Pain represents the chief complaint for nearly half of all emergency department (ED) and outpatient clinic visits in the United States, and as much as it pains the first author to admit it (being a resident physician himself), residents are the frontline clinicians who encounter these patients. Despite available resources, residents often are ill-prepared to manage these patients, particularly in regard to the use of opioid analgesics. Compared to other providers, residents are more likely to overtreat abusers of opioid analgesics and refill opioid prescriptions more quickly. The reasons for this behavior deserve further scrutiny. In this Perspectives article, we ask why residents may be more likely to prescribe opioids for pain, and we provide recommendations for educational interventions to address this.

Managing the Patient in Chronic Non-Malignant Pain

Two major differential diagnoses for chronic non-malignant pain (CNMP) include organic (tissue-based) pain versus malingering pain, and residents are often unprepared to distinguish between the 2 and manage them. The risks and rewards of prompt prescriptions for opioids can be described for both patients and providers along a temporal continuum (FIGURE). For the resident, the benefits of prescribing opioids (upper right quadrant of FIGURE) are largely immediate (eg, reduced stress during the clinical encounter). The resident who defers opioid analgesia encounters a different set of risks and benefits (upper left quadrant of FIGURE). An immediate risk is that patients may become confrontational while in clinic and/or consume additional provider time with frequent phone calls due to unrelieved pain. In contrast, future health care costs would likely be lower if patients managed without opioids required fewer CNMP-related visits to the ED and primary care clinics.

Challenges Posed to the Resident

Given the temporal profile, an inexperienced resident is likely to find it difficult to refuse to prescribe opioids when the alternative is drawn-out multidisciplinary care and regular follow-up treatment. Unfortunately, few patients with CNMP receive long-term coordinated care. According to a study of 600,000 patients, more than 80% had musculoskeletal or joint pain, yet less than 4% were referred to a rheumatologist; and although 35% had an underlying psychiatric illness, fewer than 10% were evaluated by a psychiatrist. It is not clear the extent to which this represents underreferral, a dearth of available providers, inadequate insurance coverage, or lack of knowledge of available resources.

While temporal discounting biases us toward courses of action with immediate benefits and risks, as physicians we should care about the overall balance of risk and benefit. Here, it is far from clear that prescribing opioid analgesia is best for CNMP.

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To the extent that the practice fosters overprescribing, it increases patient morbidity and mortality and constitutes wasteful spending in the context of escalating health care costs.\textsuperscript{14–16} As such, unnecessary prescribing of opioids is a poor model for residents, who will ultimately be co-responsible for guiding future health care practice and policy.

**Future Directions**

Programs, including preclinical seminars, clinical rotations, and focused curricula\textsuperscript{17–25} educate medical students and residents in countering temporal discounting of the long-term benefits of deferring opioid analgesia and the long-term risks of prescribing. It might be useful to intervene and include education for nurses and patients as well. In the clinical ambulatory setting, the standard practice of one-on-one mentoring post hoc (after the clinical encounter) might be supplemented by a rotation through the pain management service.

Several interventions have been suggested to reduce temporal discounting in vulnerable populations, and some of these may be applied in the medical education setting (TABLE). For example, contingency management has proven effective in several populations of substance abusers.\textsuperscript{18–20} Contingency management entails the repeated (often positive) reinforcement of appropriate behaviors, abstinence in the case of substance abusers, and appropriate pain management in the case of residents. In the simplest application of this technique, medical educators should continue to encourage and applaud residents for managing their patients in CNMP with non-opioid regimens or referring them to subspecialty providers when able. Using an alternative approach to temporal discounting, one study showed that a monthly review of personal budgets reduced temporal discounting in a small cohort of patients with psychiatric disease.\textsuperscript{21} Such an intervention is not unlike standard morbidity and mortality conferences held at most academic medical institutions. We encourage medical educators to tailor teaching conferences to address the difficulties inherent to managing patients with CNMP and the risks of temporal discounting when opiates may be prescribed.

Other methods that have had success in mitigating temporal discounting include the implementation of prospective thought, the provision of social influence, and the reduction of stressors among residents, where possible.\textsuperscript{18–25} These methods are summarized in the

![Image of advantages and disadvantages of prescribing opioid analgesics](image-url)
Future research is needed to determine whether improved understanding of the principles of temporal discounting would be of benefit to resident decision making and to the patients. Advice from experts and peers has been shown to diminish temporal discounting in other settings, as has preparation for decisions ahead of time (termed “precommitment”), rather than in the “heat of the moment.” Investigations in clinical settings will show if similar strategies are useful in addressing current inadequacies in managing one of the most common complaints that residents encounter.

### References


