athenainsight

Today's data. Tomorrow's healthcare.

athenainsight.com

'Today I have chosen to draw the line'

By Katy Kropf, D.O. | August 7, 2017

Editor's note: When Dr. Kropf's journal excerpt was originally published, readers responded with gratitude for her guidance as they wrestle with the challenge of opioid prescribing. We are republishing her journal today in hopes it will reach more physicians facing the crisis daily.

In 2015, University Medical Associates, a family medicine practice in Athens, Ohio, launched an ambitious project to decrease and, when possible, stop prescribing long-term opioid pain medications. Providers expected the process to test their resolve and frighten their patients.

It did.

Katy Kropf, D.O., a family medicine doctor with the practice, kept a journal during this period. Here are the edited excerpts of her journey.

July 2, 2015

I am on the cusp of a bold, courageous move.

I'm actually not convinced it is either. But I feel scared. And I'm doing it anyway. So it must at least be a bit courageous. I am not surrounded by many who have done the same. So I guess it is a little bold.

I am confused. Afraid. What is the right thing to do? And right for whom? Who am I, not having lived through horrific, unbearable pain, to say that I will not offer you this thing that is so powerful it makes people beg?

Because it controls you. I have seen it control you.

It does not allow you to live your life.

Your vital, creative, intelligent life. It numbs and constipates you. It becomes the only thing that matters when you come to see me.

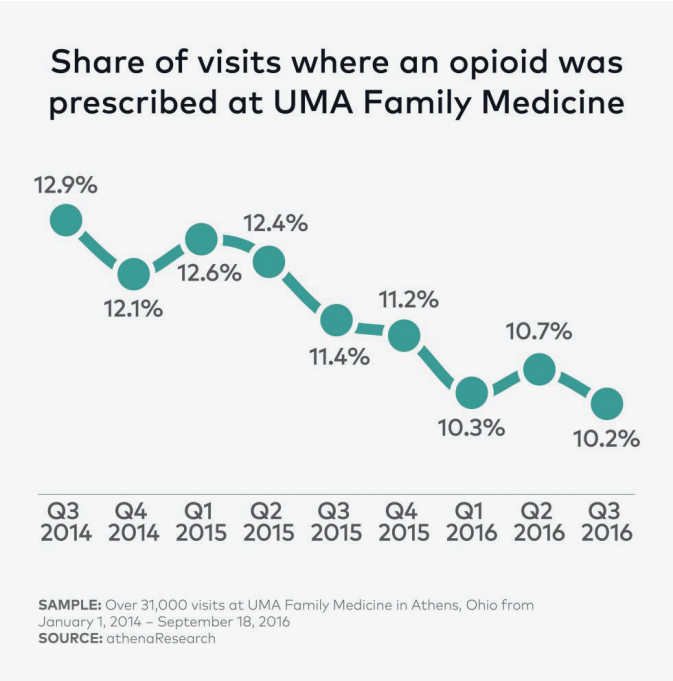
Are there exceptions? Yes, of course.

Some people appear to do quite well.

But how do I know when it is helping, and when it is harming? Where do I draw the line?

Today I have chosen to draw the line on the safe side of accidental overdose.

July 26, 2015



University Medical Associates had one of the steepest declines in opioid prescribing across the athenahealth network; a 19% reduction between July 2015 and September 2016. Data analysis by Anna Zink.

Exciting news! We have met as a practice group twice now. After the first meeting we had consensus that we are prescribing too many narcotics. We are going to get everyone down to at least 80 mg MEQ/D – that's our starting point — and work on tapering others down and off as well.

We are going to draft a letter to patients who are on narcotics, outlining the risks and harms of being on long-term opioids. We are going to give them some alternative resources and ideas of how to manage pain. We are going to back each other up.

September 6, 2015

We had our third meeting on prescribing opioids. One doctor started with clarifying the terminology. Opioids. Not narcotics, not opiates (naturally derived).

Another doctor was saying, "It's not possible for me to stop prescribing totally." I had to jump in with an insistent "Yes, it's possible. We always have a choice!"

I've practiced medicine in Ecuador, El Salvador, Guatemala. I've talked with people who have farmed for their livelihood for years, farming steep hillsides with hand tools of hoes and shovels, walking miles daily to and from their fields and their homes. Yes, they have back pain. They have never had a narcotic in their life and yet they still farm. It is out of necessity. They would be grateful to have access to some ibuprofen or Tylenol. (No CVS or Walgreens anywhere to buy it whenever they need some.)

There is pain in being alive. Are there ways we can embrace pain instead of completely shut it down with opioids? Perhaps "embrace" is not the right word. But to accept pain as part of life. To live with it, listen to it when needed, not let it control us. The goal of eliminating pain is a dangerous one. Pain is a driver of change.

A patient has been on high dose narcotics for years. I sent her to pain management and something in that interaction led her to say, "I want off this Oxycontin." She is tired of how she feels on it. She has stopped it completely. She is struggling. She keeps some leftover Oxycontin in her safe, reassured to know it is there. She has gone to her safe many times to consider getting it, but so far has gotten herself to turn away.

We have spent several hours over the past few weeks discussing her symptoms: some from physical withdrawal, mostly from psychologic withdrawal, the fears associated with decreasing these dosages. I had her talk with our behavioral health consultant, and she is going to start talking with a counselor. I am thrilled. I've tried to get her to do that for years.

Her partner is very controlling, and rarely lets her out of her sight for 30 minutes (trips to the doctor being one of the times). She has had many tragic experiences in her life, including physical abuse at the hands of a former partner. The changes with the medications may be the force she needed to look at some deeper issues around self-love and care.

October 7, 2015

All the materials are ready:

1. A letter for the patients about the risks of chronic opioids.

2. A bi-fold that talks about why we are doing this, and what we are doing, and how they can have support.

3. A list of alternative options for treating pain

4. Examples of a taper

5. An office protocol of not prescribing more than 80 MED, not starting new chronic opioids, and medications to help with withdrawal symptoms.

We plan to go live with next week.

But all these tools, papers, letters are nothing compared to the face-to-face conversation with patients. It is terrifying to sit across from someone and begin the conversation about their well-being and their opioid use. Opioids that perhaps I started or escalated, or opioids that perhaps I inherited from a former provider.

How do you know who will thrive off of opioids? And who will shrivel? For some people I think it will worsen their quality of life. For most of them at first.

I'm trying to figure out how to make this a more mutual decision and action. But the reality is that I have made the decision. I have a clearer vision of the health and healing that is available to them. Right now, they see the fear, the pain, the withdrawal.

One guy said, "I just want to be left alone," as I handed him the letter about the risks of chronic opioids. He has always said that when he retired, he'd be able to get off methadone. His job was intensive, physically demanding. But now that he is retired, he is cutting up some big trees in his yard and this is intensive, physically demanding, and he needs the pain medicine for his back.

I took him a step (a couple of steps?) too far that visit. Seeing the potential for health and well-being — my version, anyway — that he was not ready to see. His triglycerides are through the roof, and I began a discussion about sugar and refined carbs in his diet.

"Yes, I drink a lot of pop and I'm not changing," he quickly said to me. "I know you care about that stuff, but frankly, I just want quality of life, not quantity. I just want to be left alone."

How do we move forward? I clearly want more for him, but he will settle for ten years of pop drinking and taking methadone. This is not the medicine I want to practice.

October 8, 2015

A patient I saw yesterday already had tears in her eyes and a tight face as I entered the room. She was the last patient of the day, so I experienced both that sense of ease that I could take the time I needed, and the sense of fatigue that comes with carrying the stories, concerns, and diagnoses of the ten people before her.

Over the past month, we had tapered her opioid dosage considerably – 10 percent decrease for two weeks, then another 10 percent for two weeks, then a 20 percent drop. Clearly she was not happy. She is scared that she will be back in "the chair" and not mobile and less functional.

As we talked, her face relaxed a bit and some of her anger dissipated. Toward the end of the visit, she could even offer that her thinking is clearer and she's less drowsy. But the fear of being "back in the chair" has her scared, and that trumps all.

In each of these interactions, there are moments of panic. How am I going to get through this without reversing my plan or feeling like a jerk? Patients are asking me — and when it comes to opioids, often begging and pleading — how I will fix them? I take a breath, remind myself that it is not my job to fix these hurts that have existed a long time.

I feel the tightness in my face relax a bit.

Somehow I figure out how to steer us toward talking about alternatives. I pull out the sheet of paper with pain management options. Together we work toward some ideas. She agrees to see one of the docs who does [osteopathic manipulative medicine] full time. I had referred her months ago, but now the motivation is greater.

Progress. Softer faces, less tears, still fears. But we are moving forward, both of us a little more confident in the other than when we started.

Katy Kropf, D.O., practices family medicine at University Medical Associates in Athens, Ohio. She is an assistant professor of family medicine Ohio University Heritage College of Osteopathic Medicine.