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Improving Physician Training in Addiction Medicine

ADDICTION MEDICINE TRAINING IN OUR YOUNG DOCTORS

Researchers from Boston Medical Center have found that Education on Addiction Medicine is not up to scratch during medical training. Whats being done to ensure that patients at risk receive optimum medical care? You are listening to ReachMD XM 160, The Channel for Medical Professionals.

Welcome to the Clinician's Roundtable. I am your host, Dr. Mary Leuchars and joining me today from Boston is Dr. Daniel Alford. He is Associate Professor of Medicine at Boston University School of Medicine and is Director of the Chief Resident Emergent Training in Addiction Medicine at the Boston Medical Center. We are discussing physician training in the area of Addiction Medicine.

DR. MARY LEUCHARS:

Welcome, Dr. Alford.

DR. DANIEL ALFORD:

Thanks for inviting me.

DR. MARY LEUCHARS:

So what is addiction medicinal about?

DR. DANIEL ALFORD:

Addiction Medicine really deals with the clinical application of treating patients with substance abuse. We have learned a lot more over the years in terms of how addiction affects individuals, the neurobiology, and how to screen patients and how to manage them over time, and I think a lot of that research has not been translated into a form where physicians can start to practice it in their everyday practice.

DR. MARY LEUCHARS:

How long is Addiction Medicine being considered a specialty?

DR. DANIEL ALFORD:

Its actually been a very slow process, but I would say its evolved overtime where I think there was a time when it wasn't even considered part of a physician's job, then it became up psychiatry domain where psychiatrists seemed to be the physicians, who were primarily responsible for taking care of this particular issue, but I think, it became recognized that most patients with addiction present to their primary care doctor initially for their high blood pressure or their diabetes care and often times are reluctant to go to a psychiatrist and there are plenty of psychiatrists, who are not particularly interested in treating addiction. They have other interests within the psychiatric field. So I think it evolved over time to become an issue that physicians should become more aware of and better able to diagnose and manage it.

DR. MARY LEUCHARS:

How did you personally become interested in this field of medicine?

DR. DANIEL ALFORD:

I think it was during my Internal Medicine Residency training where it quickly occurred to me that a lot of the medical diagnoses that I was managing both inpatient and outpatient were directly attributable to the patient's substance abuse whether it be alcohol or drug, and so it became apparent to me early on that if I did not start managing the patient's addiction that I was going to have a hard time managing their other comorbid conditions.

DR. MARY LEUCHARS:

And when you were undergraduate and a resident did you feel that you were taught enough about addiction medicine or did you feel that you had to learn it on the job?

DR. DANIEL OLFORD:

I felt the need to learn it on the job, and I think more and more people that I talked to expressed the same level of frustration and that is that they didn't get enough training in medical school or in residency training to prepare them adequately to manage addiction while they are seeing the patient.

DR. MARY LEUCHARS:

Dr. Alford, you published a study in the Journal of General Internal Medicine about the lack of training in our resident doctors in the area of addiction medicine. Can you talk about what results you found?

DR. DANIEL ALFORD:

Sure and actually I will take a little step back in terms of how we developed the training program as it now exists. It was through a grant from the National Institute on Drug Abuse. We submitted a proposal to basically institute a train that trainers' model of training physician trainers or educators, who then spread the word and train their trainee, but we created this program to train generalist chief resident and chief residents are residents, who stay on usually for an additional year of training because they were selected by their program, the residency program because of their high achievement, but also the fact that they are excellent educators and they stay on for that additional year because of the training to train other residents and medical students in a variety of topics and so we decided to target them because of the fact that they are respected individuals within their residency programs, but also that the fact that they are talented educators. We decided to bring them to this training program prior to starting their chief resident year to one teaching about kind of evidence-based addiction medicines, state of the art addiction medicine, and also how to become better educators and then when they go back to their residency program, they are equipped to start to train others, and it is not so much to give a lecture on you know alcohol dependence or on AA meetings and things like that, but there is more to do with immigrating it into their other teaching. So when they talk to somebody about cirrhosis or someone who comes in with some other complication from alcohol or drug use that they not only talk about that complication, but they take a moment or two to talk about the disease of alcohol dependence or opioid dependence or what have you and how to manage it and what are the kind of evidences for managing it.

DR. MARY LEUCHARS:

And you call it 'The Chief Resident Emergent Training Program." Over what period of time is this program run and how intensive is it for the doctors?

DR. DANIEL ALFORD:

Yeah, so its a 4-day draining and we do bring them all to one side that's away from their usual jobs actually in Cape COD Massachusetts where we immerse them in 4 straight days of this training and its amazing how quickly people get very comfortable in that environment in learning and not distracted at all from anything else and we do a lot of skilled practice, role playing, and I think very early on people started to recognize that its a safe environment to try new things out. Use teaching strategies, but also new skills around screening and counseling patients around their addiction.

DR. MARY LEUCHARS:

If you are just joining us, you are listening to the Clinician's Roundtable on ReachMD XM160, The Channel for Medical Professionals. I am your host, Dr. Mary Leuchars and joining me today is Dr. Daniel Alford and we are discussing Addiction Medicine Training in our young doctors.

Dr. Alford, when we are talking about Addiction Medicine and when you are teaching the resident doctors what are the broad areas of addiction that you focus on?

DR. DANIEL ALFORD:

There are multiple broad topics and it really focuses on the types of patient that residents are going to see and there is a lot of focus on the patient with addictions, who gets admitted to the hospital whether it be for any medical condition, but that they go for alcohol referral or even comorbidities of alcoholism or comorbidities of opioid or stimulant dependence and so we really try to pay attention to the adult learning principles of making sure that the material is relevant for the learners, but also relevant to the people that they are going to be training. For some of the contents deals with what we call addiction science, which is really the epidemiology, the neurobiology and genetics of addiction as well as the pharmacology of the substances that our patients abuse, but then spend a lot of time talking about

clinical practice, screening patients, and assessing them when we find that they screen positive for unhealthy alcohol or drug use and then ways to counsel through something that's called motivational interviewing or motivational enhancement therapy, which are really using patient standard approaches. We are getting patients that consider changing unhealthy behaviors. These strategies not only work for addiction, but they also work for getting patients to exercise more or to be more adherent with their medication. So, they are really generalizable skills that go beyond addiction. We spent a fair amount of time also talking about effective teaching strategy, and I think along with this content not being readily taught in medical school and residency training, there is also societal stigma around these topics and at times you can come up across reluctant learners, people who just aren't interested in this topic, they don't think it is important for them to learn and so we spent a fair amount of time teaching these chief residents how to teach resistant learners or reluctant learners and then a fair amount of time talking about how to incorporate it into residency curriculum because we also appreciate the residency curriculum is jam-packed and there usually isn't a bunch of open space for new material. So we work with the chief residents to think of creative ways of teaching, but also incorporating this into curriculum.

DR. MARY LEUCHARS:

Do you ever have any dialogue with the residents about the amount of time and lack of time they have to spend with patients on the wards to talk about these issues?

DR. DANIEL ALFORD:

Yes, that topic comes up quite often, and it turns out, if you do it in a systematic way that is if you screen patients using validated screening tools and you counsel them using the strategy, you end up spending less time and then your time is really more effective in terms of getting patients to change behavior and it takes a while to get our chief resident participants to realize that I think often times when we start doing role plays, they revert back to their old ways of asking these types of questions and that is about drug use and alcohol use and they ask a lot of questions that really don't give them valuable information that they can then use to counsel patients. So, by teaching them to do it in a distinct and an effective way, they definitely spend no more time and often times it is the less time than they normally would and they use a more effective strategy.

DR. MARY LEUCHARS:

Whats the best singular question you can ask a patient about their alcohol use or potential abuse when they are coming to hospital?

DR. DANIEL ALFORD:

That's a good question and there was a time when we were really promoting questionnaire called the Cage Questionnaire, which asked the patients about have they ever felt the need to cut down or if they have been annoyed with people talking to them about their drinking or they have felt guilty or needed an eye opener or drink early in the morning and you know that is 4 questions and it was hard to get doctors to agree to even ask 4 questions and so now the question that we ask is a single question, which is do people drink above kind of recommended daily amount or are they drinking safe limits because if people are binge drinking and drinking too much, the chances are they are probably also drinking more than they should on a weekly basis, which puts them at risk for medical complications from their alcohol consumption. I think from a drug standpoint, its a little harder to come up with one question because a lot of drugs that people abuse are prescription drugs and there are drugs that are prescribed for a specific reason and even if the medication is prescribed, some patients might misuse them that is take more than what is prescribed and it does not necessarily mean they have an addiction, but it could mean they have an addiction, that they have lost control of the medication, so I think its harder to get at drug abuse with one question and often times, takes multiple questions.

DR. MARY LEUCHARS:

Have you measured patient outcomes or patient satisfaction after you have implemented this training in the residents?

DR. DANIEL ALFORD:

No, we haven't and I think some of the criticism of the reviewers of our paper was not even that question, but a question of do we know if the trainees of these chief residents actually change their behavior and so we were able to show that yes, the chief residents learn and they go back and six months later they are doing more teaching and in their own clinical practice, they are doing more screening and counseling and so yes, we know that they are training other folks, but question is are those trainees then changing their behavior and then I guess one step further or beyond that are the patients actually getting different care and do they notice the difference and so that takes it to multiple levels and I think its a little tricky from our perspective only because we are training chief residents from programs around the country. Over the last 7 years of running this program, we have trained over 150 chief residents from 78 programs from 26 different states, so its a little hard to actually get patient level or even trainee level outcome, but I think it will be useful if there was funding to do that.

DR. MARY LEUCHARS:

Well, thanks so much for joining us today, Dr. Alford. We have been discussing Addiction Medicine Training in doctors.

I am Dr. Mary Leuchars and you have been listening to the Clinicians Roundtable on ReachMD XM 160, The Channel For Medical Professionals.

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