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Doctor's Offices Can Help Stem Abuse Of Oxycontin, Other Narcotic Painkillers

ScienceDaily (Apr. 14, 2008) — Every day, thousands of doctors around the United States walk a tightrope stretched between their duty to help patients in pain -- and the risk of abetting illegal and life-destroying drug addiction and dependence, and losing their medical license for doing so.

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They walk this tightrope every time a patient asks for a prescription for a powerful opioid narcotic painkiller, such as Oxycontin or Vicodin. These drugs have eased the pain of millions, but have also become lucrative street drugs that are used by millions of people not for pain control, but to get high.

Now, a new study from the University of Michigan and the Ohio State University shows how doctors and their office staff might be able to keep their balance.

Today at the meeting of the Society for General Internal Medicine, a U-M physician will present the results of

an approach she designed and implemented while at OSU.

The results show how a busy multi-physician clinic was able to get a better handle on which patients were misusing opioid medications -- and steer dependent patients to treatment -- through a policy that logged and carefully screened all patients who were receiving the drugs for non-cancer pain. The clinic also required patients and doctors to sign an agreement about conditions for receiving such medicines. The initiative helped identify patients who were using other illicit drugs, which can interact dangerously with narcotic painkillers.

In all, the study revealed that 35 percent of the 167 patients in the clinic's opioid registry violated the new policy in some way -- with the most common violations being a mandatory urine test that showed illegal street drug use, or a check of state prescription records that showed they were getting the drugs from more than one physician at the same time.

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Patients who were receiving Oxycontin or another medicine that contained its active ingredient, oxycodone, were twice as likely as other opioid registry patients to violate the clinic policy in some way.

"Many of us in the clinic were surprised at what we found, because a doctor's job is first and foremost to trust the patient as they tell us about their pain," says study author Jennifer Meddings, M.D., who implemented the policy in collaboration with pharmacist Stuart Beatty, Pharm.D., and internal medicine residency program director Catherine Lucey, M.D. Meddings, now a clinical lecturer in the Division of General Medicine at U-M Medical School, continues, "But in order to confront this issue, and protect our ability to prescribe these drugs to the patients who truly need them, we need to have a uniform approach for all patients."

Meddings is now working with her U-M colleagues to improve implementation of a similar program in the Taubman General Medicine clinic of the U-M Health System, with hopes of having it spread to other U-M clinics -- as it did at OSU. She also hopes to study the effectiveness of such a policy more fully and prospectively.

She led the design and implementation of the policy while she was chief resident of internal medicine at OSU, treating patients at a busy resident-staffed, faculty-supervised clinic. In such a clinic, where a patient is not likely to see the same doctor at every visit, the risk of prescription opioid misuse may be higher.

In fact, the police had alerted the clinic about several patients who had sold narcotic drugs prescribed by residents, or who had tried to fill a single prescription at multiple pharmacies. Under some circumstances, such violations of the law can come back to haunt the prescribing physician and his or her entire clinic -- including the loss of the license to prescribe those medicines to any patient.

At the same time, the experience of managing so many opioid-using patients, and deciding whether to trust them, was turning younger resident physicians away from pursuing a career in primary care -- at a time when such doctors are in short supply. Clinic staff also complained of abuse from some patients.

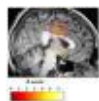
"Everyone was frustrated with the situation, and aware that this was a growing problem we had to do something about," says Meddings.

But, she adds, the clinic also wanted to ensure that it didn't punish the patients who legitimately needed the medications -- and that it offered help to those who had developed a dependence or addiction to narcotics, or whose urine tests showed they were using other illegal drugs. Also important was the need to show patients that they could still receive their other primary medical care from the clinic, even if they violated the opioid policy and could no longer receive prescriptions for Oxycontin or other drugs.

And, since Meddings had learned from national experts that it's hard to predict which patients will misuse opioids, it was decided to apply the policy to all patients receiving opioid prescriptions -- not just those who the physicians or staff suspected of having an opioid problem.

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The first step was to create a registry of all patients receiving opioid prescriptions and their prescribing clinic physicians, in order to establish a clear relationship between the patient and a specific clinic physician to oversee the opioid management plan. Clinic staff also helped screen new patients, from the moment they called for an appointment, so that patients were aware that an evaluation process was necessary before new patients could receive opioid prescriptions from the clinic.

Second, Meddings and Beatty taught their physician colleagues how to use the state of Ohio's online prescription database, which allows doctors and pharmacists to see whether a single patient has been "doctor shopping" to get prescriptions for the same drug from several providers. Michigan has a similar online service.

Third, the team developed a mandatory agreement that patients and doctors would sign -- listing the monitoring steps that were now standard for clinic patients requesting opioids, the types of behaviors that would result in ending the patient's eligibility for opioid prescriptions, and the conditions (such as forging prescriptions or being abusive to staff) that would result in immediate barring of a patient from the clinic.

Fourth, the team implemented annual and random urine screening for all patients requiring opioids for non-cancer pain, to monitor for illegal drugs such as cocaine and unexpected use of other prescribed medications that can interact dangerously with the prescribed opioids.

Meddings stresses that patients whose monitoring turned up signs of dependence or abuse weren't reported to the police, but rather were referred for treatment. Pain specialists who are licensed to provide buprenorphine can help wean patients from an opioid dependence, while others can get help from drug and alcohol abuse specialists, and community services such as Narcotics Anonymous.

In the end, Meddings says, the policy appears to have achieved much of what it set out to do. Now, she hopes that other clinics around the country can adopt the same strategy -- to help them walk the tightrope safely, and patch up the holes in the safety net that allow opioid abuse and diversion to persist.

Meddings and her co-authors note that the policy's implementation was enabled by the efforts of the OSU Internal Medicine residents and General Medicine Clinic faculty and staff. The review and preparation of the research results being presented at the SGIM meeting was greatly assisted by Meddings' colleagues in U-M General Medicine.

Adapted from materials provided by [University of Michigan Health System](#).

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