A goal of "zero"

I have practised emergency medicine for 41 years. For the past 31 years I worked full time, exclusively doing 12-hour night shifts at Dartmouth General Hospital in Nova Scotia. I am 70 years old, soon to be 71 years old. My unrestricted licence to practise medicine in Nova Scotia came into effect 9 hours after I graduated in 1967.

My goal has always been "zero"—that is, to have zero new patients waiting in the emergency department (ED) at least once during my 12-hour night shift. I am almost always successful in reaching this goal, and for the past 3 months I have always reached it.

Having zero patients, even if it happens momentarily, is a great morale booster for all ED staff. They can then concentrate on the patients already in the ED and see new patients in a timely fashion. If all the staff on a shift have zero patients as their goal (as well as good care, of course), it happens—at least that's been my experience, no matter how bad things look at the start of a shift. Getting to zero patients is becoming more challenging as time goes by, because the patients are sicker and the "quickies" are now a very small minority of the ED patient population.

I think that zero patients is a good 24/7 goal for all ED staff to have. In the daytime, practising zero might at least decrease the wait time, and perhaps prevent the night staff from starting "behind the eight ball."

To practise zero, there has to be less gabbing, and staff should not bring their new house plans to the ED to get everyone's opinion. (I've seen it happen.) If there is a congregation of staff having a "gab fest" when there is much work to be done, simply walk by and say "I'm glad we had this little talk." It works every time—the congregation quickly disbands.

Just a few "zero" thoughts.

—Michael Hebb MD CCFP(EM) DABEM
Dartmouth, NS

Competing interests
None declared

Opioids versus nonsteroidal anti-inflammatory drugs in noncancer pain

In Lynch and Fischer's comparison[1] of our research on opioid-related mortality[2] with previous research on the safety of nonsteroidal anti-inflammatory drugs (NSAIDs),[3] they imply that opioids are safer than NSAIDs.

We have shown that the opioid-related mortality rate among public drug plan beneficiaries who are prescribed opioids for noncancer pain is 1.86 per 1000 (95% CI 1.64 to 2.10 per 1000) within 2 years and 7.92 per 1000 among the small proportion of patients who are prescribed more than 200 mg of morphine or equivalent per year.[4] The all-cause mortality rate among patients prescribed opioids for noncancer pain is approximately 1% per year—roughly 5 times higher than in patients who are not prescribed opioids.

The opioid-related mortality rate of 27.2 per 1 000 000[2] reported in our study and cited by Lynch and Fischer is a population-level statistic that includes all Ontarians in the denominator, not just those prescribed opioids. It is incorrect and misleading to contrast this with the rate of NSAID-related mortality in patients who are treated with NSAIDs.

Only a well-designed randomized trial would definitively assess the relative safety of opioids and NSAIDs. No such study exists, and we must therefore look to observational studies for the best available evidence. In a high-quality cohort study, Solomon et al recently showed that older adults who were prescribed opioids were almost twice as likely to die as patients prescribed NSAIDs were.[5]

Based on these data as well as our own, we believe it is reasonable to conclude that, as currently used in clinical practice, opioids are more dangerous than NSAIDs. This finding is consistent with recommendations from the World Health Organization that acetaminophen and NSAIDs be used before opioids.[6]

—Irfan A. Dhalla MD MSc FRCPC
—Tara Gomes MHSc
—Muhammad M. Mamdani PharmD MA MPH
—David N. Juurlink MD PhD FRCPC
Toronto, Ont

Competing interests
None declared

References

1. Lynch ME, Fischer B. Prescription opioid abuse. What is the real problem and how do we fix it? *Can Fam Physician* 2011;57:1241-2 (Eng), e403-5 (Fr).
2. Dhalla IA, Mamdani MM, Sivilotti ML, Kopp A, Qureshi O, Juurlink DN. Prescribing of opioid analgesics and related mortality before and after the introduction of long-acting oxycodone. *CMAJ* 2009;181(12):891-6. Epub 2009 Dec 7.
3. Tramèr MR, Moore RA, Reynolds DJ, McQuay HJ. Quantitative estimation of rare adverse events which follow a biological progression: a new model applied to chronic NSAID use. *Pain* 2000;85(1-2):169-82.
4. Gomes T, Juurlink DN, Dhalla IA, Mailis-Gagnon A, Paterson JM, Mamdani MM. Trends in opioid use and dosing among socio-economically disadvantaged patients. *Open Med* 2011;5(1):e13-22. Epub 2011 Jan 25.
5. Solomon DH, Rassen JA, Glynn RJ, Lee J, Levin R, Schneeweiss S. The comparative safety of analgesics in older adults with arthritis. *Arch Intern Med* 2010;170(22):1968-76.
6. World Health Organization [website]. *WHO's pain ladder.* Geneva, Switz: World Health Organization; 2011. Available from: **www.who.int/cancer/palliative/painladder/en/**. Accessed 2011 Nov 15.

The top 5 articles read online at cfp.ca

1. **Clinical Review:** Zopiclone. *Is it a pharmacologic agent for abuse?* (December 2007)
2. **Clinical Review:** Canadian guideline for safe and effective use of opioids for chronic noncancer pain. *Clinical summary for family physicians. Part 1: general population* (November 2011)
3. **Clinical Review:** Update on herpes zoster vaccination. *A family practitioner's guide* (October 2011)
4. **Case Report:** Chronic vulvar irritation: could toilet paper be the culprit? (April 2010)
5. **Clinical Review:** Treatment and prevention of herpes labialis (December 2008)