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Nurturing a Caring Connection in an Opioid Epidemic

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Abstract

The current national opioid crisis poses challenges to the physician–patient relationship. This vignette describes a patient scenario which served as a personal reminder of how the physicians caring role must remain the highest priority while trying to address prescribing concerns.

Keywords

clinician–patient relationship, relationships in health care, pain management, medications/adherence, trust

"Her urine drug screen was positive for cocaine—I knew it!" the nurse exclaimed. "I knew she was playing us. Now we can finally cutoff her narcotic prescriptions." A small group of staff gathered around to hear the story. When I got a little closer, I heard someone mention D., one of my long time patients with opiate-dependent chronic neck pain. I soon realized that it was D. whom all the fuss was about.

D. has had a difficult life. She grew up in a poor suburban neighborhood with both parents jailed at various times for drug offenses. She somehow managed to get through nursing school on scholarship, but her career was derailed when she was involved in a motor vehicle accident which left her with debilitating neck and back injuries. A single mother of 2 young children, she has survived on a small income from part-time home health nursing work and public assistance. Now in her early 30s, she seems to be in a steady equilibrium, trying to get by and make the most she can of her life.

D. and I have a nice relationship that has evolved over the last few years, and I enjoy her visits. I have met her children, and we have had many discussions about her life and its challenges. She reliably shows up for her appointments and adheres to the rules of our opiate monitoring program where we closely track appropriate timing of medication refills and require regular urine drug testing. In addition to pain management, D. is treated medically for hypertension and sees our psychologist for stress issues and anxiety.

I was caught off guard and very concerned by the positive urine cocaine screen. I felt myself begin to question D.'s honesty, but I would have to give her the benefit of the doubt and hear her story without judgment. Why? Because I am her physician.

The opioid epidemic is real, and greater awareness of the risks and often tragic consequences of opioid addiction has certainly made me seek alternatives whenever possible and work harder to wean some of my opioid-dependent patients. The media fervor around this issue, however, can sometimes tempt me and our staff to turn against our patients. "Let's just send them all to Pain Management!" is a common desperate plea. Unfortunately, many of our patients have insurance or other logistical challenges to seeing a pain management consultant. The pain consultant is a valuable partner but may not have a relationship or connection with these patients that is years in the making, which may limit their ability to fully appreciate the greater context of patients' opioid use. Pain is often entwined with other medical and life challenges and cannot be as easily delegated to a specialist as say, a skin lesion. The primary care clinician's role in caring for these patients is foundational.

Even in cases when patients have inarguably transgressed and broken our rules, we are still, at the core, a team of caring professionals. In some cases, we may be the only people in these patients' lives to whom the word "caring" can be ascribed at all. What would happen if I just abruptly stopped prescribing D.'s pain medication with only a simple

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explanation like, "you broke the contract"? I fear that this would further destabilize her already fragile life, damage her confidence in physicians, and even tempt her to recede further into the substance abuse underworld.

This is not to say that I ignore the urine findings. D. deserves an empathic conversation and a chance to explain what happened. I hope that the connection we have developed will help her feel safe disclosing any struggles which have led her to use cocaine and accept any support our practice can offer. I will tell her that I cannot continue to prescribe controlled medication if she continues to use other illicit drugs, but the message will be delivered with compassion, optimism, and hope that she will get back on track. As a physician leader, I also need to acknowledge the difficulty of the support staff role, model this nonjudgmental approach, and inspire my care team to imagine life in her shoes before making conclusions. Role play, or even inviting some of my staff to join me in the exam room (with D.'s permission) is nonpunitive way to engage constructively in this effort.

The current opioid crisis is complex and exists at least in part because of irresponsible prescribing. But while we learn from past mistakes, we cannot misconstrue this as anything but an epidemic of the illness of addiction. As physicians and care teams, we are not here to scold, punish, or avoid the ill. We must care for them.

Author Biography

Jeffrey H Millstein is a practicing internal medicine physician. In his leadership role, he is a provider coach and organizational champion for patient experience and communication skills development.