



## Opioid Prescribing for Chronic Pain — Achieving the Right Balance through Education

Daniel P. Alford, M.D., M.P.H.

In recent decades, the United States has seen a dramatic increase in opioid prescribing for chronic pain. That growth has been associated with increasing misuse of prescription opioids<sup>1</sup> and has

led to increases in deaths due to unintentional opioid overdose and in the number of people seeking treatment for opioid-misuse disorders. There's probably 100% agreement that we, as a profession and society, have become overly opioid-centric in our management of chronic pain. Far more controversial are the role of long-term opioid therapy in managing chronic pain and the best strategy for ending the epidemic of prescription-opioid misuse.

Groups lobbying against prescribing opioids for chronic pain remind us that the effectiveness of long-term opioid therapy has been inadequately studied.<sup>2</sup> I believe that this is a case of absence of evidence rather than evidence of absence. As we await scientific

evidence, questions remain regarding how best to address the epidemic of prescription-opioid misuse now. Groups advocating quick fixes believe that regulations that limit opioid availability are the best plan. This strategy is well intentioned and will certainly reduce opioid prescribing, but such blunt approaches will also limit access to opioids for patients who are benefiting or may potentially benefit from them.

Such an objection is not about protecting clinicians' autonomy, but rather about protecting access to opioids for our patients who are in severe pain. These regulations will lead some clinicians to refuse to prescribe opioids even when they're indicated, seeing it as too risky or too much work.

They also create a climate of mistrust between patients and their health care teams. Clinicians are accused of both undertreating pain and overprescribing opioids, and patients with chronic pain who take opioids are viewed with suspicion. In addition, we don't know what impact indiscriminate reductions in access to prescription opioids will have on long-term clinical outcomes.

Prescriber education is a more finely tuned approach to addressing the opioid-misuse epidemic, allowing us to individualize care on the basis of a patient's needs after a careful benefit-risk assessment. That, after all, is the way we manage all chronic diseases. Education can empower clinicians to make appropriate, well-informed decisions about whether to initiate, continue, modify, or discontinue opioid treatment for each individual patient at each clinical encounter. Education has the potential to both reduce overpre-

scribing and ensure that patients in need retain access to opioids.

In July 2012, a national voluntary prescriber-education initiative was begun. The Food and Drug Administration (FDA) approved a single shared Risk Evaluation and Mitigation Strategy (REMS) requiring manufacturers of extended-release and long-acting opioid analgesics to fund accredited education on safe opioid prescribing based on an FDA curricular blueprint. Although this program has not yet trained the targeted number of prescribers, a recent evaluation suggests that REMS education can shift clinicians' self-reported practice toward safer, guideline-concordant care.<sup>3</sup> Comprehensive training in safe opioid prescribing is needed at all stages of medical education (undergraduate, graduate, and continuing), since training in this area has historically been lacking. This education must go beyond opioid prescribing to include comprehensive, multimodal pain management,<sup>4</sup> and it can be designed for the entire health care team: our nursing, pharmacy, and behavioral health colleagues have also been inadequately trained. This education can be coupled with enhanced clinical systems that support these new practices, including decision-support tools in electronic medical records.

Managing chronic pain is complex. Chronic pain is subjective and can present without objective evidence of tissue injury, which results in diagnostic uncertainties despite our most thorough assessments. Patients with chronic pain are desperately seeking immediate relief from their suffering; they tend to have unrealistic expectations regarding the potential benefits of opioids and not to fully appreciate the degree

of risk conferred by escalating their own doses in a desperate (yet futile) attempt to obtain pain relief.

Clinicians have limited tools at their disposal to help these patients. Our reimbursement system favors the use of medications alone, despite evidence supporting multimodal care. Clinicians often have no easy access to non-pharmacologic therapies and cannot obtain pain consultations because there are too few pain specialists offering comprehensive pain care. Moreover, whereas clinicians can use objective measures to guide their management of other chronic diseases, here they must rely solely on the patient's (or family's) reports of benefits (such as improved function) and harms (such as loss of control). Clinicians are thus left basing treatment decisions on a brief subjective assessment of whether there's enough benefit to justify continued opioid therapy or enough harm to justify discontinuing it.

Many guidelines for safe opioid prescribing exist, and all include similar recommendations, including use of assessments of risk of opioid misuse, signed agreements that include informed consent, and monitoring strategies such as drug testing, pill counts, and prescription-drug-monitoring programs. But it's also essential for safe-opioid-prescribing education to include teaching of effective communication skills. How does one explain to a patient who's desperate for help that an opioid treatment must be discontinued despite the lack of alternative treatments? How does one deal with a new patient who is already taking high-dose opioids and insists that it's the only treatment that helps?

It's important for clinicians to judge the opioid treatment rather than the patient.<sup>5</sup> When opioid therapy is deemed too risky or inadequately beneficial, discontinuing it means abandoning not the patient but merely an inappropriate treatment. When a clinician changes the treatment approach with a patient who tests positive for an illicit drug, that response is not about punishing the patient, but about changing the treatment plan on the basis of a new risk and addressing a newly identified problem.

When a clinician determines that discontinuing opioid treatment is appropriate, the patient may disagree and express anger. Is such frustration attributable to an appropriate desire for pain relief, inappropriate drug seeking, or a combination of the two? Though a patient-centered approach is always preferred, there are times in managing opioid therapy for patients with chronic pain when the clinician's approach must be at odds with the patient's request but intended to keep the patient safe. Such an approach may be perceived as paternalistic and may threaten the therapeutic alliance. Although transparent communication leading to a patient-centered approach is important, it goes only so far when a patient with chronic pain also shows signs of opioid misuse (e.g., unsanctioned dose escalation), necessitating discontinuation of opioid treatment.

Addressing the crisis of prescription-opioid misuse has become a national priority. To judge from the progress of the REMS program for extended-release and long-acting opioids, voluntary prescriber education may be insufficient to address this problem. Mandatory education may be re-

quired. If so, it will be important to link mandated education to medical licensure to avoid having clinicians opt out — since that could lead to reduced treatment access, as well as burnout among the clinicians who opt in. Alter-

 An audio interview with Dr. Alford is available at [NEJM.org](http://NEJM.org)

natively and ideally, we could mandate proof of clinical competence, allowing clinicians who are already well trained to test out of an education requirement. Unfortunately, it may be impossible to measure such skill-based competence on a national scale.

I believe that the medical profession is compassionate enough

and bright enough to learn how to prescribe opioids, when they are indicated, in ways that maximize benefit and minimize harm. Though managing chronic pain is complicated and time consuming and carries risk, we owe it to our patients to ensure access to comprehensive pain management, including the medically appropriate use of opioids.

Disclosure forms provided by the author are available with the full text of this article at [NEJM.org](http://NEJM.org).

From the Boston University School of Medicine and Boston Medical Center — both in Boston.

1. Dart RC, Surratt HL, Cicero TJ, et al. Trends in opioid analgesic abuse and mortal-

ity in the United States. *N Engl J Med* 2015; 372:241-8.

2. Chou R, Turner JA, Devine EB, et al. The effectiveness and risks of long-term opioid therapy for chronic pain: a systematic review for a National Institutes of Health Pathways to Prevention Workshop. *Ann Intern Med* 2015;162:276-86.

3. Alford DP, Zisblatt L, Ng P, Hayes SM, Peloquin S, Hardesty I, White JL. SCOPE of Pain: an evaluation of an opioid Risk Evaluation and Mitigation Strategy continuing education program. *Pain Med* 2015 August 25 (Epub ahead of print).

4. Fishman SM, Young HM, Lucas Arwood E, et al. Core competencies for pain management: results of an interprofessional consensus summit. *Pain Med* 2013;14:971-81.

5. Nicolaidis C. Police officer, deal-maker, or health care provider? Moving to a patient-centered framework for chronic opioid management. *Pain Med* 2011;12:890-7.

DOI: 10.1056/NEJMp1512932

Copyright © 2016 Massachusetts Medical Society.

## BECOMING A PHYSICIAN

# The Residency Application Process — Burden and Consequences

Eva M. Aagaard, M.D., and Mona Abaza, M.D.

A recurring question facing medical education is the value of the fourth year of medical school. Some observers have called for eliminating this final year of study altogether.<sup>1</sup> Others, particularly residency program directors, have raised concerns that medical students aren't being adequately trained for entering residency.<sup>2</sup> Among students, the fourth year is viewed as a critical transition time for clarifying specialty choice and preparing for residency.<sup>3</sup>

The Association of American Medical Colleges (AAMC) recently described Core Entrustable Activities for Entering Residency in an attempt to develop a standardized set of educational goals that students should achieve before graduating from medical school. These goals are meant to define minimum expected competencies.

Unfortunately, they do not address specialty-specific desirable skills, so they fall short of the entry milestones that residency programs require of incoming interns. In addition, a focus on these “entrustable” activities does not address other potentially important educational opportunities, such as exploring nonclinical career pathways (education or scientific careers) and reinforcing or building on knowledge and skills obtained during the core training years to ensure that budding physicians are well rounded.

If the fourth year is potentially expendable, why isn't it being used to meet the needs and desires of medical students, residents, and residency programs? Surely, a year is sufficient time to address these curricular goals. Unfortunately, meeting these needs is more challenging than

one might expect, at least in part because the process of preparing for and applying to residency programs has become overly burdensome.

With more than 40,000 applicants for 30,212 positions,<sup>4</sup> the application process for the 2015 National Resident Matching Program (NRMP) was more competitive than ever. Most students use the first few months of their fourth year of medical school to confirm their specialty choice and to complete work that will make them more competitive in their chosen field. That work may include taking the National Board of Medical Examiners (NBME) Step 2 Clinical Knowledge exam to improve on a lackluster Step 1 exam score, completing research, doing a subinternship or elective rotation in their chosen specialty, and participating in “away” or