The inherited chronic pain patient

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Background

The 'inherited' patient, where a patient switches to a new doctor, is a common and potentially challenging scenario, especially where drugs of dependence are involved. There are few resources to guide general practitioners (GPs) with an approach that ensures compassion and rational clinical decision-making.

Objectives

The aim of this article is to guide GPs in an approach to taking over the care of an inherited patient and focuses on considerations of rational prescribing.

Discussion

In taking over the care of a new patient's pharmacotherapy, GPs need to proactively assess how rational and legal the 'inherited' medications are, and decide whether to continue, modify or cease. Our knowledge of the role and risks of drugs of dependence has evolved considerably over the past decade. GPs, therefore, need to carefully consider the ongoing role of these medications for new and existing patients.

Case

During a routine consultation, Samantha (one of your regular patients) says 'My mother's GP unexpectedly retired because of illness. Would you be able to take her on?'. You have known Samantha for a number of years but had never met her mother. Samantha's mother, Donna, books an appointment to see you the following week. She attends primarily for renewal of her prescriptions, arriving with minimal documentation – a rather threadbare 'health summary' (Box 1).

It is not unusual in Australia for a general practitioner (GP) to 'inherit' a patient from another provider, including from another GP. Aside from the challenge of meeting a new patient, these

Box 1. Donna's health summary

Name: Donna X
Age: 68 years of age
Allergies: morphine (nausea)
Patient's medical history:
- Body mass index (BMI) >35 kg/m^2
- Obstructive sleep apnoea
- Osteoarthritis – back and knees
- Hypertension
- Anxiety/insomnia

Social: married, two daughters, retired school teacher
Family history: unknown
Medications:
- Citalopram 20 mg daily
- Coloxyl with senna two bd prn
- Diazepam 10 mg tds
- Fentanyl transdermal patch 25 µg/hr, every third day
- Oxazapam 30 mg nocte
- Oxycodone 5–10 mg q4–6h, 'for breakthrough pain'
- Oxycodone SR 20 mg bd
- Paracetamol 665 mg q8h
- Perindopril 10 mg mane
- Quetiapine XR 60 mg nocte
- Simvastatin 20 mg nocte

encounters involve considerations about the previous provider's treatment of existing medical conditions. This article discusses such considerations in the context of a patient taking prescribed drugs of dependence. It will outline some of the areas to be considered for the inherited patient – a patient who switches to a new doctor, often because of the previous doctor's death, illness or retirement, or the patient's relocation or personal choice to change doctor – as well as clinical considerations with patients using prescribed drugs of dependence.

Clinical handover

Ideally, transfer of a patient's care between providers will be completed via a clinical handover. While there are existing resources that can guide GPs with this important professional activity,[1–4] there is limited research literature to guide GPs with the clinical aspects of handover between primary care providers. The majority of literature focuses on the intra-hospital and hospital–primary care interfaces.

GPs, when aware of a patient's possible migration to another provider (eg during a patient's planned travel or relocation), or when they themselves are planning to leave their current clinic, have a responsibility to conduct a clinical handover of the patient to the new (or temporary) GP. Such a handover would usually take the form of a 'referral letter', where clear standards of the form and content of such communication exist.[1] Despite the importance of a clinical handover, many inherited patients present to their new GP without this advantage. This leaves the patient and GP exposed to risk, particularly regarding the pharmacotherapy components of patient management.

Key principles

There are known barriers for prescribers when reviewing potentially inappropriate medication. These barriers include a lack of awareness of potential problems, inertia related to low perceived value in making changes, low self-efficacy in the prescriber's ability to make the changes, and external factors limiting the feasibility in making any necessary changes.[5] In reviewing the medication for an inherited patient, a GP needs to decide whether the existing pharmacotherapy is rational, defensible, confirmed and within the GP's professional comfort.

Rational

When considering how rational the pharmacotherapy may be for the patient, GPs should consider the evidence base for these treatment approaches, as well as assess the potential beneficial and harmful effects that these medications may have on the patient.

A thorough clinical assessment of the patient is an essential component of taking over the care from another doctor, and may require more than the initial consultation to achieve. With good clinical handover, a reassessment of the patient permits a 'new set of eyes' to review the diagnoses and subsequent management. Without this handover, it is even more important to ensure there is a therapeutic need for any medication. While the clinical assessment of opioid use and benzodiazepines in chronic non-malignant pain and anxiety disorders, respectively, are outside the scope of this article, there are numerous resources available to guide this essential skill.[6–9]

When evaluating the efficacy of a medication, particularly for conditions such as chronic non-malignant pain and anxiety disorders, GPs need to assess whether the symptoms and daily function are improved by the pharmacotherapy. The goal for the use of medications such as benzodiazepines and opioids needs to focus on functional improvement through symptom reduction, not symptom reduction by itself. It should be noted that neither of these drug classes are considered first-line treatment for these conditions. When reviewing Donna's medication, there should be strong consideration of thoroughly reassessing her pain, anxiety and insomnia, and developing a management plan that optimises first-line therapeutic approaches. These approaches include weight loss and exercise for her osteoarthritis,[10] and non-drug anxiety and sleep management approaches.[6] In doing so, the emphasis can start to shift from an over-reliance on medication to more effective active management.

In addition to gauging the functional benefits of medication, the new GP needs to assess the potential harms to the patient from these medications. Knowledge of a medication's side effects, as well as drug–drug and drug–condition interactions, must be considered when weighing up the pros and cons of any particular pharmacotherapy. For example, Donna was prescribed multiple sedative medications in the setting of obstructive sleep apnoea; these medications could be causing or contributing to her sleep apnoea. Referring Donna to an accredited pharmacist, who can conduct a domiciliary medication management review (DMMR), would assist in the assessment.

Given the increased risk of significant adverse effects with the combination of opioids and benzodiazepines (including cognitive impairment, dependence, overdose, respiratory depression, death), this combination should be avoided, especially in patients with other conditions that may impair cognitive or respiratory functions. Considering opioids in isolation, there is growing evidence that high-dose opioids (doses >50 mg of oral morphine equivalence per day [OMED]) are associated with deaths from unintentional overdose.[11–13] There is evidence that the risk of serious harm to the patient is strongly associated with increasing doses of opioids.[13,14] Accordingly, for patients presenting with opioids where the OMED is >50 mg, GPs should:[13]

- carefully reassess the objective evidence of individual benefits and risks
- implement additional precautions, including increased frequency of follow-up
- consider offering naloxone (for initial treatment of an unintentional overdose) as stated in current international guidelines.

The assessment and management of patients with potential dependence from drugs such as opioids and benzodiazepine have been covered in other published resources.[9,15–17] Where dependence is assessed, GPs should obtain further assistance, referral or upskill their own training to ensure these patients receive the best available treatment for this significant, and often iatrogenic, adverse effect.

Defensible

All prescribers must ensure they are familiar with the legislative requirements of prescribing, especially schedule 8 drugs. These requirements differ around the country and resources are available to facilitate this essential knowledge.[18] The inherited patient may also have previously been prescribed medication on the Pharmaceutical Benefits Scheme (PBS) despite a lack of eligibility for PBS subsidy (eg Donna's quetiapine). The fact that a patient is new to a GP does not absolve the GP from their legislative responsibilities. Once a prescription is issued, the medico-legal responsibility lies with the (new) prescriber.

Confirmed

While most patients present to a new doctor 'honestly', there are some who may attempt to manipulate the occasion in order to source medication or doses they were not previously prescribed. 'Prescription shopping' behaviours have previously been described, as have approaches for managing these patients.[19–22] Identification of such patients should trigger a strong consideration not to prescribe the requested medication.

Confirmation of the patient's medication listing can include direct communication with the previous provider, ideally verbally and in written format. A short phone call can convey important nuanced clinical information that is not apparent in written formats. Other sources of information include the patient's pharmacy (through direct communication and DMMR); the Health Insurance Commission Prescription Shopping Information Service; electronic recording and reporting of controlled drugs (ERRCD) systems (in jurisdictions where this exists); state/territory health departments' pharmaceutical services units; and the use of urine drug screening[23] to verify the presence of the claimed medication.

Professional comfort of pharmacotherapy

The combination of the above considerations should lead to a decision about whether the medications are appropriate for the patient. In addition, GPs need to consider how this fits into their own understanding, work context and training. There may be specific workplace/community considerations (eg clinic policies, community issues) that will direct the decision-making process. There may be medications with which the GP is less familiar and uncomfortable prescribing because of complexity with the medication (eg methadone). To be able to prescribe a medication for a patient, the GP must ensure that they are professionally comfortable with prescribing it in their personal experience and local contexts.

Decision to continue

In making a decision about whether to continue with the patient's stated medications, after considering the key assessment principles noted above, the GP must decide whether the medication will be continued unchanged or continued but with some necessary modification, or is so irrational, indefensible or outside the doctor's professional comfort that continuing to prescribe it is untenable. In Donna's case, the use of quetiapine is questionable and outside of the approved indications, and ceasing this medication should be considered.

Whatever the choice, ensure the decision and reasoning are adequately documented and communicated to the patient. This is vital medico-legally, but also in the event of a future clinical handover of the same patient, so that decisions can be retrospectively understood.

Continue unchanged

Where the confirmed pharmacotherapy is considered rational and there is no other reason to alter the medication regime, GPs can continue to prescribe it. This should be done alongside continuing periodic medication and clinical reviews. The decision to continue a pre-existing medication regime should be an active decision, not just a default. For Donna, a decision to continue her laxative to minimise opioid-induced constipation can be justified, provided it was efficacious. After reviewing Donna's cardiovascular risk factors, a decision to continue or stop her perindopril and/or simvastatin should be actively made (depending on her cardiovascular risk profile[24] and Donna's own health priorities).

Continue with modification

There may be circumstances where some modifications to pharmacotherapy are required, for example, from suggestions gained in a pharmacist's DMMR report. Communicating the clinical reasoning behind these decisions with the patient allows them to understand why changes are being made. The principles of developing a mutually beneficial relationship with the new patient is vital, as will be described below.

Ceasing

'De-prescribing' or developing an 'exit strategy' is an important skill that has been largely ignored in traditional medical education, yet, it is an essential part of prescribing medications that can cause significant harm (eg opioids).[25]

The decision to discontinue the inherited pharmacotherapy does not necessarily mean deciding not to continue with the doctor–patient relationship. While significantly altering a patient's medication can be perceived as a significant threat for them, being transparent and upfront about medication concerns is an important strategy – the patient may not even have been aware of the issues. As the patient's new doctor, there is an opportunity to 'set the ground rules' early in the relationship. Making the patient aware of the concern for their wellbeing moves the discussion from 'blaming' to helping.

The pacing of any de-prescribing will depend on the urgency of the risks that have been identified. Immediate, life-threatening factors will have a completely different time-course from less immediate, longer term concerns. For the latter, de-prescribing may be undertaken in a more gradual manner, while developing the doctor–patient relationship and trust.

The GP should remember that patients such as Donna have had their medication prescribed by a doctor and the issue(s) you have identified may have been iatrogenically created. Establishment of a new therapeutic relationship with Donna is paramount in this situation.

The therapeutic relationship

Where the GP decides that ongoing prescription of drugs of dependence is not medically indicated, it is important to explain to the patient why this is the case and let them know that you would like to help them manage their pain/other conditions in other ways. Patients with chronic pain can present with clinical and psychosocial complexity that benefits from a multidisciplinary approach. Assisting a patient such as Donna to access members of such a team is an important role for the GP. The multidisciplinary team can include physical therapists, psychologists and pharmacists. Where access to a formal multidisciplinary team is not available, working with the patient towards their functional treatment goals will guide referrals and engagement with individual health providers who make up such a team. Coordinating the care from such a team, for example while undergoing a supported wean off opioids, is vital so the patient actually has an evidence-based treatment approach and does not unnecessarily experience opioid withdrawal. Clear communication of this treatment plan with the patient is essential.

Time for a 'selfie'?

As previously stated, the arrival of an inherited patient provides an opportunity to reassess the patient with a new set of eyes and set ground rules from the initial consultation. However, this topic also lends itself to re-appraising one's own prescribing habits. As doctors gather new knowledge, opportunities open up to review one's own patients with these new eyes, re-evaluating the management of the patient one has inherited from one's previous experience.

Case continued

In addition to reassessing Donna's overall health, you review her medication and express your concern about the choices and combination of medications she was taking. Without blaming her previous GP, you describe where you will be modifying her treatment and the reasons why this is important for her health. Donna responds with both apprehension (about whether her symptoms of pain, insomnia and anxiety will get worse with any changes) and relief (she feels she has been taking too many medications, but has felt helpless to change anything, or voice her concerns to her previous longstanding GP).

After spending a few consultations getting to know her, reassessing her conditions, and considering the recommendations from an accredited pharmacist's DMMR, you both agree to make one change at a time, with regular review. You discuss the management of her anxiety and insomnia, and review the role of her quetiapine. You explain that quetiapine is not approved by the Therapeutics Goods Administration (TGA) in Australia for anxiety and insomnia and is not available through the PBS for these conditions. Donna reluctantly agrees to a referral for psychotherapy to address these issues as you cease the medication.

Over time, her opioids were rationalised into one single formulation. This was done through the use of a dose equivalence calculator (eg The Australian & New Zealand College of Anaesthetists's Faculty of Pain Medicine's Opioid Calculator app, available at http://fpm.anzca.edu.au/front-page-news/free-opioid-calculator-app) to calculate the current OMED (195 mg morphine/day). A single opioid agent was selected with a 30–50% dose reduction for incomplete cross-tolerance to avoid the risk of overdose (ie 60 mg sustained release morphine twice daily – with reassurance that her previous morphine 'allergy' of nausea is highly unlikely to recur given her current opioid tolerance). The dose was then slowly tapered to <50 mg OMED through a series of reductions (aiming for 10% dose reduction every week). A pain management plan including physical, social and psychological components was put in place and followed up. This plan also included education about taking her medication as prescribed and included an acute pain plan, which focused on non-opioid modalities to avoid opioid dose increases during future episodes of acute pain.

Similarly, Donna's benzodiazepines were rationalised and tapered off. This was done alongside some well-overdue psychotherapy to help her regain a sense of control. Her hypnotic was weaned off alongside a structured sleep behaviour program guided by her psychologist. Then, Donna's diazepam dosing was very slowly tapered, reducing her dose by 5 mg/day every month over a six-month period. Donna's heightened anxiety about the weaning process was matched with an increased frequency of consultations to provide opportunities for regular review, encouragement and support.

After reviewing her cardiovascular risk factors, her understanding of primary prevention and her mental health, Donna's perindopril and citalopram were continued, and the simvastatin and quetiapine were ceased. Despite some symptomatic setbacks along the way, Donna was appreciative of your efforts, finding her mind was clearer and she was much happier with a simpler medication regime.

The last time you saw Donna she stated … 'My neighbour would like to change GPs. Would you be able to take her on?'

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