REFLECTION

Denial: The Greatest Barrier to the Opioid Epidemic

Nicole Gastala, MD

Primary Health Care, Inc, Marshalltown, Iowa

ABSTRACT

"Why can't you be like my old doctor?" This essay explores my experiences as a new family physician in a rural town endemic with liberal opioid prescribing practices and opioid addiction. I detail my inner turmoil while overcoming resistance to change, the influence of these experiences on my professional growth, and my decision to offer medication-assisted treatment.

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Mrs Smith sat anxiously on the exam table avoiding eye contact as I introduced myself and shook her hand. I understood how delicately I needed to proceed. Mrs Smith was addicted to opioids. She had been prescribed opioids following a surgical procedure and quickly began to rely on the medication for other complaints. What medications she could not steal from her mother, a chronic pain patient, she purchased illegally. We had discussed her years of abuse and her reasons for wanting treatment—loss of income, regaining control of her life, and poor relations with family due to theft and episodes of intoxication. Her feelings of embarrassment, isolation, guilt, and failure were tangible as she told her story. We discussed why she had not quit sooner and the fear and desperation in her voice was undeniable, "I was in denial for the longest time, then once I admitted I was addicted I could not go through withdrawal and function, I have tried and failed."

Denial, isolation, and failure. How could I not relate to Mrs Smith? These are emotions I had faced as I had tried to find my path amidst the opioid crisis that had overcome our country and my community. As a member of the National Health Service Corps I was eager to practice at a Federally Qualified Health Center in a small rural town. The clinic I had chosen was my dream position—with a forward-thinking administration and serving an underserved population. I was not prepared, however, for the reality of what many rural and community physicians face on a day-to-day basis: an overwhelming population addicted to illicit and prescribed opioid medications.

As the new doctor in town, despite a clinic-wide chronic pain program including pain agreements, random urine drug screens, opioid and non-opioid management, my schedule was bombarded with old and new patients seeking controlled substances. Several undeniably had pain, others were dependent or addicted to opioids, and unfortunately, some were at risk for obtaining or purchasing opioids illegally. The underlying question I heard several times per day, every day, never changed, "Why can't you be like my old doctor?" Under most other circumstances, patients are enthusiastic about new advances in medicine; when the discussion involves opioids and risks, however, the tone of the visit can turn bleak. I cited the statistics—drug overdose is the leading cause of accidental death in the United States, an epidemic killing 129 people every day. We discussed the risks and side effects of opioids, yet the response I received was, more often than not, denial and anger. Denial that opioids are a problem, denial that an accidental overdose is a possibility, and an indifference to

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CORRESPONDING AUTHOR

Nicole Gastala, MD
Primary Health Care, Inc
412 E Church St
Marshalltown, IA 50158
reizinee@gmail.com

the harmful side effects. Anger that I would adjust or change their treatment regimen to include non-opioid therapies. These patient encounters felt like a negotiation in futility. Within 3 months, I was facing burnout, feeling disillusioned as I combated an inner war between best practice and trying to meet the wants of my patients.

These intensifying feelings of self-doubt and frustration climaxed in a distinct moment of weakness. I was standing outside of a patient's room mentally preparing for the upcoming discussion of her pain medication regimen after an inconsistent drug screen. I was 40 minutes behind in the middle of a 12-hour clinic shift and I knew this was going to be an intense and time-consuming clinic visit. There was a sick feeling in the pit of my stomach, a feeling that had been occurring more frequently on a daily basis, and I wondered how I had gotten to this point. Difficult discussions are common in medicine, but not discussions in which the physician is made to consistently feel the villain. I started questioning whether the inevitable confrontation and conflict was worth it. Should I just sign another prescription? There would be no denial, no anger, no questioning of clinical judgement, and no conflict if I just said yes. I realized, however, that acquiescing would create 2 problems: it would potentiate the denial that this patient had an addiction, and would eventually place the prescribing burden on another physician. I suddenly saw the source of my frustration and self-doubt: I lacked the experience and tools to treat this overwhelming and dangerous health condition.

A colleague of mine noted my despair and invited me to a meeting at the Substance Abuse Treatment Unit of Central Iowa (SATUCI). The director of SATUCI expressed a need for a physician in our community to offer medication-assisted treatment (MAT), in particular buprenorphine and naltrexone for those addicted to opioids. I realized I could learn how to treat opioid addiction through MAT and at that moment felt the sick feeling in my stomach dissipate for the first time in months. Opioid addiction treatment with the combination of MAT and therapy has a 60% success rate and a 12% success rate with therapy alone. In our rural community, we had very limited resources and there were no MAT providers within a 60-mile radius. Without access to medication assisted treatment, patients had little incentive to self-identify as having an opioid use disorder. The fear and discomfort of withdrawal in addition to the social stigma associated with addiction was a barrier that could not be overcome without changing the way we as a clinic approached this disorder. I realized we could provide a treatment option to help stabilize those who were found to have addiction through our chronic pain program or self-identified as being addicted to opioids while they undergo addiction counseling and therapy. Following MAT training and initiation of our program, my role transformed from villain to coach as we became a key component to our patients' treatment of addiction. As we developed our program and began enrolling patients for treatment, we began to heal our patients and our community.

Mrs Smith's story was not unique; a significant amount of the opioid addiction in our community began following a prolonged prescription of opioids. Patients within our clinic began coming forward expressing their desire to be free of the destruction that follows the wake of addiction. Following the demand we had in our clinic, we wanted to expand the program to all patients in the community. We received a federal Health Resources and Services Administration (HRSA) MAT community expansion grant; however, acceptance by the local medical community proved difficult. Some providers denied opioid addiction as a problem and declined information on the program. One clinic manager stated their clinic had had 1 patient in the past 20 years with an opioid addiction. I was in shock and disbelief. After discussion with community leaders, we came to 2 possible scenarios: either patients were not being screened for addiction or there was a lack of awareness by clinicians. Many clinics have a low addiction-screening rate due to the pressure on physicians to increase productivity and patient satisfaction. Responsible opioid prescribing with random urine drug screens and pain agreements opens a door to conflict that practices may choose not to undertake. Lastly, that moment of weakness where I had contemplated avoiding the discussion and signing a script is a daily struggle for many physicians.

Whether the reasons are productivity, patient satisfaction, avoidance of confrontation or lack of resources, this professional and community self-denial is as dangerous as the epidemic itself. As family physicians, if we are not recognizing addiction and recommending appropriate treatment, we will not be doing our part to curtail the opioid and heroin crisis, and, even worse, we will contribute to the opioid epidemic. On our path toward change, it is imperative that we acknowledge many of the barriers that affect our fellow physicians. What support do we have for our solo or small practice physicians who rely on patient interaction and feedback for the survival of their practice and their own professional satisfaction? Who coaches these physicians and supports them before and after an aggressive patient encounter? Who exposes primary care physicians to the prospect and feasibility of becoming a medication-assisted treatment provider?

Chronic opioid dependence and addiction has permeated all socioeconomic and geographical levels of our society. Despite the statistics, public health announcements, and litany of celebrities who die of an overdose—denial is still the predominant response. Denial is the single largest threat in addressing the opioid epidemic—denial by patients, denial by physicians, denial by families, denial by communities, and denial through lack of access to MAT treatment. I chose not to deny the opioid epidemic, and the lack of resources and training led to burnout. The decision to provide my patients and community access to MAT led to my professional healing. In the community, our clinic created a culture of recognition of opioid addiction, openness to challenge current prescribing habits and encouragement of treatment of opioid addiction. I implore our profession to develop a similar culture and network of support for physicians to engage in when they are compared with "my old doctor."

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