

# A Prescription to Talk About Medications

10 ways to increase understanding and adherence

## DOC TALK

BY STUART FOXMAN

Dr. Barbara Lent, a family physician in London, Ont., had a patient in his 70s with atrial fibrillation. She recommended a blood thinner, but knew from past encounters that this man hated taking any sort of medication. He also felt no compelling need given that he felt perfectly fine.

“I had to spend a lot of time, over a couple of years, explaining to him the risks and benefits of taking the medication or not,” recalls Dr. Lent.

In developed countries, according to the World Health Organization, 50% of patients simply don't take their medications as prescribed. What accounts for this low rate? In studies of adherence, some of

the leading factors include the patient's lack of understanding of their condition, low health literacy, little input around their treatment,

complex drug regimens, drug costs, and perceived benefits.

To Dr. Lent, much of the issue can be summed up in one word: com-▶▶



The following recommendations have been compiled from the reports of the expert review committees of the Office of the Chief Coroner and patient safety organizations.

**Patient  
Safety**

### Identifying Knowledge gap for Hydromorphone

ISMP Canada has undertaken a survey to better understand the extent of health-care professionals' knowledge deficits or gaps that could contribute to medication incidents with hydromorphone.

A review of hydromorphone incidents that have been reported to ISMP Canada, including mix-ups between hydromorphone and morphine, suggested to ISMP Canada analysts that the difference in potency between these two drugs may not be well understood by all health-care professionals.

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# Patient Safety

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Available in oral and injectable forms, hydromorphone is about 4-7 times stronger than morphine; therefore, any confusion between these two drugs can have devastating consequences for the patient, including death.

Responses were received from every province and territory and represented health-care disciplines involved in the prescribing, dispensing, preparation, administration, and/or monitoring of hydromorphone.

The survey found that the majority of health-care providers in the nursing, pharmacy, and medicine categories (3,023 of 3,436 or 87.9%), in responding to a question related to the difference in potency, correctly identified hydromorphone 1 mg as approximately equal to morphine 5 mg. An even larger proportion of respondents (3,270 of 3,436 or 95.2%) correctly indicated that morphine and hydromorphone are “both opioid medications used to treat pain but are dosed differently.”

However, incorrect answers provided by the remaining respondents (166 of 3,436 or 4.8%) suggest that the relationship between morphine and hydromorphone is not universally understood. Specifically, 147 respondents (4.3%) answered “They are two completely different medications with different uses,” 10 (0.3%) answered that “hydromorphone is ‘watered-down’ morphine,” six (0.2%) answered

that “Morphine is a brand name for hydromorphone,” and three (0.1%) answered that “hydromorphone is a brand name for morphine.”

There was no apparent pattern to these incorrect responses in terms of disciplines: all disciplines were represented in these incorrect answers.

Other areas where scoring was lower were related to:

- ability to identify opioid tolerance (all disciplines);
- recognition that obese patients do not require higher doses of hydromorphone (all disciplines);
- recognition that patients with chronic obstructive pulmonary disease require lower doses of hydromorphone (all disciplines);
- recognition that patients who are taking a benzodiazepine require lower doses of hydromorphone (nursing and pharmacy);
- recognition that elderly patients require lower doses of hydromorphone (nursing and pharmacy);
- conversion factor for changing an oral dose of hydromorphone to an equianalgesic parenteral dose of hydromorphone (nursing);
- distinction between side effects and allergies (e.g., understanding that a side effect does not preclude the use of morphine) (all disciplines); and
- recognition of the signs and symptoms of an overdose (medicine).

The complete survey report, is available from: [http://www.ismp-canada.org/download/miscpub/ISMPCanada\\_HYDROMorphoneKnowledgeAssessmentSurveyReport\\_2012June.pdf](http://www.ismp-canada.org/download/miscpub/ISMPCanada_HYDROMorphoneKnowledgeAssessmentSurveyReport_2012June.pdf).

## Report Parents' Substance Abuse to CAS

The College reminds physicians that they are obliged to contact the Children's Aid Society if they see patients who are in a parenting capacity and there is evidence of ongoing substance abuse. Health-care providers are obligated to report any concerns about the care of children under the *Child and Family Services Act*.



This reminder is prompted by a recent case review by the Pediatric Death Review Committee, in which the physicians employed in a methadone clinic did not make a child protection referral even though the mother of a 10-month old had repeatedly tested positive for numerous illicit substances before the child's death. The physicians did not contact the CAS even though they knew the society was actively involved with the family.

Physicians who are unsure of their obligations are encouraged to review the Mandatory and Permissive Reports policy on our website at [www.cpso.on.ca](http://www.cpso.on.ca). <sup>MD</sup>