NEGOTIATING URINE DRUG TESTING OF CHRONIC PAIN PATIENTS IN PRIMARY CARE

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Introduction
Chronic pain (CP) is a prevalent problem in the province of Ontario. Frontline primary care providers (PCPs) manage the majority of CP patients, yet receive minimal training.1 Project ECHO® (Extension for Community Healthcare Outcomes) is a model that uses telehealth technology to bridge specialists in academic centres to PCPs in remote areas.2 Using a combination of didactic and case-based learning, ECHO Ontario Chronic Pain and Opioid Stewardship (“Project ECHO”) aims to disseminate knowledge and enhance capacity in PCPs across Ontario.3

Methods
- Qualitative approach
- Three in-person focus group discussions (FGDs) with Project ECHO participants during a weekend ‘mini-residency’ held in Toronto, March 2017
- Supplemental input from critical observation of 4 ECHO tele-clinics in 2014 -6, and participant observation during 3 other mini-residencies
- Thematic analysis (ongoing)

Background
- Rates of opioid misuse in patients with chronic pain have been estimated at 21% to 29% and rates of addiction from 8% to 12%4
- PCPs tasks include monitoring the pills as well as the patients
- The 2010 Canadian Opioid Guidelines (2010) advised ‘opioid contracts’, discussion of safe storage of medications, issuing pills in small batches and counting the remainder; and to conduct urine drug tests [note: UDTs dropped from new guidelines released 8 May 2017 for lack of evidence]
- 2 main types of UDT
  - Immunoassay (at point of contact; usually primary care office)
  - Lab-based specific drug identification [eg GC/MS, HPLC]
- Benefits of UDT (Calif Acad of Family Physicians/Purdue Pharma)
  - “with an appropriate level of understanding”, UDT can improve management of opioid therapy
  - can Identify misuse / addiction
  - can “advocate for patients”
- Issues with UDT
  - Originally for workplace or forensic- not clinical– use
  - Distinguishing true from false negatives is ‘fraught with peril’
  - How to handle unexpected positive result within the therapeutic alliance

Results
20 FGD participants:
- N= 5 physicians, and 15 allied health practitioners
- 8 rural, 7 peri-urban, 5 urban
- 3 men, 17 women

Participants’ experiences with UDT
- **Testing can be challenging**
  “Another difficult task can be with drug screening as well… Getting them to agree to drug screens can be sometimes difficult because they feel they’re being singled out, or that we’re accusing them, for example, and so on.” [AH. FGD 01_17]“we, as physicians, don’t like conflict. We’re supported to be helping, not being the aggressor or on opposite sides, which it sometimes seems in some of these conversations. So, a lot of us I think would want to avoid conflict. We don’t want to have long, long conversations. We don’t have time for those long, long conversations.” [MD, FGD3_17]

**ECHO solution: systemic approach**
"One thing that we did was, for example, setting up a chronic pain program where our patients come in and get assessed on a more systematic basis. They get their screens, they get their counselling, and then they go to see a pharmacist who assesses their medications. We have that kind of system working because of what we’ve learned through ECHO” [AH, FGD 01_17]

Discussion
- Chronic pain is miserable, invisible, often undetectable; its treatment with opioid medication can call up issues of trust and trustworthiness between practitioner and patient
- Michel Foucault5 on Jeremy Bentham’s concept of the ‘panopticon’—machinery of oversight in a prison in which the authority is privileged to observe all without being observed—applicability to UDT in managing patients on opioids?
- Buchman et al.6 suggest cultivation of ‘epistemic humility’: responsibly sharing treatment decisions between patient and clinician, with recognition by both parties that medical judgement is imperfect and subject to uncertainty.

Conclusions
Some healthcare providers find testing their patients’ urine for opioids problematic. Such testing makes explicit issues of trust and distrust. An unexpected result requires difficult conversations that clinicians prefer to avoid.

References