1
00:00:03,410 --> 00:00:05,940
Hello and welcome
to Mayo Clinic Talks,

2
00:00:05,940 --> 00:00:07,785
The Opioid Edition.

3
00:00:07,785 --> 00:00:08,970
I'm Tracy McCray  and with

4
00:00:08,970 --> 00:00:09,990
me today is Dr. Casey

5
00:00:09,990 --> 00:00:11,820
Clements, an
emergency physician

6
00:00:11,820 --> 00:00:13,440
and practice leader
who works in

7
00:00:13,440 --> 00:00:15,330
the Opioid Stewardship
Program at

8
00:00:15,330 --> 00:00:17,910
Mayo Clinic in Rochester.
Hello, Dr. Clements.

9
00:00:17,910 --> 00:00:19,170
Hi. Thanks for having me.

10
00:00:19,170 --> 00:00:20,490
Today we're going
to take a look into

11
00:00:20,490 --> 00:00:21,750
the opioid crisis from

12
00:00:21,750 --> 00:00:24,060
the perspective of
acute prescribing.

13
00:00:24,060 --> 00:00:25,680
Dr. Clements,
first of all,

14
00:00:25,680 --> 00:00:28,470
what is an acute
prescriber?

15
00:00:28,470 --> 00:00:31,050
So I think that there's
a general class

16
00:00:31,050 --> 00:00:32,490
of physicians who
generally are

17
00:00:32,490 --> 00:00:34,050
treating acute pain as

18
00:00:34,050 --> 00:00:36,705
opposed to long
and ongoing pain.

19
00:00:36,705 --> 00:00:38,040
That would include not only

20
00:00:38,040 --> 00:00:39,999
emergency department
physicians,

21
00:00:39,999 --> 00:00:41,360
>> but surgeons, and

22
00:00:41,360 --> 00:00:42,650
proceduralists who are

23
00:00:42,650 --> 00:00:44,254
doing painful procedures,

24
00:00:44,254 --> 00:00:45,500
as well as primary

25
00:00:45,500 --> 00:00:46,820
care providers
who are treating

26
00:00:46,820 --> 00:00:47,960
patients in

27
00:00:47,960 --> 00:00:50,060
their acute pain that
come to the clinic.

28
00:00:50,060 --> 00:00:52,850
So, if an acute
prescriber has

29
00:00:52,850 --> 00:00:54,680
got a different role

30
00:00:54,680 --> 00:00:57,140
in that in filling out
those prescriptions.

31
00:00:57,140 --> 00:00:58,130
How do you as

32
00:00:58,130 --> 00:01:00,620
an acute provider
or prescriber,

33
00:01:00,620 --> 00:01:04,745
stop or discontinue
the use of opioids?

34
00:01:04,745 --> 00:01:06,800
So first of all,

35
00:01:06,800 --> 00:01:09,440
I think that at every
single patient visit

36
00:01:09,440 --> 00:01:10,490

for a patient who's on

37
00:01:10,490 --> 00:01:12,365
Opioids, be it
acute or chronic,

38
00:01:12,365 --> 00:01:14,270
we should be trying
to address how are

39
00:01:14,270 --> 00:01:16,385
we going to get off
of these medications.

40
00:01:16,385 --> 00:01:18,470
Every piece of evidence
would say staying on

41
00:01:18,470 --> 00:01:20,720
these forever
is bad for you.

42
00:01:20,720 --> 00:01:23,285
And so at every point
of healthcare contact,

43
00:01:23,285 --> 00:01:25,220
I think it's a very
legitimate question

44
00:01:25,220 --> 00:01:26,900
to be asking the patient,

45
00:01:26,900 --> 00:01:28,610
what's your plan
on getting off of

46
00:01:28,610 --> 00:01:30,020
these medications or can I

47
00:01:30,020 --> 00:01:31,940
offer you tapering
recommendations

48
00:01:31,940 --> 00:01:33,485
for how to get off them?

49
00:01:33,485 --> 00:01:35,420
Now, there are some cases

50
00:01:35,420 --> 00:01:36,740
in which we want to stop

51
00:01:36,740 --> 00:01:38,165
opioid medications

52
00:01:38,165 --> 00:01:40,325
abruptly and all
of a sudden.

53
00:01:40,325 --> 00:01:42,725
And that's if you really
have any evidence

54
00:01:42,725 --> 00:01:45,350
of misuse or abuse of
those medications,

55
00:01:45,350 --> 00:01:46,775
if you have evidence or

56
00:01:46,775 --> 00:01:48,920
suspicion that opioids
are being diverted

57
00:01:48,920 --> 00:01:51,320
for nefarious
purposes, or if you

58
00:01:51,320 --> 00:01:52,655
think that they're
an immanent

59
00:01:52,655 --> 00:01:54,245
danger to the patient,

60
00:01:54,245 --> 00:01:55,400
such as a risk for

61
00:01:55,400 --> 00:01:57,440
accidental overdose
with drug-drug

62
00:01:57,440 --> 00:01:58,820
interacting
medications

63
00:01:58,820 --> 00:02:00,845
like benzodiazepines.

64
00:02:00,845 --> 00:02:03,560
In that case, we
should really stop

65
00:02:03,560 --> 00:02:05,750
opioid medications
and then handle

66
00:02:05,750 --> 00:02:08,735
the withdrawal
symptoms, if necessary,

67
00:02:08,735 --> 00:02:11,255
preferably with
non-opioid treatment.

68
00:02:11,255 --> 00:02:13,400
Is there ever an exception

69
00:02:13,400 --> 00:02:16,175
to that opioid
discontinuation?

70
00:02:16,175 --> 00:02:17,480
Yeah. You don't want to

71
00:02:17,480 --> 00:02:19,370

stop an opioid all
of a sudden in

72
00:02:19,370 --> 00:02:20,780
patients who are
going to be placed at

73
00:02:20,780 --> 00:02:24,035
medical risk for those
withdrawal symptoms.

74
00:02:24,035 --> 00:02:27,350
So people with significant
cardiac disease,

75
00:02:27,350 --> 00:02:31,730
including unstable
angina or

76
00:02:31,730 --> 00:02:34,010
ongoing or common
chest pain.

77
00:02:34,010 --> 00:02:35,240
You want to be
very careful about

78
00:02:35,240 --> 00:02:36,800
stopping opioids
all of a sudden,

79
00:02:36,800 --> 00:02:38,375
and also pregnant patients,

80
00:02:38,375 --> 00:02:40,820
the physiology and
pregnancy changes and

81
00:02:40,820 --> 00:02:42,110
putting a pregnant
patient into

82
00:02:42,110 --> 00:02:43,790

withdrawal can also put

83
00:02:43,790 --> 00:02:45,230
the fetus at risk

84
00:02:45,230 --> 00:02:46,865
and so we want
to be careful in

85
00:02:46,865 --> 00:02:48,230
medically compromised

86
00:02:48,230 --> 00:02:49,340
populations that would be

87
00:02:49,340 --> 00:02:52,040
at risk for the
symptoms of withdrawal.

88
00:02:52,040 --> 00:02:53,300
How do you write

89
00:02:53,300 --> 00:02:55,295
a prescription
for acute pain?

90
00:02:55,295 --> 00:02:57,710
So if you come to the
emergency department or

91
00:02:57,710 --> 00:02:59,945
to the clinic and
you have a severe,

92
00:02:59,945 --> 00:03:01,610
acute painful
condition like

93
00:03:01,610 --> 00:03:03,350
a fracture of a
bone or I had to do

94

00:03:03,350 --> 00:03:04,970
a procedure on you
that's gonna have

95
00:03:04,970 --> 00:03:08,075
some pain, or even surgeries,

96
00:03:08,075 --> 00:03:09,560
evidence would say that

97
00:03:09,560 --> 00:03:11,540
the vast majority
of those patients

98
00:03:11,540 --> 00:03:12,950
require three days or

99
00:03:12,950 --> 00:03:15,395
less of an opioid
treatment.

100
00:03:15,395 --> 00:03:16,880
And I think that
that's a bit of

101
00:03:16,880 --> 00:03:18,800
a change in the
medical culture and

102
00:03:18,800 --> 00:03:21,140
medical literature
because I

103
00:03:21,140 --> 00:03:22,220
think we've
thought while they

104
00:03:22,220 --> 00:03:23,360
have the severe pain,

105
00:03:23,360 --> 00:03:25,160
this is going to be
ongoing for some time.

106
00:03:25,160 --> 00:03:26,030
We need to provide them

107
00:03:26,030 --> 00:03:27,710
with longer-term
medication.

108
00:03:27,710 --> 00:03:29,510
Really, that's
the exception and

109
00:03:29,510 --> 00:03:31,715
the rule should be
three-day supply

110
00:03:31,715 --> 00:03:34,070
usually totaling a
100 milligram of

111
00:03:34,070 --> 00:03:35,570
morphine
equivalence or less

112
00:03:35,570 --> 00:03:37,190
as a complete prescription.

113
00:03:37,190 --> 00:03:39,110
So that's about 12 tablets

114
00:03:39,110 --> 00:03:40,670
of 5-milligram
oxycodone

115
00:03:40,670 --> 00:03:43,235
if you're going to
say that conversion.

116
00:03:43,235 --> 00:03:45,740
Most patients, or
almost all patients

117

00:03:45,740 --> 00:03:47,090
won't require
more than that,

118
00:03:47,090 --> 00:03:48,740
including for surgeries

119
00:03:48,740 --> 00:03:50,985
or acutely painful
conditions.

120
00:03:50,985 --> 00:03:53,410
Rarely do patients
require more,

121
00:03:53,410 --> 00:03:55,390
and in that case,
usually one week

122
00:03:55,390 --> 00:03:58,090
supply of seven days
or 200 milligram

123
00:03:58,090 --> 00:04:00,010
morphine equivalence is the

124
00:04:00,010 --> 00:04:01,720
indicated or
recommended dose,

125
00:04:01,720 --> 00:04:03,580
at least by our group.

126
00:04:03,580 --> 00:04:04,990
And then they would need to

127
00:04:04,990 --> 00:04:05,890
follow up if they’re

128
00:04:05,890 --> 00:04:06,640
still requiring

129

00:04:06,640 --> 00:04:08,185
further treatment
at that time.

130
00:04:08,185 --> 00:04:10,675
Is it unusual or is
it more common for

131
00:04:10,675 --> 00:04:13,165
a patient to get
that 100 milligram,

132
00:04:13,165 --> 00:04:15,700
you know, a few
days' worth and

133
00:04:15,700 --> 00:04:18,880
then start to show a
dependence that quickly?

134
00:04:18,880 --> 00:04:20,200
This is a great question.

135
00:04:20,200 --> 00:04:20,890
And I think that there's

136
00:04:20,890 --> 00:04:22,600
been a lot of
fear around this,

137
00:04:22,600 --> 00:04:25,060
both from a patient side
and a provider side.

138
00:04:25,060 --> 00:04:26,260
The patients are
afraid that they're

139
00:04:26,260 --> 00:04:28,075
going to be in
pain longer-term.

140
00:04:28,075 --> 00:04:29,650

And the providers
are scared

141
00:04:29,650 --> 00:04:30,940
that we're going
to make a lot of

142
00:04:30,940 --> 00:04:32,140
addicts by prescribing

143
00:04:32,140 --> 00:04:33,675
a few days of medication.

144
00:04:33,675 --> 00:04:35,540
We do have some
pretty good evidence

145
00:04:35,540 --> 00:04:37,925
from big data that
would say that

146
00:04:37,925 --> 00:04:39,620
patients who have

147
00:04:39,620 --> 00:04:40,940
an acutely
painful condition

148
00:04:40,940 --> 00:04:42,080
and get only a couple of

149
00:04:42,080 --> 00:04:43,940
days of medications
are not at

150
00:04:43,940 --> 00:04:46,610
the highest risk for
addiction potential.

151
00:04:46,610 --> 00:04:48,170
And so we would

152

00:04:48,170 --> 00:04:49,760
recommend that
short course and

153
00:04:49,760 --> 00:04:52,955
a re-evaluation than
longer term prescribing.

154
00:04:52,955 --> 00:04:56,014
Certainly, the risk of
dependence or misuse

155
00:04:56,014 --> 00:04:57,170
needs to be weighed

156
00:04:57,170 --> 00:04:59,360
against the benefits
of the treatment,

157
00:04:59,360 --> 00:05:00,410
which as we said in

158
00:05:00,410 --> 00:05:02,705
a previous episode,
or really improving

159
00:05:02,705 --> 00:05:04,700
the function of
the patient and

160
00:05:04,700 --> 00:05:06,815
being able to make
their pain tolerable.

161
00:05:06,815 --> 00:05:09,050
What is the first sign

162
00:05:09,050 --> 00:05:10,310
or symptom or how can you

163
00:05:10,310 --> 00:05:11,630
tell if someone is

164
00:05:11,630 --> 00:05:14,825
maybe having issues
with dependency?

165
00:05:14,825 --> 00:05:16,100
I think this is

166
00:05:16,100 --> 00:05:18,020
a really important
question as well.

167
00:05:18,020 --> 00:05:19,700
You know, we certainly have

168
00:05:19,700 --> 00:05:21,290
diagnostic criteria for

169
00:05:21,290 --> 00:05:23,690
opioid use disorder. The

170
00:05:23,690 --> 00:05:26,750
psychiatry manual or

171
00:05:26,750 --> 00:05:28,400
Bible of the Diagnostic

172
00:05:28,400 --> 00:05:29,660
and Statistical Manual.

173
00:05:29,660 --> 00:05:31,865
The most current
version, DSM-5,

174
00:05:31,865 --> 00:05:34,220
has 11 different criteria

175
00:05:34,220 --> 00:05:35,690
for opioid use disorder.

176
00:05:35,690 --> 00:05:36,740
And if at any point you

177
00:05:36,740 --> 00:05:38,120
meet two of those criteria

178
00:05:38,120 --> 00:05:39,860
within 12 months you have

179
00:05:39,860 --> 00:05:42,260
the diagnosis of
opioid use disorder.

180
00:05:42,260 --> 00:05:43,850
I think that that may be

181
00:05:43,850 --> 00:05:45,755
a little bit
over-complicated

182
00:05:45,755 --> 00:05:47,630
at the risk of
offending some

183
00:05:47,630 --> 00:05:49,670
of my addiction colleagues.

184
00:05:49,670 --> 00:05:51,440
I think that if you

185
00:05:51,440 --> 00:05:53,450
have concerns that
the patient is

186
00:05:53,450 --> 00:05:55,520
potentially misusing
their medications

187
00:05:55,520 --> 00:05:57,170
or is developing
a problem with

188
00:05:57,170 --> 00:05:59,555
these medications

that we need to have

189
00:05:59,555 --> 00:06:01,280
frank and honest
conversations

190
00:06:01,280 --> 00:06:02,420
with our patients of,

191
00:06:02,420 --> 00:06:05,930
hey, I think that you
might have a problem,

192
00:06:05,930 --> 00:06:09,380
can we talk about
this? In general,

193
00:06:09,380 --> 00:06:10,580
how is that comment or

194
00:06:10,580 --> 00:06:12,695
that question
received by patients?

195
00:06:12,695 --> 00:06:13,550
I mean, I'm sure
they're not

196
00:06:13,550 --> 00:06:14,945
all the same, but do,

197
00:06:14,945 --> 00:06:16,280
do some patients say,

198
00:06:16,280 --> 00:06:17,525
I think you might be right,

199
00:06:17,525 --> 00:06:19,100
or does everybody disagree?

200
00:06:19,100 --> 00:06:21,080
No, some patients do

say, you might be right.

201
00:06:21,080 --> 00:06:22,160
And I think that we

202
00:06:22,160 --> 00:06:24,320
have misconceptions
about how

203
00:06:24,320 --> 00:06:28,130
that conversation will
go. But in general,

204
00:06:28,130 --> 00:06:29,660
especially for people
who've been on

205
00:06:29,660 --> 00:06:31,970
these medications
for a long time,

206
00:06:31,970 --> 00:06:34,520
they're hurting for
different reasons.

207
00:06:34,520 --> 00:06:35,900
And so we need to

208
00:06:35,900 --> 00:06:37,430
meet the patients
where they are

209
00:06:37,430 --> 00:06:39,500
and that invitation to

210
00:06:39,500 --> 00:06:41,360
a conversation
is received well

211
00:06:41,360 --> 00:06:43,940
sometimes and it should
continue to be asked

212
00:06:43,940 --> 00:06:45,200
even if it's not
received while

213
00:06:45,200 --> 00:06:47,000
the first, second
or third time.

214
00:06:47,000 --> 00:06:50,210
Because eventually
a patient is going

215
00:06:50,210 --> 00:06:51,470
to need some help
and we need to

216
00:06:51,470 --> 00:06:53,300
make sure that we're
there to help offer it.

217
00:06:53,300 --> 00:06:54,650
I know one of the things in

218
00:06:54,650 --> 00:06:55,790
past interviews
that I've done,

219
00:06:55,790 --> 00:06:57,665
I've heard people say

220
00:06:57,665 --> 00:07:00,335
if a if an opioid
is prescribed,

221
00:07:00,335 --> 00:07:02,300
there should always
be a second visit,

222
00:07:02,300 --> 00:07:03,410
not just here's your

223
00:07:03,410 --> 00:07:04,550

prescription and send
you on your way.

224
00:07:04,550 --> 00:07:05,930
There always should
be a second visit

225
00:07:05,930 --> 00:07:07,280
to see how we're
doing there.

226
00:07:07,280 --> 00:07:10,294
But what we're
talking about here is

227
00:07:10,294 --> 00:07:14,540
if they say yes, I
have an issue or okay,

228
00:07:14,540 --> 00:07:16,490
I will go talk to
a social worker.

229
00:07:16,490 --> 00:07:17,810
You're not going to hold

230
00:07:17,810 --> 00:07:18,680
their hand and take

231
00:07:18,680 --> 00:07:19,700
them to the social worker,

232
00:07:19,700 --> 00:07:21,020
but how do you make
sure that that

233
00:07:21,020 --> 00:07:22,790
handoff happens,

234
00:07:22,790 --> 00:07:24,470
that that patient...
You should get him

235
00:07:24,470 --> 00:07:26,255
to come back
and talk about,

236
00:07:26,255 --> 00:07:28,505
OK, how is the
opioid use going?

237
00:07:28,505 --> 00:07:30,080
How do you get them to hand

238
00:07:30,080 --> 00:07:31,160
off to the next person to

239
00:07:31,160 --> 00:07:32,180
make sure they get
that help they

240
00:07:32,180 --> 00:07:33,815
need and don't fall
through the cracks?

241
00:07:33,815 --> 00:07:36,470
So just like any
other addiction or

242
00:07:36,470 --> 00:07:39,830
drug that patients may
have problems with,

243
00:07:39,830 --> 00:07:43,520
opioids require a
multidisciplinary approach.

244
00:07:43,520 --> 00:07:45,140
And I do think that
we need to engage

245
00:07:45,140 --> 00:07:47,030
our Addiction Medicine
colleagues and get

246

00:07:47,030 --> 00:07:48,710
people into treatment
that's going to be

247
00:07:48,710 --> 00:07:51,139
longer-term than
just a visit or two.

248
00:07:51,139 --> 00:07:52,610
So to answer
the first part of

249
00:07:52,610 --> 00:07:54,350
your question of Does
everybody who gets

250
00:07:54,350 --> 00:07:55,160
a prescription need

251
00:07:55,160 --> 00:07:56,420
a follow-up
visit to see how

252
00:07:56,420 --> 00:07:58,850
they're doing? You know,

253
00:07:58,850 --> 00:08:01,370
for anybody who's on
long-term opioids,

254
00:08:01,370 --> 00:08:03,440
I absolutely think that
follow-up is going to

255
00:08:03,440 --> 00:08:05,660
be the most
important thing. For

256
00:08:05,660 --> 00:08:06,740
patients who have an

257
00:08:06,740 --> 00:08:08,690
acutely painful condition

258
00:08:08,690 --> 00:08:10,370
that requires a
short-term treatment,

259
00:08:10,370 --> 00:08:11,120
I don't think that

260
00:08:11,120 --> 00:08:12,770
our medical
infrastructure is

261
00:08:12,770 --> 00:08:14,450
capable of following up

262
00:08:14,450 --> 00:08:17,255
every one of those
patients three days later.

263
00:08:17,255 --> 00:08:20,360
That doesn't exist in
our country right now.

264
00:08:20,360 --> 00:08:22,100
And so the
follow-up plan is

265
00:08:22,100 --> 00:08:23,930
important if they
have continued pain.

266
00:08:23,930 --> 00:08:24,590
But I don't know that

267
00:08:24,590 --> 00:08:25,730
an acute prescribing that

268
00:08:25,730 --> 00:08:27,560
we can say you need
to see somebody else

269
00:08:27,560 --> 00:08:29,990

if I'm giving you an
opioid prescription.

270
00:08:29,990 --> 00:08:32,090
Certainly, to get back
to the second part of

271
00:08:32,090 --> 00:08:32,930
the question when we're

272
00:08:32,930 --> 00:08:33,710
starting to talk about,

273
00:08:33,710 --> 00:08:35,570
okay, I think this
patient has a problem.

274
00:08:35,570 --> 00:08:37,325
What do I do with this?

275
00:08:37,325 --> 00:08:39,560
Social Work was mentioned.

276
00:08:39,560 --> 00:08:41,690
I think that social
work resources

277
00:08:41,690 --> 00:08:43,505
are key to this a
lot of the time

278
00:08:43,505 --> 00:08:45,020
And they can facilitate

279
00:08:45,020 --> 00:08:46,760
providing resources
to patients

280
00:08:46,760 --> 00:08:47,600
to make sure that they're

281
00:08:47,600 --> 00:08:48,440

getting help that they

282
00:08:48,440 --> 00:08:50,690
need for their
addiction treatment.

283
00:08:50,690 --> 00:08:52,040
And referrals to addiction

284
00:08:52,040 --> 00:08:53,195
medicine are important.

285
00:08:53,195 --> 00:08:55,580
What don't we,
the lay public,

286
00:08:55,580 --> 00:08:58,220
what don't we understand
about opioids?

287
00:08:58,220 --> 00:08:59,720
I mean, it is
occurring to me as

288
00:08:59,720 --> 00:09:01,490
I'm going through
the process

289
00:09:01,490 --> 00:09:03,170
of interviewing, you find

290
00:09:03,170 --> 00:09:05,555
physicians for this podcast,

291
00:09:05,555 --> 00:09:07,970
that the way that
I feel about it is

292
00:09:07,970 --> 00:09:10,445
I'm afraid to even
take one pill.

293

00:09:10,445 --> 00:09:12,764
I've never had an
addiction problem.

294
00:09:12,764 --> 00:09:14,710
When I have
had to take them,

295
00:09:14,710 --> 00:09:16,705
I get really sick.

296
00:09:16,705 --> 00:09:19,240
I just don't even

297
00:09:19,240 --> 00:09:21,175
want to have them
in my house.

298
00:09:21,175 --> 00:09:23,320
But perhaps I'm
being a little

299
00:09:23,320 --> 00:09:24,940
bit like it’s a bogeyman
kinda thing.

300
00:09:24,940 --> 00:09:26,410
I don't need to
be that afraid.

301
00:09:26,410 --> 00:09:28,630
And then there's all
the way the other side.

302
00:09:28,630 --> 00:09:29,930
People like yeah, pop ‘em

303
00:09:29,930 --> 00:09:31,765
like candy, no big deal.

304
00:09:31,765 --> 00:09:33,190
What is it that you want

305
00:09:33,190 --> 00:09:34,060
the general public to

306
00:09:34,060 --> 00:09:35,350
understand about opioids as

307
00:09:35,350 --> 00:09:36,940
we move forward as

308
00:09:36,940 --> 00:09:39,580
a nation and this
problem continues?

309
00:09:39,580 --> 00:09:41,530
So I think a healthy dose

310
00:09:41,530 --> 00:09:43,090
of fear is probably OK.

311
00:09:43,090 --> 00:09:44,590
There's no bogeyman.
Okay. I don't

312
00:09:44,590 --> 00:09:46,345
think you have to
worry about that.

313
00:09:46,345 --> 00:09:48,490
I do think that what we

314
00:09:48,490 --> 00:09:50,650
don't understand,
both as patients

315
00:09:50,650 --> 00:09:52,795
and in society
in general, is

316
00:09:52,795 --> 00:09:55,109
the risks of these
medications to a

317
00:09:55,109 --> 00:09:57,905
personal level. We
understand the risks,

318
00:09:57,905 --> 00:10:00,155
oh, these patients, some
people get addicted,

319
00:10:00,155 --> 00:10:02,735
but in general when
we're in pain or when we

320
00:10:02,735 --> 00:10:04,130
think that these
medications may be

321
00:10:04,130 --> 00:10:05,615
indicated for us
as a patient,

322
00:10:05,615 --> 00:10:06,920
we don't see ourselves as

323
00:10:06,920 --> 00:10:09,125
at that risk
for addiction.

324
00:10:09,125 --> 00:10:10,700
And I, I think
that we need to

325
00:10:10,700 --> 00:10:14,180
have more granular data and

326
00:10:14,180 --> 00:10:16,850
more frank discussions
with, here's

327
00:10:16,850 --> 00:10:21,095
your risk for developing
misuse, dependence,

328

00:10:21,095 --> 00:10:23,825
abuse of these medications.

329
00:10:23,825 --> 00:10:25,445
That's going to involve

330
00:10:25,445 --> 00:10:28,280
physicians and allied
health and nursing

331
00:10:28,280 --> 00:10:32,000
staff having discussions
with patients for

332
00:10:32,000 --> 00:10:33,980
risks and benefits
for what we

333
00:10:33,980 --> 00:10:35,180
would usually
have considered

334
00:10:35,180 --> 00:10:36,560
a simple prescription.

335
00:10:36,560 --> 00:10:38,330
This is probably
something that we can do

336
00:10:38,330 --> 00:10:39,710
on other medications as well

337
00:10:39,710 --> 00:10:40,970
that would benefit
our patients.

338
00:10:40,970 --> 00:10:42,050
But I really think that in

339
00:10:42,050 --> 00:10:44,240
opioids we're going
to start to have to

340
00:10:44,240 --> 00:10:46,220
have that consent
discussion even for

341
00:10:46,220 --> 00:10:48,830
prescription, as if
this were a procedure.

342
00:10:48,830 --> 00:10:50,240
Here's what we're trying to

343
00:10:50,240 --> 00:10:51,890
accomplish with
this prescription.

344
00:10:51,890 --> 00:10:54,080
And here's the risks
of the bad things

345
00:10:54,080 --> 00:10:56,420
that might happen
as well, to you,

346
00:10:56,420 --> 00:10:58,610
not just to society.

347
00:10:58,610 --> 00:11:01,760
And finally, I think
part of what got us to

348
00:11:01,760 --> 00:11:03,440
this point is that
people wanted

349
00:11:03,440 --> 00:11:06,045
to better manage pain,

350
00:11:06,045 --> 00:11:08,065
erase pain,

351
00:11:08,065 --> 00:11:09,550
and now maybe

we're stepping

352
00:11:09,550 --> 00:11:10,660
back a little
bit and saying,

353
00:11:10,660 --> 00:11:11,890
instead of erasing
your pain,

354
00:11:11,890 --> 00:11:13,420
we're just going to
better manage your pain.

355
00:11:13,420 --> 00:11:15,430
Is that semantics or
is that really what's

356
00:11:15,430 --> 00:11:18,055
happening in the
Emergency Department?

357
00:11:18,055 --> 00:11:19,990
Or for you as an acute physician?

358
00:11:19,990 --> 00:11:21,640
I had this discussion just

359
00:11:21,640 --> 00:11:23,605
yesterday with one
of my colleagues.

360
00:11:23,605 --> 00:11:26,155
He said, you know,
I remember when

361
00:11:26,155 --> 00:11:27,670
The Joint
Commission came out

362
00:11:27,670 --> 00:11:29,500
with the additional
vital sign

363
00:11:29,500 --> 00:11:30,880
have pain intensity and

364
00:11:30,880 --> 00:11:33,715
an idea that oligo
analgesia of, we're

365
00:11:33,715 --> 00:11:35,470
under-treating or
not treating pain

366
00:11:35,470 --> 00:11:38,425
adequately was
really a big push.

367
00:11:38,425 --> 00:11:39,820
And he said, and
now we're going

368
00:11:39,820 --> 00:11:41,290
back this other
direction and

369
00:11:41,290 --> 00:11:42,490
I feel really torn

370
00:11:42,490 --> 00:11:44,560
about what should
we be doing.

371
00:11:44,560 --> 00:11:47,305
And so I think that that
is a consideration.

372
00:11:47,305 --> 00:11:49,095
I don't think that
it's just semantics.

373
00:11:49,095 --> 00:11:51,170
I think that we
have had a push

374
00:11:51,170 --> 00:11:53,000
and our providers
and prescribers

375
00:11:53,000 --> 00:11:54,980
feel that push to treat

376
00:11:54,980 --> 00:11:57,200
pain more and more and
more aggressively.

377
00:11:57,200 --> 00:11:59,420
And some people in society

378
00:11:59,420 --> 00:12:01,700
have borne the
cost of that,

379
00:12:01,700 --> 00:12:03,680
including the crisis that

380
00:12:03,680 --> 00:12:05,015
we're talking about today.

381
00:12:05,015 --> 00:12:06,620
I don't know that
it's a single

382
00:12:06,620 --> 00:12:08,360
cause, but it contributes.

383
00:12:08,360 --> 00:12:10,250
What are the steps
to identifying and

384
00:12:10,250 --> 00:12:11,630
referring a patient that

385
00:12:11,630 --> 00:12:13,460
may need treatment
for addiction?

386
00:12:13,460 --> 00:12:15,320
We spoke a little
bit about engaging

387
00:12:15,320 --> 00:12:17,240
social work to get
resources and the like

388
00:12:17,240 --> 00:12:19,460
and I think that
addiction medicine has

389
00:12:19,460 --> 00:12:20,930
a really important place

390
00:12:20,930 --> 00:12:22,670
to play in this crisis.

391
00:12:22,670 --> 00:12:23,960
Now that being said

392
00:12:23,960 --> 00:12:25,160
is, they are a valuable

393
00:12:25,160 --> 00:12:27,020
resource in the community.

394
00:12:27,020 --> 00:12:28,970
And there's
regional variations

395
00:12:28,970 --> 00:12:31,295
on access to
addiction services.

396
00:12:31,295 --> 00:12:32,660
There's some
places that have

397
00:12:32,660 --> 00:12:34,370
a lot of addiction
specialists and

398
00:12:34,370 --> 00:12:35,600
there's some places
when they are

399
00:12:35,600 --> 00:12:37,970
extremely few
and far between.

400
00:12:37,970 --> 00:12:41,210
However, any primary
care provider

401
00:12:41,210 --> 00:12:43,970
can refer people to
addiction services.

402
00:12:43,970 --> 00:12:46,055
and I think that
we should do that

403
00:12:46,055 --> 00:12:47,480
at the point
where the patient

404
00:12:47,480 --> 00:12:48,980
is receptive to it.

405
00:12:48,980 --> 00:12:51,215
We have to meet patients
where they are

406
00:12:51,215 --> 00:12:53,300
and I think that if
the patient says yes,

407
00:12:53,300 --> 00:12:54,695
I'm willing to
get some help,

408
00:12:54,695 --> 00:12:56,540
that we need to
engage addiction at

409
00:12:56,540 --> 00:13:00,530
that point.
And the screening tools

410
00:13:00,530 --> 00:13:02,585
that are used for
that, what are those?

411
00:13:02,585 --> 00:13:04,100
Yeah. So for patients

412
00:13:04,100 --> 00:13:05,855
who are on chronic opioids,

413
00:13:05,855 --> 00:13:08,030
there are some
screening tools which

414
00:13:08,030 --> 00:13:10,040
would indicate
risk of misuse,

415
00:13:10,040 --> 00:13:11,270
abuse, or dependence,

416
00:13:11,270 --> 00:13:13,395
like the opioid risk tool.

417
00:13:13,395 --> 00:13:15,685
Those are not validated for

418
00:13:15,685 --> 00:13:17,425
acute pain or
acute prescribing.

419
00:13:17,425 --> 00:13:18,640
So while we don't have

420
00:13:18,640 --> 00:13:21,010
a tool to tell us
who's going to be at

421
00:13:21,010 --> 00:13:23,290
risk for addiction or

422
00:13:23,290 --> 00:13:25,045
misuse of these
medications.

423
00:13:25,045 --> 00:13:27,025
We do have their

424
00:13:27,025 --> 00:13:28,720
co-morbid conditions
which are

425
00:13:28,720 --> 00:13:32,380
associated with risk
for abuse or misuse,

426
00:13:32,380 --> 00:13:34,180
and that includes
addiction history

427
00:13:34,180 --> 00:13:35,500
to other substances,

428
00:13:35,500 --> 00:13:38,620
as well as co-occurring
psychiatric illnesses,

429
00:13:38,620 --> 00:13:40,210
which seem to
place patients

430
00:13:40,210 --> 00:13:42,370
at risk because of
their self-treatment of

431
00:13:42,370 --> 00:13:45,130
their underlying mental
health disorders.

432

00:13:45,130 --> 00:13:48,160
What about when you've
seen a patient,

433
00:13:48,160 --> 00:13:49,450
you've had a
patient present,

434
00:13:49,450 --> 00:13:51,775
who is requesting
an opioid.

435
00:13:51,775 --> 00:13:53,890
They say, Dilaudid is
the only thing that

436
00:13:53,890 --> 00:13:56,500
works for me, whatever
the circumstance.

437
00:13:56,500 --> 00:13:58,600
But you're not sure that

438
00:13:58,600 --> 00:14:00,970
that is maybe the
patient's best interests.

439
00:14:00,970 --> 00:14:02,950
What is it, first of
all, that makes you,

440
00:14:02,950 --> 00:14:03,940
I would say if somebody

441
00:14:03,940 --> 00:14:05,350
says I only want Dilaudid,

442
00:14:05,350 --> 00:14:09,025
what do you do
in that situation?

443
00:14:09,025 --> 00:14:11,800
And for many emergency

providers that is

444
00:14:11,800 --> 00:14:13,270
a trigger phrase
that brings us

445
00:14:13,270 --> 00:14:15,100
back to unpleasant
circumstances, so...

446
00:14:15,100 --> 00:14:16,870
For me it would be,
please don't

447
00:14:16,870 --> 00:14:19,105
give me that.
Fair enough.

448
00:14:19,105 --> 00:14:22,075
That being said,
this is a very,

449
00:14:22,075 --> 00:14:25,810
very common scenario.
It is.
Yeah, almost daily

450
00:14:25,810 --> 00:14:27,220
do we have
patients that have

451
00:14:27,220 --> 00:14:29,770
an expectation that opioids

452
00:14:29,770 --> 00:14:31,315
are what they need,

453
00:14:31,315 --> 00:14:33,520
and honestly, a lot of

454
00:14:33,520 --> 00:14:35,680
the time it's not in
their best interest.

455
00:14:35,680 --> 00:14:36,850
Well, because to
go back to your

456
00:14:36,850 --> 00:14:38,730
first point, previous

457
00:14:38,730 --> 00:14:42,245
that we don't want to
have pain anymore.

458
00:14:42,245 --> 00:14:44,720
So, William Mayo said, “that

459
00:14:44,720 --> 00:14:45,920
the needs of the
patient are the

460
00:14:45,920 --> 00:14:48,020
only needs to
be considered.”

461
00:14:48,020 --> 00:14:50,270
So if I go down in history

462
00:14:50,270 --> 00:14:52,010
for being famous
for anything,

463
00:14:52,010 --> 00:14:54,470
I want it to be, “that
the hard parts

464
00:14:54,470 --> 00:14:55,610
of medicine, regardless

465
00:14:55,610 --> 00:14:57,320
of your specialty, are
when the needs of

466
00:14:57,320 --> 00:14:59,540

the patient aren't the
wants of the patient.”

467
00:14:59,540 --> 00:15:02,225
And so this is one
of those scenarios.

468
00:15:02,225 --> 00:15:06,545
So first of all,
it takes time,

469
00:15:06,545 --> 00:15:08,480
this is going to
take more time

470
00:15:08,480 --> 00:15:10,340
to have a conversation
with the patient

471
00:15:10,340 --> 00:15:11,540
that's desiring an opioid

472
00:15:11,540 --> 00:15:12,950
prescription who
you don't want to

473
00:15:12,950 --> 00:15:14,300
give it to, then

474
00:15:14,300 --> 00:15:15,830
to just write the
prescription.

475
00:15:15,830 --> 00:15:18,050
And that's a
major barrier to

476
00:15:18,050 --> 00:15:20,750
improving our
prescribing practices,

477
00:15:20,750 --> 00:15:23,540
nationally.

So when this

478
00:15:23,540 --> 00:15:24,935
happens, I know, okay,

479
00:15:24,935 --> 00:15:28,055
I'm in this for
15 or 20 minutes

480
00:15:28,055 --> 00:15:29,570
and you have to go in and

481
00:15:29,570 --> 00:15:30,725
you have to talk
to the patient.

482
00:15:30,725 --> 00:15:32,209
Now I think that
that conversation

483
00:15:32,209 --> 00:15:34,235
can go a couple of
different ways.

484
00:15:34,235 --> 00:15:36,080
I think that the
first part is

485
00:15:36,080 --> 00:15:37,820
you have to acknowledge
that the patient

486
00:15:37,820 --> 00:15:39,530
is in pain and

487
00:15:39,530 --> 00:15:41,240
let them know that
you're going to treat

488
00:15:41,240 --> 00:15:43,280
that pain, with
whatever modality

489
00:15:43,280 --> 00:15:46,385
you choose. So
you might say,

490
00:15:46,385 --> 00:15:49,610
Tracy, I really
appreciate that you're in

491
00:15:49,610 --> 00:15:51,095
pain and I'm gonna
do my absolute

492
00:15:51,095 --> 00:15:52,970
best to help you
feel better.

493
00:15:52,970 --> 00:15:56,330
But I will say that
these medications are

494
00:15:56,330 --> 00:15:58,640
dangerous and we have

495
00:15:58,640 --> 00:15:59,390
a long history of

496
00:15:59,390 --> 00:16:00,980
understanding that
they're dangerous.

497
00:16:00,980 --> 00:16:02,900
And I don't think it's
in your best interest

498
00:16:02,900 --> 00:16:04,700
to use opioid medications.

499
00:16:04,700 --> 00:16:06,470
I think that it's
important to be

500
00:16:06,470 --> 00:16:09,050

concrete about
that up front and

501
00:16:09,050 --> 00:16:11,030
to also set that
expectation as

502
00:16:11,030 --> 00:16:13,625
early as possible in
the patient encounter.

503
00:16:13,625 --> 00:16:16,160
Now once you've set
that expectation,

504
00:16:16,160 --> 00:16:17,210
you can go on to

505
00:16:17,210 --> 00:16:18,920
having further
conversations.

506
00:16:18,920 --> 00:16:20,300
Have you had problems with

507
00:16:20,300 --> 00:16:21,890
opioid use in the past?

508
00:16:21,890 --> 00:16:23,390
Do you think that you
have a problem with

509
00:16:23,390 --> 00:16:24,740
these medications
and require

510
00:16:24,740 --> 00:16:25,985
treatment for addiction?

511
00:16:25,985 --> 00:16:27,260
That's not every patient.

512

00:16:27,260 --> 00:16:28,775
That's the rare patient.

513
00:16:28,775 --> 00:16:30,725
But very frequently,
you might say,

514
00:16:30,725 --> 00:16:32,210
now I know that

515
00:16:32,210 --> 00:16:34,670
nausea is a major
part of your pain

516
00:16:34,670 --> 00:16:36,650
Here, we have some
nausea medications

517
00:16:36,650 --> 00:16:37,370
that can make people

518
00:16:37,370 --> 00:16:38,630
feel much more comfortable,

519
00:16:38,630 --> 00:16:39,785
can we do that,

520
00:16:39,785 --> 00:16:41,150
let's try that with a non-

521
00:16:41,150 --> 00:16:43,490
opioid medication,
for example.

522
00:16:43,490 --> 00:16:44,900
And then you get buy-in and

523
00:16:44,900 --> 00:16:46,385
you can have a
plan that will

524
00:16:46,385 --> 00:16:49,520

provide pain control
once you've set

525
00:16:49,520 --> 00:16:51,230
the expectation that
you're not going

526
00:16:51,230 --> 00:16:53,345
to use opioids
for this patient.

527
00:16:53,345 --> 00:16:55,460
This is a nuanced approach

528
00:16:55,460 --> 00:16:57,484
and I'm sure I'm
not perfect at it,

529
00:16:57,484 --> 00:16:58,460
but I think that it's

530
00:16:58,460 --> 00:16:59,480
one of the things that we

531
00:16:59,480 --> 00:17:01,250
have to become
facile with if

532
00:17:01,250 --> 00:17:02,630
we're going to
move the needle on

533
00:17:02,630 --> 00:17:05,000
the opioid crisis is
learning how to say no.

534
00:17:05,000 --> 00:17:05,750
How often does that

535
00:17:05,750 --> 00:17:07,250
happen in your
regular shift?

536
00:17:07,250 --> 00:17:10,520
Every day. Really?
Yeah. Thanks so

537
00:17:10,520 --> 00:17:12,080
much for joining us today.

538
00:17:12,080 --> 00:17:14,030
If you've enjoyed
this podcast,

539
00:17:14,030 --> 00:17:16,250
please subscribe and
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545
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Thank you, Dr. Clements.

546
00:17:32,885 --> 00:17:34,770
Thank you for having me.