lack street knowledge on issues such as child custody, employment options for felons, and the rules around subsidized housing; that is why you surround yourself with peer experts in group therapy. And yes, starting a recovery program will require leadership to overcome the inertia of your staff and colleagues, because you innately know that everyone must be on board to do the work well.

No one is better qualified to treat addiction than a family doctor. We know that substance use disorder—of all diseases—cannot be cured by drugs alone. We believe that hearing the story and nurturing a relationship are indispensable modalities of treatment. We are willing to become what our patients require: their weekly dose of parental affection, the arbiters of fairness and accountability, a buttress against their flagging self-esteem, the partner who hears more than their anger, or a compass for those without purpose or direction.

Let us be the standard-bearers for a community-based response to the opioid epidemic. While there is a critical need for informed public health policy, our work is on the ground. There are no signposts here, only patients alongside us. No one expects us to fix the problem, least of all the patients we treat. Our challenge is to "be there" for them, acknowledge their struggle, and maintain what is still, too often, a narrow, uncertain, and unmarked path toward recovery.

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**POINT/COUNTERPOINT**

# Medication-Assisted Treatment Should Be Part of Every Family Physician's Practice: No

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The magnitude and tragedy of the national opioid epidemic has prompted The Office of National Drug Control Policy and the US Department of Health and Human Services to prioritize increasing access to medication-assisted treatment.[1,2] The Drug Addiction Treatment Act of 2000[3] enables physicians who complete an 8-hour online course to prescribe schedule III, IV, and V opiates, including buprenorphine/buprenorphine naloxone (B/BN) for opioid use disorders in settings other than outpatient treatment centers such as methadone maintenance clinics. Despite the potential for great expansion, use of B/BN remains limited.[4-6] The need to expand the reach of medication-assisted treatment across the country has led many policy makers, academics, and some physicians to suggest that primary care physicians be at the front lines of this effort. While the number and geographic distribution of primary care physicians makes them likely candidates to deliver the care, there are a number of other factors that make this a poor decision for both primary care physicians and patients.

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## SPECIALIZED TREATMENT REQUIRED

Patients requiring B/BN have likely exhausted or failed at all other forms of nonmaintenance treatment inter-

ventions including abstinence efforts and Alcoholics Anonymous/Narcotics Anonymous/sponsors, other nonagonist pharmacotherapies, addiction counseling, intensive outpatient treatment, partial hospitalization, residential programs, and other forms of rehabilitation, perhaps even court-ordered treatment with mandatory accountability and urine toxicology screenings. The opioid-dependent patient population being considered for buprenorphine treatment in primary care settings therefore represents a more severe and treatment-resistant population that requires specialist intervention. Just as primary care doctors will routinely treat mild to moderate forms of diabetes and hypertension but will refer the more severely ill patients to endocrinologists or nephrologists for expert consultation and treatment, so too should opiate-dependent patients requiring maintenance with agonists/mixed agonist-antagonists be referred to or seen by specialists in addiction medicine or addiction psychiatry—and not in a primary setting by generalists, or registered nurses with little training on addiction and the use of buprenorphine.

## COMORBID PSYCHIATRIC ILLNESS

Further complicating the care of many opioid-addicted patients is the fact that they are much more likely than the general population to suffer from comorbid psychiatric disorders. In one study[7] it was estimated that co-occurring disorders were quite common: mood disorders (40% to 42%), anxiety disorders (24% to 27%), posttraumatic stress disorder (24% to 27%), severe mental illnesses (16% to 21%), antisocial personality disorder (18% to 20%), and borderline personality disorder (17% to 18%).[4] Treating dually diagnosed patients is clinically challenging and requires a greater level of clinical expertise than is required to treat a single one. Treating the substance dependence and the psychiatric illness concurrently and not sequentially has been shown to result in better outcomes.[8] This requires a clinical skill set that is acquired through extensive training and experience with this population. Most primary care physicians do not have experience using integrated treatment with the dually diagnosed population and clinicians with this skill set will be difficult to find. Although a more highly trained team of registered nurses and other physician extenders might be put in place to perform the bulk of clinical work with patients while primary care physicians conduct physical exams and write prescriptions for the controlled meds, it remains to be seen how many primary care physicians will find this role comfortable or acceptable for their level of training in addiction medicine. While primary care physicians routinely use physician extenders to help with patient care in other chronic disease states such as hypertension and diabetes, the highly trained and experienced primary care physician remains the most knowledgeable and capable member of the health care team. This would not be the case for the primary care physician role in the treatment of opioid use disorders in primary care.

## METHODS SHORTCOMINGS

Research from emerging models of care suffer methodological shortcomings that make results difficult to interpret for primary care implementation.[9]

- The studies are short-term (ie, 12 weeks to 6 months). Given the remitting-relapsing but chronic nature of substance dependence, and studies showing high rates of relapse with discontinuation of B/BN treatment,[10] longer studies are needed to gauge the longitudinal value of a given model/intervention.
- The studies lack generalizability. One study looking at the effect of counseling on outcomes after 12 or 24 weeks for those treated with buprenorphine excluded patients who "were psychotic, suicidal, or otherwise psychiatrically unstable," and further characterized the study population as "largely employed, well educated, (having) relatively brief opioid use histories, and little other current substance use".[11]
- Urine collected for toxicology screens must be observed to avoid adulteration. Studies in the reviewed literature either use unobserved urine collection or do not specify how this critical test of treatment efficacy was performed.

## BURNOUT RISK

Primary care physicians risk more job dissatisfaction and burnout if asked to add medication-assisted treatment to their practices. Providers are already overworked and don't need another major initiative to further divide their attention from their current caregiving roles. A recent national survey of physicians found that 46% reported some burnout, 38% had a positive depression screen, and a similar number felt their work schedule prevented a good work-life balance.[12] Family medicine was 4th on a list of burned-out physician specialties. Adding another responsibility to the primary care physician's plate is risky, but adding the care of this very complicated time-intensive population would seem to be asking for more physician burnout and may not result in the favorable outcomes we all desire for this most vulnerable patient population.

Chemical dependency is a relapsing and remitting illness that is often aptly referred to as "baffling, cunning, and powerful." Even if further research establishes an "optimal" model of care for use in primary care, the

nature of the disease itself will place undue clinical burden on an already overextended clinical workforce. Perhaps future efforts and funding should be directed toward the development of readily accessible referral networks of mental health/addiction centers, both public and private. Such centers should be staffed with psychiatrists, addiction specialists, and other clinicians and caregivers experienced and skilled in treating substance dependence and psychiatric disease and could offer services to a patient population in desperate need of immediate, appropriate, and specialized care.

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