

Opioid Prescribing Education in Surgical Residencies: A Program Director Survey

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BACKGROUND: Opioid abuse and misuse is a public health crisis. A national effort to reduce this phenomenon is ongoing. Residents represent a large pool of opioid prescribers but, are often not the target for opioid prescribing education (OPE). We developed a survey to assess current opioid prescribing practices and education among surgical residents.

STUDY DESIGN: An Institutional Review Board and Association of Program Directors in Surgery approved survey was electronically mailed to surgical program directors (PDs). The survey included questions regarding residency type, location, number of graduates per year, perceived value of OPE, residency policy on prescribing outpatients controlled substances, presence of OPE, and preferred method of OPE.

MATERIALS AND METHODS: A total of 248 PDs were e-mailed the survey with 110 complete responses (44.4%). Of all 104 (94.5%) allow residents to prescribe outpatient opioids with 24 (23.1%) limiting the opioid class prescribed. A total of 29 (27.9%) programs require residents to obtain their own Drug Enforcement Administration registration.

Only 22 (20.0%) programs had in place mandatory OPE, 7 (6.4%) PDs were unsure if OPE was a mandatory educational requirement. Furthermore, 70 (79.5%) of programs currently without OPE are considering adding it. Didactic lecture (18, 81.8%) is the most common modality for OPE. The mode time dedicated to OPE was 1 hour. When PDs were asked about which method would be best to deliver OPE, the most common response was case-based scenarios

(39, 35.5%). Bivariate statistics were performed and no association was found between OPE and program characteristics'.

CONCLUSIONS: Most surgical residency programs allow residents to prescribe outpatient opioids, very few require OPE. The most common method of OPE was didactic lectures. To enhance a resident's knowledge in prescribing opioids, programs should incorporate OPE into their curriculum. (J Surg Ed ■■■■-■■■. © 2017 Association of Program Directors in Surgery. Published by Elsevier Inc. All rights reserved.)

KEY WORDS: opioid education, surgical residency, opioid prescribing

COMPETENCIES: Patient Care, Practice Base Learning and Improvement, Systems Based Practice

INTRODUCTION

Opioid abuse and misuse are a public health epidemic in the United States, where the number of opioid-related deaths has exponentially increased in the past several years. In 2005, there were approximately 15,000 opioid-related deaths.¹ In 2015, there were over 33,000 deaths related to opioids. Of those, over 22,500 were related to opioid pain relievers.² In 2013, the National Institutes of Health estimated 1.9 million people suffer from substance use disorder related to prescription opioid pain medications. This number is expected only to increase.³ Alarming, the American Association of Addiction Medicine estimates that 80% of new heroin users first accessed opioids through prescription painkillers, indicating an urgent need to address the ways in which physicians prescribe these medications.⁴

Multifactorial initiatives have been implemented to address this epidemic. Patient level interventions include

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education and prevention campaigns and improved access to addiction treatment and overdose prevention programs.^{4,5} System level interventions include rescheduling hydrocodone to a more restrictive class II from less restrictive class III scheduled controlled substance, decreasing the national amount of scheduled II opioids that can be manufactured for use, more aggressive law enforcement efforts, diverting people with substance abuse disorder to drug courts, and increased surveillance programs to monitor for abuse.^{2,4,6,7}

Prescriber-focused modalities include provider opioid prescribing education (OPE), establishment of prescription drug monitor programs (PDMP), limitations on the quantity of opioid medications prescribed, and increased availability of clinical practice tools to address pain and opioid use.⁵ Unfortunately, many of these efforts are geared toward fully licensed physicians, not physicians in training, which is problematic because most opioid prescriptions written by surgeons are surgeons in training.⁸ Recently, efforts are beginning to address OPE during medical school. One example is the Commonwealth of Massachusetts launching a campaign to develop 10 “core competencies in preventing and managing prescription drug misuse in the state's 4 medical schools.”⁹ Many initiatives may miss this subset of prescribers who write a significant number of opioid prescriptions. However, research has indicated that resident analgesic prescribing practices can be significantly changed by using low-cost educational campaigns.¹⁰

During this study, we sought to gain knowledge on the current landscape of controlled substance prescribing among surgical residents. We hypothesized that many programs allow surgical residents to prescribe controlled substances but do not provide OPE as a part of their education. Through an anonymous surgical residency program director (PD) survey, we tested our hypothesis.

METHODS

We developed an 18 question web-based survey with the assistance of opioid education and policy experts. The study was deemed exempt by the Partners Healthcare Institutional Review Board. Consent was implied by completing the survey. The Association of Program Directors in Surgery (APDS) Research Committee reviewed the survey and approved its release to its members. The survey was e-mailed via the APDS listserv. Follow-up e-mails were also sent to all active civilian surgical residency PDs in the United States using the APDS directory of surgery programs to assure each PD was offered participation, totaling 248.¹¹

The survey instrument included questions regarding geographic location of the program, program type, number of residents per year, the PDs perceived value of OPE to residents, and the clinical care of patients, resident policy on

prescribing opioids for outpatient use, residents use of the hospital's or individual physician's Drug Enforcement Agency (DEA) registration number, presence of a mandatory OPE for residents along with methods used for its delivery, and the best method to deliver OPE.

Univariate and bivariate statistics were performed to assess associations between program location, program type, and other covariates on OPE outcomes of interest using STATA statistical software (v10, College Station, TX). Student's *t*-test was used for continuous variables and Pearson's chi-square or Fisher's exact test were used for categorical variables.

RESULTS

A total of 110 PDs completed the survey. Using the APDS surgery program list as described earlier, the response rate was 44.4%. Of the responses 56 (50.9%) programs were university-based residencies, 27 (24.5%) were university-affiliated, and 27 (24.5%) were independent. Most had between 4 and 7 graduating surgical residents (69, 62.7%) per year (Table). When queried about the PDs perceived value of OPE to the clinical care of patients, the mean response was 73.1 (range: 7-100) on a 100 point scale where 100 is very valuable and 0 is not valuable. Using the same scale, PDs rated the value of OPE in surgical residency with the mean being 78.3 (range: 8-100).

Of the respondents, 104 (94.5%) allow residents to prescribe opioids in the outpatient setting, 1 (0.9%) was unsure if this was permitted, and the remaining 6 (5.5%) do not allow this practice. Among programs that allow resident opioid prescribing for outpatient use ($n = 104$), 24 (23.1%) limit the opioid class residents prescribe and 52 (50.0%) allow residents to prescribe benzodiazepines. A total of 29 (27.9%) programs require residents to obtain their own DEA registration, whereas 5 (4.8%) PDs were unsure if the hospital required residents to obtain a DEA for outpatient prescriptions. Approximately, 73 (70.2%) programs allow hospital DEA use.

Of all 22 (20.0%) require OPE during surgical residency. Interestingly, 7 (6.4%) were unsure if this was required. Of the programs that did not have a mandatory OPE ($n = 88$), 70 (79.5%) are considering adding OPE to the curriculum (Table). Of the required OPE programs, most (68.2%, $n = 15$) took 1 hour or less to complete. Furthermore, 4 (18.2%) programs' OPE was between 1 to 3 hours and 3 (13.6%) programs education was >3 hours.

Training methods varied, with 11 programs using more than 1 modality to deliver their mandatory OPE (Fig. 1). When the PDs were asked which would be the best method to deliver an OPE, most (39, 35.4%) selected case-based scenarios, followed by hospital developed computer-based education programs (20, 18.2%), and didactic lectures (20, 18.2%) (Fig. 2).

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