Conflict can arise when colleagues within the same practice have differing narcotic prescribing behavior for patients with chronic pain. Perhaps the following case presentation is familiar to you:

“Hey Coach. Dr. New inherited a number of difficult/complex patients on controlled medicines. He seems to have difficulty in handling these doctor-patient encounters. We have no expectation of him to prescribe medicine he feels his patient doesn’t need, but the longer tenured physicians in the practice do in fact prescribe narcotics to chronic pain patients, within generally accepted guidelines. Instead, Dr. New is telling all chronic pain patients he will prescribe NO narcotics, so those complex patients are either (a) changing to his colleague’s patient panels, or (b) leaving the practice altogether. The former seems unfair to colleagues, and the latter seems uncaring to patients.”

Let’s begin by separating the interwoven issues:

SAFE PRESCRIBING OF NARCOTICS IN PRIMARY CARE. While any physician with an unrestricted license and an active DEA Certificate can legally prescribe narcotics for patients, substantive standards and/or guidelines may exist and often differ across communities. All or some of the following elements have a role in determining the clinical appropriateness of narcotic prescribing to a given patient, in diminishing order: (a) the specific clinical situation, (b) state licensing boards, (c) national academies (“specialty colleges”), (d) policies and procedures of your medical practice/group, and (e) local standards of care. All likely publish their guidance on the internet or an intranet, and physicians are encouraged to seek them out. In situations in which interpretation of the various inputs is ambiguous, the attending physician’s sound judgement and medical reasoning should dominate.

Several tools are invaluable for the physician prescribing narcotics on a long-term basis for a given patient: (a) narcotic compacts between patient and physician; (b) state-wide prescription drug monitoring programs (PDMP) to ensure the patient is not seeking narcotics from multiple doctors; and (c) formal and informal peer-review.

And of course it’s desirable for a second physician, perhaps a Pain Management physician, to add a note in the chart annually affirming that no reasonable alternative exists for chronic opioid use. In this case, Dr. New has an obligation to obtain and consume the available guiding clinical information, and incorporate it into his/her practice (the individual’s obligation to regularly upgrade clinical knowledge and skills).

Lastly, if your inner voice tells you, “something isn’t quite right here”, it probably isn’t. And make use of stepping out of the room for a deep breath and a “Zen moment” from time to time, particularly if it saves us from behavior we later regret.

VARIATION IN PRESCRIBING PATTERN BETWEEN PHYSICIANS WITHIN THE SAME SPECIALTY AND PRACTICE. Whether we are discussing the sticky-wicket of narcotic prescribing, or the handling of any clinical condition, there is no substitute for healthy “group practice”. Physicians within the same specialty will meet to review the prevailing published science for a common condition or high-stakes clinical scenario, and agree to follow a diagnostic and/or therapeutic guideline they create (or at least negotiate!), thus reducing unwarranted variation in the care of patients with same or similar presentations. Outcomes are better, and costs lower.

HOLDING OUR COLLEAGUES ACCOUNTABLE. As a group practice, we’re committed to helping each other continuously improve faster than we would otherwise be able to do. We must, however, hold each colleague accountable to fully and reliably behave in accordance with the culture of the practice. That might mean “don’t add to your colleague’s burden, and if you do, observe the principle of reciprocity”. It could also mean “don’t marginalize or alienate patients who act in rational, albeit sometimes troublesome, ways”. I’ve found the number one reason a junior colleague falls short of expectations is that her/his more-tenured colleagues don’t make the expectations clear! Once expectations are set and physicians are in alignment, we must be prepared for some patients to voluntarily leave the practice for a variety of reasons beyond the control of the physician. As long as we as providers have offered them medically-appropriate help in good faith, it’s OK.
Caring for patients who require long-term opiates can be one of the most taxing things we do. Making use of clinical guidelines and tools can keep both provider and our patients safe. Relying on the strengths of group practice can help develop mastery, and being mindful of our responsibility to colleagues can prevent conflict among physicians.

RESOURCES:


STUDER GROUP LEARNING LAB RESOURCES:
One-Sheeter: Communicating with Drug-Seeking Patients in the ED (2015)