to strive to provide good quality of care.

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