VIEWPOINT

Responding to Unsafe Opioid Use: Abandon the Drug, Not the Patient

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Physicians have a legal and ethical duty to protect their patients and support them during times of clinical need; the decision to end a doctor-patient relationship should not be made lightly. However, in a recent survey of 794 primary care practices, 90% reported discharging patients in the previous two years, often for opioid-related issues.[1] Disruptive or inappropriate behavior was the most common reason for discharge (81%), but 78% reported dismissing patients for violations of a chronic pain or controlled substance agreement. We find this practice worrisome, particularly since many controlled substance agreements use coercive and stigmatizing language that patients may reluctantly sign or have trouble understanding.[2] Although violent, threatening, or disruptive behavior may be a valid reason to discharge patients in certain circumstances, opioid misuse should rarely rise to this threshold.

Surprisingly, prominent medical societies such as the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), and the American Academy of Pediatrics (AAP) remain largely silent on this issue. Only a now-expired ethics case study from the ACP touches upon opioid-related discharge practices.[3] And yet, the data suggest that providers often respond to patients with aberrant opioid use behaviors as if they were intentionally disrupting a medical practice rather than exhibiting an underlying pain or substance use problem.

This misunderstanding is likely indicative of the opioid knowledge gap and stigma surrounding opioid addiction that is so pervasive across the United States. According to a 2018 national survey, over 53 million people aged 12 or older used illicit drugs within the past year and nearly 10 million misused pain medications, so the impact of substance and opioid misuse and the importance of safe opioid prescribing cannot be overstated.[4] Additionally, as recently as the 2010's, medical schools were sorely lacking in their pain curricula, allotting a median of only nine teaching hours on pain and its management.[5] Furthermore, pain education modules are frequently bundled in with other core curricula and rarely addressed in full. A recent systematic review of pain education in medical schools across the world concluded that in the USA and the UK, 96% of medical schools had no compulsory dedicated teaching on pain medicine.[6] It is therefore unsurprising that physicians might feel ill-prepared to address opioid prescribing and misuse in an informed and ethical manner.

To address this challenge, we need to appreciate the differential diagnosis of aberrant drug use behaviors (ADUBs) and unexpected toxicology results. ADUBs take many forms ranging from early refill requests to prescription forgery and may be due to problems unrelated to addiction or drug diversion for material gain. For example, patients may fear inadequate analgesia from their current opioid regimen, particularly during pain flares. This can result in pill hoarding, exhausting medication supplies early, or using non-prescription sources of opioids to maintain pain relief or functional improvement. In these cases, urine drug testing may be unexpectedly negative for the prescribed drug or may show non-prescribed opioids used to self-medicate symptoms. Other patients may misuse opioids to cause intoxication, treat withdrawal, or alleviate mood symptoms. In these circumstances, ADUBs and unexpected toxicology results may represent an opioid use disorder (OUD) or psychiatric illness. Additionally, some patients may have concomitant pain and substance use disorders and display both pain-relief seeking and drug-seeking behaviors that can be challenging to distinguish. In any case, we believe these ADUBs represent inadequately treated pain, mood, or substance use disorders that require further evaluation and care, not dismissal from the practice.

As physicians, we would not discharge a patient for having any other inadequately treated condition. For example, we would not discharge a patient with diabetes, found to have profound glucosuria. Neither would we discharge a patient for

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exhibiting symptoms of a previously undiagnosed chronic medical disease, such as major depressive disorder. We do not reflexively discharge patients when they are non-adherent to their cholesterol medications. Nor do we dismiss patients for cigarette smoking or overeating when they do not follow our medical advice. Rather, we proceed with closer monitoring, improved care coordination, and potential referral to a subspecialist for enhanced treatment. In our opinion, patients struggling with safe opioid use should be treated no differently.

Understandably, it may seem justified to dismiss a patient when a physician feels betrayed; it can be difficult to stay objective when patients engage in dangerous drug use behaviors with little consideration for their own safety or the impact they may have on a medical practice. However, we believe that it is inappropriate and unethical to respond with threats of punitive measures, denial of care, and dismissal from the practice.[2] To be clear, we consider it appropriate to reevaluate the safety of opioid treatment and discontinue opioids when it becomes evident that the dangers of ongoing use outweigh their benefits. However, we assert that physicians should evaluate and terminate the care plan, not the patient. This is particularly important when previously undiagnosed addiction comes to light. In addition to death from inadvertent overdose, OUD is also associated with increased rates of HIV and hepatitis C as well as serious legal consequences and incarceration.[7] To dismiss a patient from the practice in the face of this untreated illness—absent violent or threatening behavior—is to abandon the patient in a time of severe need. The patient may decide to seek care elsewhere when faced with opioid therapy discontinuation or a new diagnosis of addiction, but this decision should come from the patient, not the provider.

Like chronic pain, addiction remains a highly stigmatized condition and patients may not be forthcoming with their concerns. Providers must resist retaliatory approaches to ADUBs. Instead, they should reflect on how addressing these behaviors provides an opportunity to strengthen the patient-provider relationship, facilitate reassessment of a treatment plan, and, ultimately, reduce the potential harm of a dangerous medication. Prescribers should become familiar with drug treatment programs in their community and consider becoming waivered to prescribe buprenorphine for OUD right in the office. Treating substance use disorders, which are estimated to afflict approximately 20 million persons age 12 or older in the past year,[4] is rapidly becoming a core element of primary care. Instead of retreating from patients with addiction, physicians can learn to diagnose and treat the disorder themselves.

In conclusion, we recommend the following. First, we urge primary care providers to resist the temptation to dismiss patients from their practice solely because of opioid misuse or addiction. Care plans may need to change. Prescribers may need to abandon the opioid, but they should not abandon the patient. Second, patients should not be dismissed from a practice because their underlying medical disorder is insufficiently treated or was previously undiagnosed. Patients must be empowered to discuss their pain, their opioid use, and their underlying mental health needs honestly and without concern for prejudice or reprisal. Third, we recommend that physicians educate themselves about safe opioid prescribing and addiction; there are many excellent courses available, including several outstanding opioid Risk Evaluation and Mitigation Strategy (REMS) programs and buprenorphine waiver training programs. Finally, we suggest that professional societies provide specific guidelines for physicians to navigate this common clinical and ethical quandary, and we call on the medical community to rise to the challenge.

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