Medical errors, old habits, bad practice

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How many things served us yesterday for articles of faith, which today are fables for us?
Michel de Montaigne (1533-1592)

Staying up to date with changing evidence is the goal of every conscientious physician. In striving for this ideal, members of the College of Family Physicians of Canada make a commitment to lifelong learning. Nevertheless, in everyday practice, habits based on years of following previous guidelines make it difficult to change course. Inevitably, these habits are reinforced by our patients, who have come to expect certain medications, tests, and approaches.

Family physicians are bombarded with guidelines. As the broadest discipline, we have the widest range of guidelines to try to keep up with, let alone implement.[1] Inevitably, we find that some guidelines conflict with other guidelines or contradict our clinical experience, especially in patients with several chronic conditions. We regularly face true management dilemmas: people suffering from painful osteoarthritis who also have hypertension and gastroesophageal reflux disease represent but one common example.

I recently attended a workshop on deprescribing, the delicate art of weaning people off medications that they have been taking for years. It is difficult to tell patients that a medication they have been using—and that we have been prescribing—is doing them more harm than good. It can sometimes be a little easier to discuss this with those patients we have "inherited." For example, for those patients who use sedatives for insomnia that their previous physicians prescribed, we can gently explain to them that the evidence has evolved since they started using it. However, at this stage of my own practice life, I have been looking after most of my patients for many years; so the "previous physician" whose advice they have been following and who has been writing their prescriptions is none other than … me.

The drug category makes a difference: I find that it is straightforward to tell patients that their proton pump inhibitor is not ideal for long-term management of mild gastroesophageal reflux disease. Yes, it was the latest-and-greatest drug a few years ago, and likely was the right choice when the specialist started it following the gastroscopy; but over the long haul, the strongest medication is not necessarily the best.[2] It is much more challenging with narcotic and sedative medications. In those cases, our desire to relieve serious symptoms—such as chronic pain, considerable anxiety, or poor sleep—and the patient's experience that the medication provides relief both conspire to maintain a pattern that we recognize as problematic. A lot of people do not have coverage for nonpharmacologic options, such as physiotherapy or cognitive behavioural therapy, that can help manage symptoms while reducing medication dependence.

The workshop definitely triggered a sense of guilt, leaving me ruminating on the remaining people in my practice who have been taking narcotics or sedatives for years. It is a relatively small group, the ones who are most resistant to my efforts to introduce today's best practices. The reasons that it is difficult are usually evident: difficult life circumstances, multimorbidity, and concomitant mental health problems. As workshop participants shared their clinical stories, there was comfort in knowing that we were all grappling with this. There was reassurance in the knowledge that a patient-centred approach was the foundation for success. Fortunately, I could leave with a sense of cautious optimism and several tools that will help me to help my patients.[3,4]

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References

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