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Cancer Care and the Opioid Crisis

Navigating Challenging Conversations About Nonmedical Opioid Use in the Context of Oncology

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Abstract

Opioids are commonly used in the context of oncology to treat cancer-related pain. In the context of increased awareness of nonmedical use of opioids, including misuse and opioid use disorder among individuals with cancer, oncologists may find themselves having difficult conversations with patients regarding the use of opioids. We offer a review of pertinent literature and a conversation framework for providers to use, as well as key communication strategies for clinicians. Building on the therapeutic alliance between provider and patient, emphasizing the importance of nonabandonment, and using a benefit-to-harm framework, we hope clinicians find they are more able to navigate these challenging but important conversations with patients. ***The Oncologist*** 2019;24:1299–1304

Implications for Practice: Providers may find it difficult and uncomfortable to discuss nonmedical use of opioids with patients. To the authors' knowledge, no previous articles discuss ways to communicate about nonmedical use of opioids in the oncology setting. This work borrows from other specialties and offers a communication framework and key communication strategies to help clinications communicate more effectively with patients who may have an opioid use disorder or may be using their prescribed opioids for reasons other than their pain.

Introduction

Oncology has made great strides in improving access to effective pain medication for individuals with cancer. Central to the treatment of cancer-related pain is the use of opioid medications [1]. Medical use of opioids has led to improvement in quality of life for patients, but opioids also have unintended consequences and significant potential adverse events including substance misuse and overdose. Oncologists now recognize that individuals with a serious illness are not immune to nonmedical opioid use and substance use disorders (SUDs) [2]. Confronting nonmedical opioid use is difficult, with studies demonstrating a lack of education and comfort surrounding the discussion and treatment of SUDs among palliative care providers [3, 4].

In this article, we describe how to explore symptoms and discuss decisions about opioid prescribing in the context of nonmedical opioid use. This is a term that describes a range of phenomena. It includes patients who use opioids to treat symptoms other than those for which they are prescribed, such as anxiety or insomnia, or taking opioids for the feeling or experience they produce. In some situations, oncologists may continue to prescribe opioids but with more discussions of limits and aggressive treatment of nonpain symptoms [5]. Signs of an opioid use disorder (OUD) include the four C's: loss of **c**ontrol over use, a **c**ompulsion to continue to use, **c**ravings for the substance, and use despite negative **c**onsequences [6]. Many patients with cancer have a degree of difficulty controlling their opioid use and may have a mild OUD in addition to cancer-related pain; other patients may have a more severe OUD, making it unsafe to prescribe opioids at all. In this article, we describe a framework for discussing all of these types of nonmedical opioid use. The overall communication principles (empathy, nonabandonment, expressing concern about the behavior, and setting limits) are the same across these discussions, regardless of prescribing decisions.

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Why Communication About Nonmedical Opioid Use Is Challenging

Existing research on communication about pain is prevalent in primary care and pain medicine [7–13], with relatively little focus specifically on individuals with substance use disorders and chronic pain receiving opioid therapy [14, 15]. Research on communication about opioid misuse is primarily limited to studies of chronic pain in primary care settings. When discussing nonmedical opioid use in the setting of cancer, the rationale for using opioids may be different, but the communication challenges are similar. These conversations are challenging for several reasons. Bringing up substance use is uncomfortable for many clinicians [3]. Substance use, particularly use of drugs like heroin, is highly stigmatized. Most physicians have not been trained in how to raise the issue of misuse or addiction and may not be aware that many SUDs are treatable, chronic diseases.

In addition, nonmedical opioid use may feel like a betrayal of the trust that is core to the provider-patient relationship, particularly when the patient is unable to be honest about their use. The clinician may ignore their own worries, not wanting to interfere with the provider-patient relationship and believing that doing so would jeopardize the patient's cancer treatment. This may lead to nonmedical opioid use increasing. The oncologist may withdraw from the relationship and simply refuse to prescribe any further. Patients in this situation may resort to doctor shopping or even buying opioids illicitly [16, 17].

These conversations often involve conflict. Conflict may develop when patients and their providers have different ideas about the nature of the individual's pain, how appropriate opioids are as a pain treatment, and whether there is a SUD present. As clinicians, we may need to convey clinical decisions that the patient may not be happy with. It is particularly difficult to have limit-setting conversations with patients who have a progressive disease and a limited lifespan.

Although challenging, integrating conversations about opioid misuse and OUD into routine oncologic practice is necessary and important. Individuals with SUDs are frequently marginalized by society and experience worse health outcomes than individuals without SUDs [18]. Open, nonjudgmental discussions surrounding substance use can normalize it and allow patients to receive appropriate treatment for a SUD if present or help patients manage their opioid use more effectively.

Below we offer a framework to guide oncologists through difficult conversations regarding nonmedical opioid use. First, we describe the spirit of the conversation, including the development of the therapeutic alliance and maintaining a stance of nonabandonment. Second, we describe communicating decisions about opioid prescribing using a benefit-to-harm framework—balancing the potential harms of opioids, including the risks of OUD, with the benefits of opioids for pain and function. Next, we apply these principles to two case examples of an interaction between patient and provider and give specific language to use. Finally, we close with a discussion on the importance of reflecting on challenging conversations and the reactions that these conversations may elicit.

The Spirit of the Conversation

The core of any provider-patient interaction is the relationship between the two individuals. This relationship is referred to as the therapeutic alliance. The empathic bond between provider and patient has long been the focus of psychotherapy literature but has only more recently been studied within oncology [19]. The therapeutic alliance is based on shared goals, mutual understanding, caring, trust, respect, acknowledgment of the patient as a person, honesty, and competency [18]. In the context of an individual with cancer who also has a SUD, part of developing a strong therapeutic alliance is the recognition by the provider that SUDs are illnesses and substance misuse is often a source of suffering.

In addition to the cultivation of the therapeutic alliance, understanding and applying the principle of nonabandonment is essential to providing good care. Nonabandonment was initially defined as "open-ended, long-term, caring commitment to joint problem solving" by Drs. Quill and Cassel [20], and subsequent empirical findings about nonabandonment in individuals with life-threatening diagnoses found that nonabandonment consisted of actionable components [21, 22]. These components include providing continuity and facilitating closure of a therapeutic relationship. For oncologists communicating about nonmedical opioid use or SUDs with their seriously ill patients, nonabandonment means a continued decision to care for an individual despite problematic opioid use. The patient will not be "fired" for nonmedical opioid use; although opioid prescribing may no longer be offered, the commitment to treat cancer and associated symptoms (through safer means) remains.

Together, nonabandonment and the formation of a therapeutic alliance form the bedrock for successful provider-patient interactions surrounding opioid misuse. To foster that alliance, providers must be ready to overcome stigma, particularly regarding the use of illicit drugs. Stigma serves to reduce a person from someone who is whole and holds many different aspects and identities to a singular "discredited" part [23]. Stigma can exist at many levels: at a societal level, at an interpersonal level (between provider and patient), and internalized within an individual [24]. Stigma is closely connected to the language we use when speaking about SUDs. Frequently the terms "abuser," "addict," "drug seeking," "narcotic," and "dirty" are used to describe people with a SUD or to denote the presence of unprescribed medications or illicit substances in a urine sample [25]. Abuse is a highly charged term, associated frequently with rape, domestic violence, and child molestation [26]. When communicating with patients who use drugs as well as documenting drug use, it is important to use person-first language: We describe a "patient with an opioid use disorder" rather than a "drug user," just as we would describe our patient as a "patient with pancreatic cancer" rather than a "cancerous person." Using appropriate language to talk about SUDs signals to the individual that they are valued by the provider and not stigmatized further. It serves to elevate SUDs from a moral failing to what they are, chronic diseases with biological, social, and environmental underpinnings, much like other serious illnesses that we treat [27].

A Benefit-to-Harm Framework for Opioid Prescribing

Challenging provider-patient relationships where opioids are prescribed often fall into one of two paradigms. In the first, the physician-patient discussion is a negotiation in which the patient "bargains" for a higher dose and the physician negotiates for something else, leaving both patient and doctor feeling uncomfortable. In the second, the physician acts like a law enforcer. The patient signs a "contract" at the beginning of prescribing, and if he or she violates the contract, it is "voided" and the patient is "punished" by stopping opioid therapy. We propose instead that oncologists view and communicate prescribing decisions with a benefit-to-harm framework, first suggested by Nicolaides [28]. Just as with decisions about whether to administer cancer therapies, where oncologists balance benefits with potential toxicities, the prescriber of opioids balances the benefit to the patient in terms of pain control with the risks of opioids, including addiction, overdose, and side effects.

To use the benefit-to-harm framework, it is important for prescribers to understand that addiction is itself a disease. Having an active addiction is not a pleasant experience, even when there is access to the substance. Individuals with a severe SUD may experience their disease as a cycle of withdrawal, craving, and dangerous consequences that can cause chaos in their life and in the lives of those in their family [29]. The risks and benefits will be weighed differently in each patient encounter. For cancer survivors or those with a longer prognosis, the risk of continued pain treatment with opioids may be high in the setting of unsafe opioid use. For other patients, such as some with a history of opioid use disorder, pain due to progressive cancer, and a short prognosis, the benefits of using opioids to address pain may outweigh the risks. There are clear risks in providing opioids to an individual who is actively using substances. In these cases, some of the most difficult discussions a provider will have will be communicating the decision to taper the opioids.

Key Communication Strategies

The following strategies, based on our clinical experience and existing research on patients' experiences of these conversations, will help prescribers discuss nonmedical opioid use in a way that maintains the therapeutic alliance between provider and patient, and decrease the stigma of discussing substance use.

Validate the Patient's Pain and Experience of Suffering

The physician should explore the patient's physical and mental suffering, regardless of whether substance misuse is present. During the entire conversation, the physician returns to empathic statements, such as "I know you are in pain." The provider also expresses understanding that emotional suffering often lies beneath nonmedical use of opioids and explores the patient's coping and life circumstances.

Ask Directly About Nonmedical Use and Substance Use Disorders

When there is concern about nonmedical use, providers should not be afraid to ask directly about nonmedical use or the use of nonprescribed opioids. This should be phrased as a neutral, nonjudgmental question, rather than a question that assumes a certain answer (i.e., "Have you ever used heroin?" rather than "You haven't ever used heroin, have you?"). This reduces the stigma associated with nonmedical use and brings it out into the open. If a patient is at high risk for substance misuse or has a history of a SUD, prescribers should ask directly, one by one, about specific substances such as heroin and whether patients have bought pills illicitly or taken pills from friends or family. For patients who have a history of an acknowledged SUD (in the past or present), prescribers should ask directly about their experiences with treatment (such as methadone or buprenorphine clinics and 12-step groups) and length of sobriety.

Express Concern for Harms Associated with Nonmedical Use of Opioids

In an initial discussion about prescribing opioids, prescribers should make it clear that there are risks associated with opioids and that their use will be monitored carefully. This is particularly true for patients with a history of a SUD or who are otherwise at high risk for opioid misuse. When there are signs of nonmedical use of opioids in a patient who is currently receiving opioid therapy, prescribers should present what they are seeing nonjudgmentally and describe why it makes them concerned. Concerning signs may include requests for early refills, lost or stolen prescriptions, or urine drug screens that include nonprescribed substances. Patients presented with information from urine drug screens may deny its validity and offer excuses. It is usually not helpful to attempt to explain why results could not be false positives. Instead, prescribers should directly name their concern. For patients who are using prescribed opioids to treat symptoms other than pain, the provider might state that they are worried that the patient is using their medications for reasons other than the symptom for which it is prescribed. This discussion should include the risks of such use, including overdose. If the physician is worried about addiction, naming it explicitly and describing it as a disease is important.

Set Clear Limits

The provider should be clear regarding instances when they will not prescribe opioids. This may include stating that opioid prescriptions will not be filled early or that use of illicit substances will prompt the provider to no longer prescribe opioids at that time. Limits may need to be set repeatedly in a single conversation and in multiple conversations. It is usually not helpful to negotiate or explain the reasoning behind the decision repeatedly if the patient attempts to negotiate; the physician should recognize repeated questioning of their decision as more expressions of emotion than requests for information.

Express Commitment to Ongoing Treatment

In the spirit of nonabandonment, it is important to explicitly name that the provider will continue to care for the patient, even if the individual uses illicit substances or has difficulty controlling their opioid use. This includes offering ongoing cancer treatment, as well as pain treatment, which may or may not involve opioid medications. When consistent aberrant behavior leads to the provider being concerned about a SUD,

Table 1. Specific skills and phrases for discussing nonmedical opioid use

Skill	Sample phrases
Validate the patient's pain and suffering	"I can't imagine what this all must feel like. You have been through a lot." "I know you have pain."
Ask directly about nonmedical use and substance use	"Have you ever taken your medication for reasons other than pain?" "Have you ever taken medications that were not prescribed to you?" "Have you been using heroin?"
Express concern for the harms of nonmedical use or substance use	"With your history (of addiction in the past), we have to be careful about prescribing opoids." "I'm worried that the way you're taking your pills is dangerous to you." "I'm concerned that, in addition to the cancer, you have another problem, which is addiction."
Set clear limits	"If you run out of your medication early, we will not be able to give you a refill and you may feel sick without it." "Given what I'm seeing, I can't continue to safely prescribe oxycodone for you at this time."
Express commitment to ongoing treatment	"This doesn't mean I will stop caring for you or welcoming you into our clinic" "We can use medications other than opioids to treat your pain." "I want to help treat this problem. I have colleagues who treat addiction, and if you are willing, I would like to refer you for an evaluation"

addiction treatment options should be offered, in conjunction with other nonopioid modalities. Oncologists who have connections with a multidisciplinary team, which can offer behavioral health and addiction treatment, can express that they will actively help connect the patient with these resources.

Table 1 illustrates these skills and some common phrases.

Below we illustrate the principles above in two different types of conversations about nonmedical opioid use. In the first case, the physician understands that the patient has been overusing her opioids and suspects that she is taking them to self-medicate symptoms other than pain. Dr. M enters the conversation intending to explore the patient's use, assess for a potential SUD, offer alternatives to treat the patient's distress, and set limits on prescribing opioids in order to keep the patient safe from harm.

Case 1

Ms. J is a patient with metastatic non-small cell lung cancer receiving treatment. The oncologist, Dr. M, has noticed that Ms. J has twice run out of her oxycodone early and called in after-hours asking for refills. A routine urine drug screen was positive only for the oxycodone she was prescribed. She has no prior history of SUDs; she does have an anxiety disorder as well as pain due to metastases in her ribs.

Dr. M: I notice that you ran out of your prescription early again this month. Tell me about what's going on with your pain.

Ms. J: I just hurt all over. The oxys are the only thing that makes it better. They just take the edge off.

Dr. M: It sounds like you feel like your pain is not under good control, and we want to work on that. I'm wondering, though, do you ever take the oxycodone for anything else other than pain, like to calm you down or help you sleep?

Ms. J: It's all just so overwhelming! Sometimes I just want to take a pill and forget everything.

Dr. M: Yes, cancer is overwhelming for a lot of my patients. You are dealing with a lot. It's understandable that you'd want to get away from it all sometimes.

Ms. J: Yes! I just don't know what's going to happen.

Dr. M: That's frightening, not knowing what is going is happen. I want to make sure we talk about that during this visit, but for right now, is it OK if I ask you some other questions about how you are using your medication and other things? I want to make sure that you are safe and that we have the right treatment for you.

Ms. J: Yes.

Dr. M: Do you ever use any street drugs, like heroin or cocaine?

Ms. J: No, I've never touched any of that stuff.

Dr. M: What about buying pills?

Ms. J: No.

Dr. M: Have you ever gotten pills from friends or family members?

Ms. J: No.

Dr. M: OK. Do you ever use alcohol to help you deal with some of the anxiety and overwhelmed feelings?

Ms. J: No, I'm not really a drinker.

Dr. M: OK, thanks for sharing that with me. It's important that we're able to talk honestly about how you're using your medications and any other substances. I am committed to treating your pain and will work with you on finding other ways to help. At the same time, I'm worried that you are taking your oxycodone for reasons other than pain. Sometimes when people do that it can be harmful and lead to accidentally taking too much. Would you be willing to talk to me and other members of our team here about other ways to manage those feelings you are having about your cancer?

Ms. J: Absolutely—I simply want to feel better than I'm feeling now.

Dr. M: I do have to let you know that we can only give you a certain amount of oxycodone every 2 weeks. I want you to take no more than four pills a day. If you run out of the medication early, we won't be able to give you a refill.

This scenario is common in oncology. Approximately 20% of individuals with cancer use prescribed opioids for symptoms other than pain [30]. In this example, the provider explored the patient's suffering, asked directly about substance use, and continued to show her concern for the patient and offer treatment for the anxiety the patient was experiencing, while setting clear limits to decrease the likelihood that the patient will take more of her opioids than prescribed in the future.

Case 2

Mr. S is a patient with head and neck cancer. Mr. S has been erratic in his clinic attendance, often missing chemotherapy sessions and then appearing at the clinic when he does not

have an appointment to ask for more pain medication. On his last visit, the oncologist ordered a urine drug screen, which was positive for a heroin metabolite. On this visit, Dr. X has decided he can no longer prescribe opioids for Mr. S, as the concern for his worsening addiction outweighs the benefit of opioid therapy for pain.

Mr. S: You must do something about this pain; the medication isn't working. I can barely feel an effect from the oxycodone. Can't you prescribe something stronger? I can't deal with this!
Dr. X: What I hear is you are worried about being in uncontrolled pain, and you feel like you are not being heard.
Mr. S: Yes, that's true; I don't feel like you are taking me seriously. This is real pain!
Dr. X: I absolutely want to your help your pain. And at the same time, I'm seeing some signs that worry me, that you are running into a problem with opioids and they are causing you more harm than good.
Mr. S: What are you talking about?
Dr. X: Your urine drug screen showed a chemical related to heroin. That makes me worry that you might be having another problem in addition to the cancer—you might be developing a problem with addiction. I know you worked hard to beat heroin in the past, and you don't want to go back there.
Mr. S: I did…
Dr. X: Tell me what's going on with the heroin use these days.
Mr. S: I just need a little to take the edge off sometimes. Just when I run out.
Dr. X: What do you think about it?
Mr. S: It's not a problem for me. If you would just give me a little more oxy, I wouldn't need it.
Dr. X: I hear that you feel like pain is the primary reason you are using the heroin. I want to help you with your pain. With the heroin use, we can't use oxycodone anymore. What we can do is help you get into treatment for addiction and use other types of medication that are safer to treat your pain.

This conflict between Mr. S's views of his use and Dr. X's concerns will not be easy to resolve. It's unlikely that Mr. S will leave this visit happy. However, Dr. X, despite the difficulty of discussing a clinical decision that the patient is not happy with, maintains his commitment to continue treating Mr. S, including assisting with referral to addiction treatment. This is one of the more difficult conversations that a prescriber can have with a patient—and one of the most important. Mr. S may not accept Dr. X's views of his opioid use now, but with continued feedback from Dr. X and other physicians, he may eventually enter addiction treatment and be able to address both his addiction and his cancer.

After the Encounter: Reflecting on the Conversation

Returning to Case 2

At the end of the discussion with Mr. S, the patient leaves the exam room, angry, but grudgingly says he will investigate the resources Dr. X has provided. Dr. X 's heart is racing and he feels on edge. He wonders if he did the right thing—will Mr. S continue his cancer treatment if Dr. X doesn't prescribe him any further opioids? And yet he would have been profoundly uncomfortable continuing to prescribe oxycodone for a patient who is using heroin. It feels like there was no good answer. This feeling continued to bother Dr. X once he left the clinic.

Providing care for individuals with comorbid SUDs and navigating conversations regarding nonmedical use of opioids frequently requires time, patience, and a willingness to have difficult discussions often without an immediate resolution. Providers may feel anxious, alone in caring for the patient, or even a sense of dread when thinking about future interactions. It is important to first recognize that challenging patient encounters bring up a wide range of reactions and emotions and that experiencing these emotional reactions is normal. As one begins to recognize the feelings that are elicited by the interaction, one can begin to cultivate self-awareness. Self-awareness as described by Novack et al. is the "insight into how one's life experiences and emotional make-up affect one's interactions with patients, families, and other professionals" [31]. Developing self-awareness has been identified to reduce burnout and compassion fatigue. Finally, to sustain oneself in caring for individuals who have a SUD, it is often necessary to find supports within one's community. This may mean debriefing sessions after difficult cases, partnering with a colleague in addiction medicine or psychiatry to talk through cases, or creating a more formal process where providers can share the challenges and rewards of caring for patients with SUDs.

Conclusion

Navigating difficult conversations surrounding opioid misuse is challenging but also provides an opportunity to extend care to patients often marginalized by medicine. Open discussion of nonmedical opioid use is a needed part of oncologic care in the current climate of the opioid epidemic and serves to raise awareness of the suffering of individuals with SUDs as well as those misusing opioids. By thinking broadly about the provider-patient relationship, identifying stigma, using a benefit-to-harm framework, practicing specific skills, and finally returning to reflect on difficult conversations and acknowledge the need to care for oneself, we hope that providers will feel more comfortable having these challenging conversations.

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