that there is much to be gained by learning from each other. For more information about the GME Initiative, and how one can join, contact Mannat Singh at mannat.singh@gmail.com.

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AFMRD Association of Family Medicine Residency Directors

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OPIOID PRESCRIBING: A GENERATIONAL PERSPECTIVE

As our nation grapples with an epidemic that fractures families and wreaks havoc in communities, an aspect of the opioid crisis often goes unspoken. How has this complex patient care dilemma affected family medicine education? Can there be a teachable moment in our past to improve our future? The AFMRD leadership shares 2 stories, one from a faculty physician teaching for over a decade and one from a resident physician in the middle of training.

Faculty Physician

Fresh out of residency in 2004, trained in the era of "pain is the fifth vital sign" and the upswell of OxyContin prescribing that began in the mid to late 90s, I felt overwhelmed by the number of my patients suffering from chronic pain and unprepared to help them. A woman with bipolar disorder had compartment syndrome in her right arm after a suicidal ingestion that left her unconscious in her car for 18 hours. The muscle atrophy and scars from fasciotomy were impressive, resulting in a combination of severe neuropathy and hyperalgesia that were impossible to heal, and it was with consultation that I prescribed her fentanyl patches and later methadone for pain. The guidelines at the time purported that patients receiving opioids for pain relief did not become addicted and that doses should be titrated to pain relief without a ceiling. Medicine has no pain-relieving options more immediately effective than opioids, and I remember the discomfort of first realizing I have the power to dispense or withhold them based on my own judgment of someone else's suffering, and first experiencing the anger and fear this can generate in patients. It is much clearer today than it was then, that a policy of unlimited dose escalation for chronic non-cancer pain is a recipe for dependence, addiction, overdose, potential diversion, and little to no benefit. The drawing of rigid lines, however, can disregard the situations where these powerful medications can provide significant improvements in function and quality of life. I see doctors coming out of training today, immersed in the crisis of opioid addiction, and fearful of offering even very small prescriptions of opioids or of taking on the challenge of connecting with patients who have been dependent on them for decades. The laws and regulations that now limit my prescribing are based on better science, and I try not to resent them as I fill out prior authorization paperwork to allow my patients access to pain medication when I believe they do need it. We are all constantly looking for that balance between compassion and caution, between guidelines and individualized medicine.

Resident Physician

She has a deep vein thrombosis (DVT). It is the first textbook DVT I have seen in my short career, but she won't go to the hospital. She is here today for her 50 MME of codeine and morphine. I have never met her before. She is angry at me because I don't want to prescribe her monthly prescription unless she goes to the hospital; I worry her narcotics are concealing her life-threatening pain. I feel helpless; I feel like a drug dealer. I do not feel that I am helping her and I don't know how to help her. The surge of frustration rises; I want to quit. I alternate rapidly between disgust and pity and confusion. The laws are mounting and the insurance coverage is tightening against my choices, but I have not started ANY of my patients on regular controlled substances. I am drowning in evidence against chronic opiates for these diagnoses but cannot follow any of the recommendations without losing these patients or putting them through withdrawal and suffering. I have walked into a trap of addiction and these patients will desperately and persistently strategize ways to maintain access to my prescribing habits. When I start my clinic day, I look up all new patients on the state controlled substance database. I scan for other acute pain complaints to make sure I am prepared for the demands of my opioid-seeking patients. I avoid starting new patients on these high-risk medications unless there is a very clear clinical need. I seek alternative therapies, though most patients cannot afford acupuncture, talk therapy, or topical analgesics. I set appropriate expectations for pain management, but this is not helpful for the patients I inherited. What I am lacking is the ability to safely treat opioid dependence. I don't know how to help them, so I sustain them.

Two stories, two generations, one emotion: frustration. As resident education moves forward, family medicine must be a part of the solution to this epidemic. Resident physicians are an untapped resource

in the opioid epidemic. They are desperate to get their patients off these substances and are driven to set boundaries with the patients they inherit, but they need the training. More family medicine residency programs are offering training in pain management and care of those addicted to opioids. More family physicians trained in buprenorphine prescribing, better access to behavioral health specialists, and an education of our population about reasonable pain management are needed. There are encouraging efforts by family physicians to promote legislation supporting these goals. In the meantime, we need to listen to our shared experiences and learn from them.

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From the North American Primary Care Research Group

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2018 PBRN CONFERENCE HIGHLIGHTS: ADDRESSING HEALTH DISPARITIES IN PBRN RESEARCH

The 2018 NAPCRG Practice-Based Research Network (PBRN) Conference brought together the energy of 160 participants from the United States, Canada, Haiti, and Australia in Bethesda, Maryland on June 25-26, 2018. The theme for this year's conference was "Addressing Health Disparities in PBRN Research." Conference co-chairs, Donald Nease, Jr and Denise Campbell-Scherer provided the welcome and orientation for this Agency for Healthcare Research & Quality (AHRQ)-sponsored conference.

Robert McNellis, MPH, PA, Senior Advisor for Primary Care at the AHRQ, highlighted AHRQ's Primary Care areas of interest and achievements of which several were produced by PBRNs.

Dayna Bowen Matthew, F. Palmer Weber Research Professor of Civil Liberties and Human Rights at the University of Virginia School of Law and author of *Just Medicine: A Cure for Racial Inequality in American Health Care,* delivered the first plenary on "Who and What We Study Affects Who and How We Heal," highlighting how filling the gaps in research participation and design could contribute to narrowing health disparities. Ms Matthew noted that research questions that impact the populations most burdened by disease and injury are not being asked. Although social determinants have been shown to have great impact on health outcome, researchers have not equipped primary care clinicians with the knowledge to confidently screen, much less prescribe treatment for the inequitable housing, educational attainment, food security, exposure to violence, and other social determinants that must be addressed to close health disparity gaps that persistently plague our nation.

The second plenary was delivered by Donna Manca, MD, MClSc, FCFP, Program Lead of The BETTER Program, entitled "A BETTER Way of Addressing Disparities in Primary Care Research." Dr Manca's presentation discussed how the BETTER program has developed an effective approach that bridges the "second valley of death" and positively impacts patient-level outcomes. Additionally, participants learned about the effective BETTER intervention to chronic disease prevention and screening, including how the intervention has been adapted to address chronic disease prevention and screening in various settings, including for those living in rural and in low-income neighborhoods.

The third plenary was given by Dedra Buchwald, MD, Director of the Initiative for Research and Education to Advance Community Health (IREACH), as well as the Founding Director of the Partnership for Native Health and the Washington State Twin Registry. Dr Buchwald offered an overview of 3 unique programs at Washington State University: (1) the new community-based medical school at Washington State University in Spokane; (2) the institutionally supported Initiative for Research and Education to Advance Community Health (IREACH), and (3) the Native Investigator Development Program. Dr Buchwald discussed how the medical school uses a geographically dispersed model of training and focuses on training physicians that will practice in rural and underserved areas of Washington State.

The 11-member PBRN Planning Committee reviewed 106 abstracts leading to 51 poster presentations, 9 workshops, and 40 oral presentations. Each submitter was asked to include a statement of why their research is relevant to clinical practice and patients. The 10 oral presentation tracks included PBRN Infrastructure, Network Operations, Practice Facilitation, Quality Improvement, Health Disparities, Chronic Care Management, Dissemination and Implementation, Behavioral Health, Community Engaged Research, and other clinical topics.

The planning committee allowed for substantial time to accommodate 9 workshops. The workshop topics covered a variety of topics, including: innovation, building a national primary care research infrastructure, measuring quality in primary care, and using community infrastructure to reduce health disparities, just to name a few.