

MEDICAL SCHOOL AND RESIDENCY PROGRAM CURRICULUM RESOURCES ON DRUG ABUSE AND ADDICTION

A Faculty Development Workshop for Primary Care Preceptors: Helping Your Residents Care for Patients Requesting Opioids for Chronic Pain

Harvard Medical School/Cambridge Health Alliance
(Massachusetts Consortium)

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November 8, 2009



Harvard
Medical
School



Cambridge Health Alliance



<http://www.drugabuse.gov/coe>

These curriculum resources from the NIDA Centers of Excellence for Physician Information have been posted on the NIDA Web site as a service to academic medical centers seeking scientifically accurate instructional information on substance abuse. Questions about curriculum specifics can be sent to the Centers of Excellence directly.

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Introduction

The Director of the National Institute on Drug Abuse (NIDA) has described the abuse of prescription medications, particularly opioid analgesics, as a growing public health concern and has called for further research to develop safe and effective pain management strategies and medications with less potential for abuse (see Reference 1). Because opioid analgesics are currently the most effective medications for pain management, it is also critical that physicians are trained in the appropriate prescribing of these medications, recognizing the signs of possible prescription drug abuse, particularly among chronic pain patients, and discussing these issues with their patients. This faculty development workshop is designed to address these issues by educating the educators, i.e., the faculty preceptors in resident physicians' training programs. Using a typical resident presentation of an unfolding patient case in a primary care setting, this workshop provides an overview of diagnosis, treatment, and management of patients who are at risk for prescription drug abuse. In addition, it focuses on effective communication and interpersonal skills and explores physician biases and emotional responses to patients seeking medication for chronic pain.

The module consists of a 1½- to 2-hour session for preceptors of primary care resident physicians. The curriculum uses facilitated discussion, case-based problem solving, and role playing. The primary teaching points are embedded in the Facilitator Guide.

Key words: Drug abuse; drug addiction; substance abuse; prescription drug abuse; opioid analgesics; medical school faculty development

Educational Objectives

- Review basic terminology, epidemiology, and management strategies when considering the use of opioids for patients who are at risk for prescription drug abuse.
- Learn effective communication and interpersonal skills in caring for patients at risk for prescription drug abuse, and help your residents do the same.
- Explore personal biases and emotional responses toward patients seeking opioids for chronic pain, and help residents do the same.

Facilitator Guide

Intended audience: Primary care preceptors of internal medicine and family medicine residents

Workshop size: Ideal workshop size is 12 to 24 participants

Supplies: Flip chart, markers

Approximate duration of workshop: 1½ to 2 hours

Introduction

This faculty development workshop is designed to be interactive, with facilitated discussion, problem solving, and role playing in response to an unfolding case. The case is designed to represent a typical resident presentation of a patient case in the primary care setting. The goals of the workshop are to:

- Review basic terminology, epidemiology, and management strategies when considering the use of opioids for patients who are at risk for prescription drug abuse.
- Learn effective communication and interpersonal skills in caring for patients at risk for prescription drug abuse, and help your residents do the same.
- Explore personal biases and emotional responses toward patients seeking opioids for chronic pain, and help residents do the same.

The main teaching points are embedded in this Facilitator Guide. A few introductory statistics might be useful to frame the workshop (see Epidemiology section).

Epidemiology

According to the *Results from the 2008 National Survey on Drug Use and Health* (NSDUH) report (see Reference 2):

- The nonmedical use of prescription psychotherapeutic drugs—and of pain relievers in particular—is now second only to marijuana use among the Nation’s most prevalent drugs.
- In 2008, there were 6.2 million (2.5 percent) persons aged 12 or older who used prescription-type psychotherapeutic drugs nonmedically in the past month. Of these, 4.8 million used pain relievers.
- Among persons aged 12 or older who used pain relievers nonmedically in the past 12 months, 55.9 percent reported that the most recent time they used the drug, it was obtained from a friend or relative for free. Another 18 percent reported they received the drug from just one doctor. Only 4.3 percent received the pain relievers from a drug dealer or other stranger, and only 0.4 percent reported buying the drug on the Internet.

This curriculum resource is to be regularly updated as new data become available (see <http://www.oas.samhsa.gov>).

Note: Distribute terminology handout to participants at beginning of session.

Terminology

Although a common vocabulary has not been established in the field of prescription drug abuse, for the purposes of this workshop we define **prescription drug abuse** (adapted from Reference 5) as a pattern of nonmedical use of prescription drugs that causes one or more of the following:

- Failure to fulfill major obligations
- Use when physically hazardous
- Recurrent legal problems
- Recurrent social or interpersonal problems.

Addiction is a primary, chronic, neuropsychiatric disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by impaired control over drug use, craving, compulsive use, and continued use despite harm.

Nonmedical use is defined as the use of a prescription medication without a prescription, or the use of a prescription medication for purposes other than those for which it is prescribed.

Physical dependence is a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. Physical dependence does not equal addiction.

Pseudoaddiction is the iatrogenic syndrome resulting from the misinterpretation of relief-seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief-seeking behaviors resolve upon institution of effective analgesic therapy.

Note: Distribute case handout and ask two participants to role play aloud Part One.

Case: Part One

The resident you precept in primary care clinic comes to you, obviously annoyed.

Resident: “I’m about to go in and see this 44-year-old drug-seeking patient. I’m sure all he wants from me is Percocet.”

You: “What makes you think that?”

Resident: “Well, I looked through his chart, and this guy always sees different providers for his back pain. It’s documented that Motrin and Tylenol bother his stomach, and codeine makes him itch. He’s also tried physical therapy, heat, and ice without results. The last two docs he saw in our system raised the question of drug-seeking behavior—but they still ended up giving him Percocet, six a day! The nurse tells me he’s looking for me to prescribe eight Percs a day. He has some story about getting a part-time job delivering Meals-on-Wheels. He’ll be more active and in more pain, so he needs more meds. I’ll bet you anything he’s just looking for narcotics. I wanted to give you a heads up about him because I’m sure he’ll be angry when I refuse to prescribe to him.”

Part One Discussion Questions 1–3 (15 minutes):

1. What are your initial responses to this resident’s concerns?
2. How are you feeling toward the patient?
3. How are you feeling toward the resident?

Faculty Facilitator

The goal of the facilitator should be to create an environment in which participants feel comfortable discussing their emotional reactions toward patients requesting opioid prescriptions for chronic pain. The facilitator might say, “Patients who present seeking narcotics can be challenging to care for. During this workshop, we want you to feel comfortable sharing whatever experiences or reactions you have had, including negative ones. We also ask the group to agree to hold confidential any clinical or personal experiences shared.”

You might encourage participants to share brief stories of their experiences with similar patients. In any group, you may expect to have participants who feel anger toward such patients (perhaps those who have been “duped” in the past) and those who are more sympathetic toward such patients. Some participants may be sympathetic with the concerns raised by the resident (and the manner in which he/she raised them), while others may not. Get members of the group to talk with each other. The facilitator should model with his/her own language a respectful tone and terminology (e.g., “patient requesting help with pain control” versus “drug seeker”) while simultaneously empathizing with and reflecting back the experience of participants.

Participants should explore the ways in which intensely negative emotional responses to patients may interfere with optimal care.

- Such negative feelings may cloud the physician’s clinical judgment.
- Treatment options might not be fully explored.
- Snap decisions might be made in an attempt to “get rid of” a difficult patient.
- Trust will not be established.
- The opportunity to help a patient in need (whether that need is pain, addiction, or both) may ultimately be lost.

Part One Discussion Questions 4–5 (20 minutes):

4. How can the preceptor help the resident prepare to evaluate this patient? (Specifically, what information should the resident gather?)
5. What goals and priorities should the preceptor have for the teaching encounter with the resident?

Faculty Facilitator

You might say to participants: “This scenario might strike you as a ‘teachable moment.’ What do you hope to accomplish with this resident in the few minutes you have prior to the resident going in to see the patient? What important factual information should the resident obtain when he interviews the patient? What communication strategies might you coach the resident in to best interact with the patient?”

The important points to bring out are that the resident should be encouraged to:

- Acknowledge his/her own emotional response toward the patient.
- Be open to the variety of possible diagnoses in this case.
- Have a plan for evaluating the patient for risk factors for prescription drug abuse.

The importance of doing a complete history and physical exam (despite the resident’s initial negative reaction to the patient) should be emphasized. An addiction history, including past patterns of alcohol, illicit drug, and prescription drug use, should be obtained. Participants should be discouraged from extensive discussion of a detailed differential of back pain itself (e.g., spinal stenosis, sciatica, etc.), as this will detract from the primary goals of the workshop. Instead, the facilitator should encourage participants to focus on the broad categories of:

- Well-managed chronic pain
- Undertreated chronic pain
- Addiction
- Diversion
- A combination of the above.

Remember that pain and addiction are two separate (yet interrelated) problems. The preceptor can discuss with the resident that addiction is a chronic, relapsing brain disease that should be treated as a disease rather than a moral failing. This approach should help reinforce the idea that the resident should not take the patient’s behavior personally.

The potential risk factors for prescription drug abuse should be reviewed at this juncture in the discussion (from Reference 3). These factors include:

- History of drug or alcohol abuse
- Smoking
- History of emotional, physical, or sexual abuse
- Psychiatric disorders
- Criminal record.

Communication strategies for the resident to use with the patient that might prove useful in this interaction include:

- Reflective listening
- Validating the patient's experience of pain
- Expressing concern for the patient
- Being respectful (e.g., "I know you have overcome serious addictions in the past. I'm concerned that the use of increasing doses of opioids would place you at high risk of relapse.")
- Limit setting (if necessary) with the patient in a calm and empathetic manner.

The importance of using nonjudgmental language in communicating with the patient should be emphasized.

Optional: Ask participants to pair up and role play the precepting interaction with the resident. One partner takes the role of the preceptor, and the other takes the role of the resident. The goal of the preceptor is to focus on the most important teaching points and to help the resident prepare for the clinic session with the patient. The advantage of role play rather than only discussing teaching strategies is to give the preceptor practice with effective word choice/use of language. Like any communication skill, effective precepting benefits from practice.

Note: Ask for a participant to read Part Two aloud.

Case: Part Two

Additional history obtained by the resident:

When Jack Carter got out of the military, he worked as a long-haul truck driver. He was using some speed to help him stay awake, and then would need alcohol and marijuana to bring him down so he could sleep. He took an exit ramp too quickly, flipped his rig, and crashed into an abutment. He fractured several vertebrae, his pelvis, and both legs.

On discharge after 4 months in the hospital and rehab, he was very depressed. He started drinking heavily and taking as much pain medication as possible. Then he met a new girlfriend and started getting really involved with her church and going to Alcoholics Anonymous (AA). He notes a few relapses, but now hasn't had a drink in 3 years. He and his girlfriend are living together; no kids. He goes to AA only occasionally. He states that his former doctor in a neighboring city had weaned him down to six Percocets per day, plus diazepam for muscle spasm and gabapentin for neuropathic pain in his legs. He is on SSDI, but he feels bored and depressed sitting around all day. A friend at church put him on to this new job delivering meals, which he thinks he can do, but he will need more pain meds to deliver all those meals.

On exam he was pleasant and very earnest. There was no evidence of any drug intoxication or withdrawal, although he had tobacco stains on his forefinger and teeth. His gait was shuffling and antalgic; he used a cane. His exam was otherwise unremarkable.

The resident tried to reach the patient's former doctor but got a message saying the practice is closed. The patient says he would like to establish a relationship with one physician who will help him with his back pain and other medical problems.

Part Two Discussion Questions 1–4 (15 minutes):

1. What is your assessment of the patient at this point?
2. Is this patient at risk for abuse of prescription medication? Why or why not?
3. What do you suspect the likelihood is that this patient is abusing prescription medications?
4. Would you suggest that the resident prescribe the requested medications at this visit? Why or why not?

Faculty Facilitator

One goal of the assessment is to consider risk factors for prescription drug abuse. Discussants should recognize that this patient is at risk for prescription drug abuse because of these risk factors: smoking, history of drug and alcohol abuse, and history of psychiatric disorder. Ideally, the facilitator can lead the participants in a discussion about the pros and cons of prescribing opioid analgesics at this visit. A significant *pro* is the opportunity to establish trust with a new patient and treat his pain. A significant *con* is the risk of abuse.

Aspects of the case that participants might want to consider when deciding if they will prescribe opioids for this patient include the following:

- On history and exam today, aside from tobacco use, there is no evidence of active addiction or substance misuse.
- He is at risk for prescription drug abuse.
- The providers have no records of his previous care, nor have they been successful in contacting his previous provider for confirmatory information.
- For this patient to develop a meaningful relationship with his new primary care provider, a level of trust needs to be developed. Providing an initial prescription of opioids might be an effective way to develop that trusting relationship. One could argue that even if he has an addiction disorder that is uncovered later, having a trusting relationship might be the basis for trying to help the patient accept care for his addiction disorder.

If all those present share the same opinion about whether to prescribe the requested medication, you might suggest that the resident doesn't feel comfortable with that plan and suggests doing the opposite. The facilitator should gently challenge participants to articulate the clinical reasoning process leading to a decision, as well as how they might help the resident formulate the assessment and treatment plan. There is general consensus that it is appropriate to consider providing opioid prescriptions for chronic nonmalignant pain, even for patients at risk for prescription drug abuse. As long as some participants will consider prescribing opioids (perhaps with the intention of ultimately obtaining confirmatory documentation from the prior provider), it is now useful to move on to the following question.

Part Two Discussion Question 5 (10 minutes):

5. When prescribing opioids to patients who are at risk for prescription drug abuse, what methods might be used to decrease the risk of future abuse?

Faculty Facilitator

It might be useful here to elicit a discussion of techniques that participants have used in their own practices when faced with this challenge. It might also be worthwhile to explore how effective the techniques were. There are many expert opinions in the literature, but little research exists that demonstrates one technique or set of techniques is more effective than is another.

Note: You should not feel obliged to cover all the suggestions below during the workshop. It is likely more useful for the participants to consider a few techniques in detail rather than to be exposed to a long list of options. One important question is which techniques are most appropriate to the setting in which your participants practice.

Some methods for safer prescribing recommended by experts include (see References 1, 4–5):

- Ideally, the provider and patient jointly develop realistic goals. Then the doctor must ensure the patient is benefiting from the prescribed medication. If a patient does not benefit from the treatment, alternative treatments should be provided.
- Manage pain primarily with long-acting opioids that have relatively low street value.
- Write prescriptions in a manner that discourages tampering.
- Provide only a limited supply of medications to be prescribed.
- Avoid giving multiple refills without office visits.

The physician may consider signing a medication contract (or “patient–physician agreement form”) with the patient. In all contracts, the consequence of improper use should be specified. The agreement should be clear for all cross-covering providers as well. The medication contract may include all, or some, of the following:

- Require that the patient use a single pharmacy for all prescriptions.
- Require that the patient obtain prescription pain medications from only one provider.
- Require that the patient avoid illicit substances.
- Require frequent appointments.
- Describe a clear policy for lost or stolen prescriptions or pills.
- Require regular and/or requested urine toxicology screens. Urine toxicology screens might be useful adjuncts, but they need to be used thoughtfully. The plan and rationale for including routine urine toxicology screens in the care of patients treated with chronic opioids for chronic, nonmalignant pain should be discussed in advance with the patient. Positive results for medications not prescribed, as well as illicit drugs, may be a helpful adjunct to assess concurrent drug abuse. In addition, negative urine toxicology screens for the opioid prescribed might provide useful information suggesting abuse or diversion. However, to properly interpret urine toxicology screens, a detailed understanding of the pharmacology of the prescribed opioid and its relationship to the urine-testing technique must be understood by the prescribing provider.

Regardless of the specific plan developed between the patient and provider, meticulous documentation in the medical record of both the indication for the medication and the details of all prescriptions is essential. In addition, for all patients it is important to identify and appropriately treat concurrent anxiety, depression, and other psychiatric disorders.

Note: Ask for a participant to read Part Three aloud.

Case: Part Three

Two hours later, as post-clinic conference is wrapping up, you get a call from a pharmacist to confirm the prescription for Percocet. The pharmacist notes that the patient just picked up a prescription for 120 Percocets from another physician at another branch of the same pharmacy 2 days ago.

Part Three Discussion Question 1 (10 minutes):

1. What is your assessment now?

Faculty Facilitator

Clearly this is a red flag for prescription abuse or divergence. It appears that the patient is either personally abusing the medicine (e.g., he may be bingeing or using excessive daily quantities) or diverting these medications to others (e.g., selling them on the street or giving them to friends). If you haven't already done so, this is an appropriate opportunity to review other red flags for prescription drug abuse, including (from Reference 4):

- The patient is more concerned about the drug than the problem.
- The patient reports multiple medication sensitivities.
- The patient says he cannot take generic drugs.
- The patient refuses diagnostic workup or consultation.
- The patient has sophisticated knowledge of drugs.
- The patient reports lost prescriptions.
- The patient calls the clinic after hours when he knows their primary care physician is unavailable.
- The patient seeks out multiple physicians.

Part Three Discussion Question 2–4 (15 minutes):

2. How do you feel about the patient?
3. What are your goals for your next precepting encounter with the resident?
4. What plan will you help your resident construct?

Faculty Facilitator

If the pharmacist is able to destroy the prescription, and you document this in the patient's medical record, this might be an initial step. A more challenging issue is to contact the patient using a nonaccusatory approach and offering a follow-up appointment soon. This patient may have an untreated addiction problem that is not being addressed. It would be appropriate to offer to continue caring for the patient but also to be clear that continued prescribing of Percocet at this time is not possible. A consultation with a pain or addiction specialist, or referral to a pain or addiction treatment program, may be advisable.

Conclusion

Establishing a trusting doctor-patient relationship will help in trying to better diagnose the problem and help the patient, but this relationship is unlikely to develop if the resident perceives this new information as a personal affront rather than the behavior of a patient who may have a serious addiction problem. The resident's anger may interfere with the care of the patient. The resident should come to understand that addiction is a chronic, relapsing brain disease that should be treated as a disease rather than a moral failing; this approach should help reinforce the idea that the resident should not take the patient's behavior personally.

Note: Evaluation tools for this module consist of anonymous written program evaluations (narrative and Likert scale), observation, and feedback. As part of our continuing efforts at improving this resource, please send copies of the evaluations to NIDAMED@nida.nih.gov.

References

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(An overview of the demographics and potential etiologies of the prescription drug abuse epidemic; priorities for further research and practice guidelines are identified.)
2. Substance Abuse and Mental Health Services Administration. *Results from the 2008 National Survey on Drug Use and Health: National Findings* (2009). Rockville, MD: Office of Applied Studies, NSDUH Series H-36, HHS Publication No. SMA 09-4434. Available at <http://www.oas.samhsa.gov>. Accessed 8-30-09.
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4. Isaacson JH, Hopper JA, Alford DP. Prescription drug use and abuse: risk factors, red flags, and prevention strategies. *Postgraduate Medicine* (2005); 118:19–26.
(An excellent clinical review of many issues related to prescription drug abuse, including legal issues, prevention strategies, recommended prescribing practices, and interventions.)
5. Federation of State Medical Boards of the United States. *Model Policy for the Use of Controlled Substances for the Treatment of Pain* (May 2004). Available at http://www.fsmb.org/pdf/2004_grpol_Controlled_Substances.pdf. Accessed August 30, 2009.
(This succinct policy covers many of the practical principles and requirements of using opioids to treat chronic pain.)

Further Readings

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(A detailed review of the use of urine toxicology screening in the care of patients prescribed medications with abuse potential.)
2. Gourlay DL, Heit H, Almahrezi A. Universal precautions in pain medicine: a rational approach to the treatment of chronic pain. *Pain Medicine* (2005); 6(2):107–112.
(A commentary with a practical approach to the treatment of chronic pain.)

Pilot Information

Sixteen Harvard Medical School faculty members participated in our pilot faculty development workshop on October 29, 2008, at the Harvard Faculty Club. The workshop received excellent ratings (“high” or “very high” by most participants in all categories). Specific feedback included praise for the case-based, group discussion/role play format. One challenge for the facilitator was to make the discussion useful and accessible to participants from various levels of training (both fellows and attending physicians) and specialties (internists, family physicians, and psychiatrists). That said, the diversity of backgrounds of participants added richness and perspective to the workshop. It is important to be clear in the advertising of the workshop that it is focused on practical problem solving, interpersonal and communication skills, and precepting skills. While some content about prescription drug abuse is covered, that is not the focus of the workshop.

Participant Handout: Three-Part Case: “Nothing Else Works, Doc!”

Case: Part One

The resident you precept in primary care clinic comes to you, obviously annoyed.

Resident: “I’m about to go in and see this 44-year-old, drug-seeking patient. I’m sure all he wants from me is Percocet.”

You: “What makes you think that?”

Resident: “Well, I looked through his chart and this guy always sees different providers for his back pain. It’s documented that Motrin and Tylenol bother his stomach, and codeine makes him itch. He’s also tried physical therapy, heat, and ice without results. The last two docs he saw in our system raised the question of drug-seeking behavior—but they still ended up giving him Percocet, six a day! The nurse tells me he’s looking for me to prescribe eight Percs a day. He has some story about getting a part-time job delivering Meals-on-Wheels. He’ll be more active and in more pain, so he needs more meds. I’ll bet you anything he’s just looking for narcotics. I wanted to give you a heads up about him because I’m sure he’ll be angry when I refuse to prescribe to him.”

Discussion Questions:

- What are your initial responses to this resident’s concerns?
- How are you feeling toward the patient?
- How are you feeling toward the resident?
- How can the preceptor help the resident prepare to evaluate this patient? (Specifically, what information should the resident gather?)
- What goals and priorities should the preceptor have for the teaching encounter with the resident?

Case: Part Two

Additional history obtained by the resident:

When Jack Carter got out of the military, he worked as a long-haul truck driver. He was using some speed to help him stay awake and then would need alcohol and marijuana to bring him down so he could sleep. He took an exit ramp too quickly, flipped his rig, and crashed into an abutment. He fractured several vertebrae, his pelvis, and both legs.

On discharge after 4 months in the hospital and rehab, he was very depressed. He started drinking heavily and taking as much pain medication as possible. Then he met a new girlfriend and started getting really involved with her church and going to Alcoholics Anonymous (AA). He notes a few relapses, but now hasn't had a drink in 3 years. He and his girlfriend are living together; no kids. He goes to AA only occasionally. He states that his former doctor in a neighboring city had weaned him down to six Percocets per day, plus diazepam for muscle spasm and gabapentin for neuropathic pain in his legs. He is on Social Security Disability Insurance (SSDI), but he feels bored and depressed sitting around all day. A friend at church put him on to this new job delivering meals, which he thinks he can do; but he will need more pain meds to deliver all those meals.

On exam he was pleasant and very earnest. No evidence of any drug intoxication or withdrawal, although he had tobacco stains on his forefinger and teeth. His gait was shuffling and antalgic; he used a cane. His exam was otherwise unremarkable.

The resident tried to reach the patient's former doctor but got a message saying the practice is closed. The patient says he would like to establish a relationship with one physician who will help him with his back pain and other medical problems.

Discussion questions:

- What is your assessment of the patient at this point?
- Is this patient at risk for abuse of prescription medication? Why or why not?
- What do you suspect the likelihood is that this patient is abusing prescription medications?
- Would you suggest that the resident prescribe the requested medications at this visit? Why or why not?
- When prescribing opioids to patients who are at risk for prescription drug abuse, what methods might be used to decrease the risk of future misuse and abuse?

Case: Part Three

Two hours later, as post-clinic conference is wrapping up, you get a call from a pharmacist to confirm the prescription for Percocet. The pharmacist notes that the patient just picked up a prescription for 120 Percocets from another physician at another branch of the same pharmacy 2 days ago.

Discussion questions:

- What is your assessment now?
- How do you feel about the patient?
- What are your goals for your next precepting encounter with the resident?
- What plan will you help your resident construct?

Participant Handout: Terminology

Terminology (adapted from Reference 5):

- **Prescription drug abuse** is a pattern of nonmedical use of prescription drugs that causes one or more of the following: failure to fulfill major obligations, use when physically hazardous, recurrent legal problems, and recurrent social or interpersonal problems.
- **Addiction** is a primary, chronic, neuropsychiatric disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by impaired control over drug use, craving, compulsive use, and continued use despite harm.
- **Nonmedical use** is defined as the use of a prescription medication without a prescription, or the use of a prescription medication for purposes other than those for which it is prescribed.
- **Physical dependence** is a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. Physical dependence does not equal addiction.
- **Pseudoaddiction** is the iatrogenic syndrome resulting from the misinterpretation of relief-seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief-seeking behaviors resolve upon institution of effective analgesic therapy.

When evaluating a patient for long-term opioid use, take a thorough pain history and a thorough addiction history, and evaluate for risk factors for substance abuse/misuse. Risk factors may include:

- History of drug or alcohol abuse
- Tobacco use
- History of emotional, physical, or sexual abuse
- Psychiatric disorders
- Criminal record.

Physicians should be aware of the ways in which their own biases and/or emotional reactions to patients requesting opioid medications may affect the doctor-patient interaction and/or treatment choice.

When prescribing opioids for chronic pain, consider using safe prescribing practices, such as:

- Regularly reassess the medication's effect on the pain with frequent appointments.
- Avoid giving multiple prescriptions without office visits.
- Document the plan meticulously in the medical record.
- Write tamper-proof prescriptions.
- Consider a medication contract or patient-physician agreement.
- Provide clear policy for lost prescriptions.

- Consider regular urine toxicology screening.
- Limit the supply of medications.
- Use opioids with relatively low street value.
- Ensure that the patient uses only a single pharmacy for all refills.
- Ensure that the patient obtains prescriptions from only one provider.
- Ensure that the patient avoids illicit substances.

Participant Handout: Evaluation Tools

Narrative Feedback (Very Important to Us!)
What is a specific aspect of this workshop that should be maintained in the future?
Please recommend a specific change that would increase the quality of the educational experience:
Other comments/suggestions:

Please rate each session using the following code: 1= lowest rating.....5 = highest rating	1	2	3	4	5
1. OVERALL VALUE of session:					
2. How clear were the objectives?					
3. How organized did you find the presentation of materials (i.e., how effectively did the session flow)?					
4. How useful were the concepts covered during the workshop?					
5. How well did the workshop prepare you to teach/precept students/residents about prescription drug abuse?					
6. How effective were the instructors?					
7. How useful were the opportunities to network?					
8. How useful were the handouts/reference material?					