Original Article

"I Feel Uncomfortable 'Calling a Patient Out'": Educational Needs of Palliative Medicine Fellows in Managing Opioid Misuse

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Abstract

Context. During the past 10 years, advocates of palliative care have sought to be included earlier in the course of patients' illnesses. Palliative care providers may thus be more likely to care for patients who misuse and abuse opioids.

Objectives. To assess whether hospice and palliative medicine (HPM) fellows see patients at risk for opioid misuse and how competent they perceive themselves to be to treat pain in these patients.

Methods. An electronic survey was distributed to 102 HPM fellows. The survey included questions assessing self-perceived competency in care for patients who misuse opioids. Responses were rated using a Likert scale of one to seven, where one = strongly agree and seven = strongly disagree; any number greater than two was considered to be nonagreement.

Results. Fifty-seven (56%) fellows from 34 programs responded to the survey. In the previous two weeks, 77.2% of respondents had seen at least one patient with a substance use disorder (SUD) and 43.9% had treated a patient whom they were concerned was misusing opioids. Half (47.2%) of respondents stated that they have a working knowledge of addiction, 41.4% agreed their training has prepared them to manage opioid misuse, and 36.8% felt they knew how to differentiate pain from addiction. Only 21.1% were satisfied with how they treat symptoms in this population. Fellowship training in opioid misuse was associated with increased satisfaction.

Conclusion. HPM fellows regularly see patients who are at risk for opioid misuse and feel unprepared to treat pain in these patients. There is a need for more education of fellows in this area. J Pain Symptom Manage 2012;43:253–260.

Key Words

Medical education, specialization, palliative care, attitude of health personnel, pain/therapy, opioid-related disorders, program development, questionnaires, risk assessment, substance abuse, analgesics, opioid, needs assessment, clinical competence, opioid/adverse effects, opioid/therapeutic use

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Introduction

The last decade has seen an increase in the use of prescription opioids throughout medical practice in the U.S.[1,2] This change has been accompanied by an increase in prescription opioid overdoses.[3–5] Prescription opioids are now the largest category of drugs of abuse, with 533,000 new nonmedical users of oxycodone reported in 2006.[6] During the same period, palliative care programs have proliferated, fueled by evidence that they improve quality of life and symptom burden[7,8] and save money for health systems.[9–11] Based on this, advocates have called for palliative approaches to be integrated earlier in the course of patients' diseases, alongside disease-modifying treatments. The intersection of these two phenomena—increased prescription drug abuse and early palliative care consults—may lead palliative care clinicians to encounter more patients who misuse their prescribed opioids.

Palliative care physicians must be prepared to manage opioid prescribing in a population that may be at higher risk for opioid misuse than patients in the last few weeks of life. Aberrant drug-taking behaviors indicative of misuse include obtaining opioids from multiple providers, preoccupation with certain medications, buying medication on the street or obtaining it from friends, repeatedly requesting dose escalations without a change in the medical condition, and reporting lost or stolen medications. These behaviors are red flags for medication misuse, including misuse severe enough to be described as substance abuse.

The misuse of medication in populations with serious illness may have complex causes. In some cases, it may be related to the disease of addiction; in others, it may represent a maladaptive pattern of dealing with emotional distress. This phenomenon has been termed "chemical coping"[12] and should be considered another type of opioid misuse. Furthermore, some patients may exhibit aberrant drug behaviors because of uncontrolled pain (a phenomenon that has been labeled "pseudoaddiction"[13]).

It is difficult to manage pain well while minimizing opioid misuse and in particular, to differentiate between inadequate analgesia, chemical coping, and addiction. Although guidelines exist for identifying high-risk behavior and managing opioid prescribing in chronic nonmalignant pain,[14,15] there are no recommendations addressing risk management in chronic cancer pain or noncancer pain in the setting of a life-limiting illness.

In primary care, medical trainees and practicing physicians have been shown to lack competence in diagnosing substance use disorders (SUDs) and setting limits on opioid prescribing in cases of misuse.[16,17] There are no studies of hospice and palliative medicine (HPM) trainees' skill or confidence in this area. We sought to assess the need for opioid misuse and addiction curricula in HPM fellowships by asking fellows how frequently they encounter patients who are at risk for opioid misuse, their training in opioid misuse and addiction, and their perceived competency in treating pain in this population. We hypothesized that previous training in opioid misuse and substance abuse would be associated with greater perceived competency.

Methods

We developed a survey based on the validated Drug and Drug Problems Perceptions Questionnaire (DDPPQ). The DDPPQ, a modification of an alcohol-related questionnaire, evaluates three components of nonphysicians' readiness to provide care for patients with SUDs: knowledge, role support, and self-efficacy.[18] Because our survey was directed toward prescribers of opioid medications, we modified existing questions to reflect competencies specific to physicians, such as interpreting urine drug screens and knowledge of prescribing strategies to minimize risk of opioid misuse. As there is evidence that provider education in shared decision making can affect attitudes and behavior about opioid prescribing,[19] we added a fourth category of questions related to management of, and decision making regarding, opioids in the setting of high-risk behavior.

Within the survey, "SUD" was defined as applying to patients who carry a previous diagnosis of abuse of alcohol or drugs in the medical record, including illicit and prescription drugs (opioids, benzodiazepines, or others). We did not require the respondents to apply the Diagnostic and Statistical Manual (DSM) or other