In pain or drug-seeking? Resident continuity clinic, chronic nonmalignant pain, and addiction

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THE PROBLEM

Pain is the most common complaint with which patients present to physicians' offices. Ten to 16 percent of outpatients seen in a general practice have problems related to drug or alcohol addiction.[1] The distinct problems of pain and addiction are relatively common in medical practice, and are likely to be seen together in some patients. Patients who are addicted to drugs are subject to pain in the same manner as any other patient, so they can also benefit from appropriate treatment for relief of pain.[2] Successful treatment of pain may include prescription of medications with potential for abuse, such as opioid analgesics. Rates of drug abuse, dependence, and addiction among pain patients range from 3.2 to 18.9 percent,[3] which corresponds to prevalence estimates of alcohol and drug addiction among the general population.[4] Rates of abuse of opioid analgesics among patients with pain seen in primary care resident teaching practices are unknown.

Several professional societies have developed consensus statements for acute and chronic pain management in disease populations; however, there is no current standard for assessing, treating, and monitoring patients with chronic nonmalignant pain. This likely owes to the diversity of nonmalignant diagnoses for which chronic pain medications are used and the number of therapeutic options available, including nonpharmacologic therapy, nonopioid pain medications, and opioid analgesics. The result is inconsistency in training physicians to manage chronic nonmalignant pain and, thus, physician practice in assessing, treating, and monitoring these patients. Lack of consistency in evaluation, monitoring, and documentation for prescribing opioids for chronic pain results in higher rates of aberrant medication-taking behaviors among patients of residents in a primary care clinic.

As opioid analgesics have significant potential for harm due to side effects, medication interactions, misuse or abuse, and unlawful practice, there is a lack of comfort and confidence among physicians who have not been adequately trained in the use of these medications. This phenomenon has been labeled "opiophobia."[5] There is no consistent healthcare system approach to the outpatient management of chronic pain. Lack of consistency in the physician and healthcare system approaches to treating chronic pain using opioid analgesics may result in harm to patients from inappropriate prescribing practices. This includes overtreatment, medication interactions, side effects and medication abuse. Additionally, patients may be undertreated and experience severe pain that results in aberrant medication-taking behavior (i.e., pseudoaddiction).[6] Identifying training deficiencies as well as healthcare system variables that lead to inconsistency in opioid prescribing practices is the first step toward developing solutions that can reduce potential harm to patients and improve patient outcomes.

Referral sources for patients with chronic nonmalignant pain are inadequate, especially for those with limited financial resources. Increasingly, primary care resident continuity clinics are the default care centers for these complex patients. Most resident academic practices lack policies that ensure consistent prescribing practices, faculty and residents who are trained in assessing and managing patients with chronic nonmalignant pain, and the infrastructure that supports a multimodal treatment approach. Although the Accreditation Council for Graduate Medical Education (ACGME) guidelines require resident training in pain management, there is no current training standard for continuity clinics. Barriers in this particular setting include time limitations, infrequent patient visits, frequent physician turnover, and patient resistance.

THE CLINIC

With the goal of creating order out of chaos and thereby improving patient outcomes, our institution has attempted to address some of these issues regarding resident education in pain management within the context of a primary care continuity clinic. An initial step was creating a specialty pain clinic within the existing resident continuity clinic. The primary care pain clinic is staffed by an internist who specializes in pain management and addiction medicine, as well as two other internal medicine primary care attending physicians who have special interest in developing expertise in these areas. This allows physicians with experience in pain

management to teach by example, because residents rotate through this primary care pain clinic as part of their ambulatory care educational block. Residents not rotating through the pain clinic still have easy access to a pain expert for advice while in their own continuity clinic for issues that arise in the course of usual patient care, because the pain clinic is physically located within the continuity clinic setting. A second step is having the resident continuity clinic teach attending physicians as they rotate through the specialty pain clinic. This helps them to improve their practice with this common issue and learn clinical pearls to pass along to residents.

THE CURRICULUM

The team that implemented the primary care pain clinic is now in the process of developing a pain curriculum for residents. This is designed as interactive learning in modules for "multiple small feedings of the mind" that can be delivered between patient visits to highlight a few specific clinical points. An example of a module is a simple overview of interpreting urine drug screen results in the context of patients using multiple opioids.

Another key to providing consistent care for patients with complaints of chronic pain while educating residents in proper pain management is putting specific policies into place in the resident continuity clinic. Basic tenets of good pain management practice have been codified in a policy that also provides a set of guidelines for addressing commonly encountered issues. The policy includes monthly visits specifically for evaluating pain in patients on long-term opioids for chronic pain, consistency in obtaining information (including gathering corroborating information in the form of records from previous physicians), standardized forms, use of medication agreements, communication with other treatment providers, and urine drug screening guidelines. In our continuity clinic, the policies have provided guidance where there had been very little previously. Several of the residents have commented that they no longer have the same anxiety regarding visits with their chronic pain patients, and they are actually beginning to look forward to those visits because they have a therapeutic plan in place.

THE RESEARCH

The medical literature reveals very few studies of education of medical residents with regard to management of chronic pain and addiction. Guidelines established by the ACGME require residents to have education about treatment of pain. There has been at least one study on the effect of resident prescribing practices on the inpatient service after the intervention of a palliative care curriculum.[7] Little data are available, however, on prescribing practices of medical residents for chronic pain management in the outpatient setting. A study of opioids and the treatment of chronic pain in a primary care sample did involve medical residents but was not an exclusive description of the population and prescribing habits of a resident teaching clinic.[8] Prescribing practices among residents in a primary care clinic for outpatient management of chronic pain have not been studied previously.

Several clinical research projects have been integrated into the primary care pain clinic at our institution. An initial study underway is a simple chart review of patients with chronic pain on opioids for at least 12 consecutive months. This study will evaluate resident documentation with prescription of controlled substances for pain, and can also be used as feedback for residents and teaching attendings on proper procedures. Another planned study is an outcomes evaluation of the pain management curriculum. Having a research component to the primary care pain clinic provides additional learning opportunities for residents at an academic institution. We hope to report on these research findings in the future in publications such as the *Journal of Opioid Management.*

Our institution has developed an innovative approach to address some of the issues regarding education of medical residents in pain management, appropriate prescribing of controlled substances, and awareness of the impact of addiction on primary care practice. Having a pain clinic within the resident continuity clinic allows for a collaborative educational process and rapid dissemination of teaching points. The residents have responded very positively from the start. We plan to continue to evaluate our progress toward addressing these issues in resident education. If other academic institutions develop similar educational models, the next generation of physicians will be better equipped to deal with chronic pain and their patients will benefit.

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