Family Physicians and the Humanizing of Opioid Use Disorder Management

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Our patient arrives to clinic for a prenatal appointment. We go through all the usual review of systems, update her medication list, and discuss labor precautions. Her fundal height is appropriate for gestational age, as are fetal heart tones. Now she's quiet, visibly shifting from relaxed to guarded. Years of stigma and shame have reinforced the armored demeanor she dons as we move to the next, inevitable conversation.

The methadone clinic has her on a split dose that she picks up every day, and she's staying on top of this daily routine despite barriers to transportation and the rigor of raising her young child at home. Hands fidgeting in her lap, we discuss any other substances she's been taking recently. Slowly, she begins to unravel the story she has kept so tightly wrapped up inside. She's been using fentanyl again, she doesn't know why because she's not craving it like she used to, but every time she tries to cut back she feels the panic of withdrawal creeping up on her.

It's late in the third trimester and labor is looming before her. What will happen if her urine is positive for more than methadone when she delivers? She loves her children in that deep, visceral way that only a parent can understand. She desperately wants to bring her baby home with her from the hospital, which is why she's coming to our clinic today, to our addiction medicine physicians.

At East Pierce Family Medicine in Puyallup, Washington, our clinic and residency program are fortunate to have an addiction medicine fellowship within our walls. These providers precept us in our continuity clinic as well as in our outpatient Substance Treatment and Recovery Training (START) clinic, where pregnant and postpartum women can receive obstetric care incorporating management of substance use disorders in order to give both mothers and babies their best chance for healthy outcomes. Our addiction medicine team is also consulted in the hospital for patients of all ages and demographics with substance use disorders requiring management beyond the scope of most inpatient providers, and their influence on Labor and Delivery has grown exponentially since the recent opening of our inpatient START unit for pregnant patients requiring more intensive care for substance use disorders than can be provided in the outpatient setting. Working with this team has certainly been a privilege – not only for the learning experience, but for the insights into how integral addiction medicine is in meeting our community's needs and the impact that family physicians trained in this field can have.

Substance use disorders take many forms, though perhaps the most infamous in recent years is opioid use disorder (OUD). OUD and its sequelae can affect patients from all walks of life, from newborns with neonatal opioid withdrawal to geriatric patients with years of OUD weighing on them, and every age and situation between. As a specialty that prides itself on providing healthcare from "womb to tomb", it seems only natural that family physicians should be on the forefront of managing OUD in our communities, particularly as morbidity and mortality from opioids continue to escalate.[4,20,20]

From Miracle to Epidemic

According to the CDC there were 68,630 opioid overdose deaths in 2020, which accounted for 74.8% of overdose deaths from all drugs.[4] How did OUD escalate to this level of crisis?

Opium (and its derivative products) has been used for millennia in myriad cultures around the world for a variety of purposes including pain relief, other medicinal functions, religious rituals, and recreation.[2,9,19] The oldest recorded use of opium was recently discovered in an ancient burial site in Israel, where traces of opium were detected in pottery buried with the body approximately 3,400 years ago.[2] Prior to the 1800s the options for effective pain relief were extremely limited, thus the search for any potent analgesic was almost desperate in nature.[9,17,19] This pursuit yielded the derivation of morphine from the opium poppy by 1805 and its use rapidly accelerated with the invention of hypodermic syringes in the 1850s.[1,5,14]

Within a few decades morphine was ubiquitous within American society and the effects of chronic use and dependence began to manifest.[1,9,19] Diacetylmorphine was created in 1874 and eventually named heroin in 1898 when Bayer started marketing it as a more potent yet less-addictive alternative to morphine.[1,9] This echoes the chorus of Purdue Pharma in the 1990s with development of controlled-release oxycodone in 1995 and subsequent advertisement of OxyContin as a new pain management option with lower abuse potential due to its longer onset/duration of action.[8,9,17,21,23]

Over the past three decades the landscape of the opioid epidemic has shifted significantly. With increasing number and accessibility of opioids, mortality from prescription opioids skyrocketed in the 1990s and became the leading cause of opioid overdose deaths.[4,17] As the exponential increase in prescription opioid misuse (particularly OxyContin) prompted reforms to opioid marketing and prescribing, deaths from heroin overdoses increased in the 2010s as deaths from prescription opioids plateaued.[4] However, both were overtaken by fentanyl and other synthetic opioids which have continued to dominate opioid overdose deaths since 2015.[4,20] In the current (early 2020s) phase of the opioid epidemic, illicit fentanyl remains the main culprit in overdose

deaths, and the widespread street market sale of illicit fentanyl mixed with other substances increasingly complicates the dangers of modern drug use.[4,20]

Person or Pariah?

Opioid use is not new; however, the level of devastation OUD has caused and its recognition as a medical condition (as opposed to a lack of moral fiber) is a relatively recent phenomenon.[3,9,19,22] As mentioned above, opioids were widely accepted in many societies globally for millennia and were a mainstay of American medicine in the 1800s.[1,9,19] The view of opioids in the United States shifted from healthcare panacea to dangerous substance in the late 1800s and early 1900s.[1,9,19,22] This reshaping of public opinion was only in part fueled by the wave of opioid addiction that morphine and heroin created; xenophobia towards Chinese immigrants and colonial expansion into areas of the world with robust opium trades also spurred America's overwhelmingly white political structure to target not just morphine and heroin but all forms of opium.[19]

The view that opioid dependence was due to poor character, in addition to the racist connotations of drug prohibition, laid the foundation for how OUD would be addressed in the 1900s and the present day.[3,7,13,19] Criminalization of drug use has been shown to disproportionately impact communities of color while these same communities tend to have more limited access to healthcare resources for the treatment of substance use disorders.[3,7,13] There is also a classist component of recognizing OUD as a disease as opposed to a personal failing, with one study showing that people with OUD in the working-class are viewed more harshly than people with OUD in middle- and upper- classes.[19,24]

Over time, many within the medical community and nation at large have begun to view OUD as a chronic condition requiring medical treatment.[3,7,9,17,22] This may be in part due to recognition of the large role our healthcare system played in accelerating opioid use.[3,9,17,23] It is no small irony that physicians who overprescribed opioids while treating pain as the "fifth vital sign" in the 1990s are now tasked with prescribing suboxone and managing the long-term complications of OUD.[3,9,15,23] It has also been noted that the majority of people with OUD in the United States are white, which may help explain why opioid use has had an easier time being accepted as a medical condition than crack cocaine or other substances that have historically been associated with communities of color.[3,7,13,19]

Even with this shift in medical standards of practice, treating OUD has many logistical barriers and the effects of criminalization loom large over our society.[3,7,13,22,25] These barriers, in the setting of more than a century of social stigma, can make it difficult for patients with OUD to seek out and receive the treatment they need to maintain a healthy and stable life. For example, the patient described at the opening of this essay wanted to be admitted to the inpatient START unit for methadone dose stabilization prior to delivery, but she had no one to care for her young child at home while she would be in the hospital, so admission would be untenable. She also feared that entering the START unit would essentially be an admission of illicit opioid use that would trigger serious repercussions in her relationships with family and friends. As family physicians it is our duty to help patients overcome these barriers as best we can. To do this, we need to see more than the disorder – we need to see their pain, their trauma, their struggles, and most importantly their inherent value and humanity.

Next Steps

It is inspiring as a resident to see the extent of what family physicians are doing in addiction medicine. As demonstrated above, we have physicians providing obstetric care while managing OUD, and when this patient delivers it will be our family medicine residents managing the routine newborn care in addition to any neonatal opioid withdrawal. Meanwhile, we may have a post-surgical inpatient with OUD that our family medicine inpatient team is consulting on for pain management, or any number of possible presentations of OUD requiring our care.

While most family physicians may not pursue an addiction medicine fellowship and career specializing in this field, there are many ways that those without fellowship training can incorporate addiction medicine into their practice. There may be some providers who shy away from addiction medicine in any capacity, who fear the complications (both medically and socially) that can accompany substance use disorders. However, the need for provision of this care in our country is obvious, and if we refuse to treat substance use disorders then we will ultimately end up treating the sequelae. Additionally, there is national momentum to emphasize the management of substance use disorders in family medicine, as evidenced by the American Academy of Family Physicians (AAFP) publishing guidelines for incorporating addiction medicine into family medicine residency curricula, as well as creating continuing medical education (CME) opportunities that are available for purchase on their website.[11,16]

The AAFP has also recognized that any medical practice must be viewed through the lens of trauma-informed care and with the use of destigmatizing language, and has published statements and training materials on these topics.[6,10,12,16,18] Though both of these concepts are becoming catchphrases in medicine, the power of our words and perceptions can truly impact a patient's engagement with their medical care.[10,12,18,25] As part of this effort, in July 2022 the Resident 3 Reference Committee passed a resolution calling on the AAFP to "submit recommended

curriculum guidelines for family medicine residents for training in trauma-informed care to the Accreditation Council for Graduate Medical Education for consideration and guidance for programs on implementation for the existing program requirement for education in trauma-informed care".[6,12]

These are (hopefully) just the first steps in mainstreaming addiction medicine within our specialty. Family physicians are positioned to play a critical role in managing OUD in the coming years and, with the support of the AAFP and myriad other addiction medicine resources available today, we have the necessary tools to do so. Whether we step up to this challenge or let it fall to the wayside may be the subject of another resident's essay a decade or two from now, so let's make our family medicine history a success worth writing about.

References:

1. As morphine turns 200 drug that blocks its side effects reveals new secrets. UChicago Medicine. https://www.uchicagomedicine.org/forefront/news/as-morphine-turns-200-drug-that-blocks-its-side-effects-reveals-new-secrets. Published May 19, 2005. Accessed October 11, 2022.
2. Berg R. Earliest evidence of opium use found in burial site in Israel. *BBC News*. https://www.bbc.com/news/world-middle-east-62930429. Published September 20, 2022. Accessed October 11, 2022.
3. Bridges KM. Race, pregnancy, and the opioid epidemic: white privilege and the criminalization of opioid use during pregnancy. *Harvard Law Review*. 2020;133:770-851. https://harvardlawreview.org/wp-content/uploads/2020/01/770-851_Online.pdf. Accessed October 11, 2022.

4. Death Rate Maps & Graphs. Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/deaths/index.html. Published June 2, 2022. Accessed October 11, 2022.
5. Farmilo CG, Rhodes HLJ, Hart HRL, Taylor H. Detection of Morphine in Papaver setigerum DC. *United Nations Office on Drugs and Crime*. January 1953:26-31. https://www.unodc.org/unodc/en/data-and-analysis/bulletin/bulletin_1953-01-01_1_page005.html. Accessed October 11, 2022.
6. Gonzales A, Hazle M, Pareek R, Wakabayashi M. National Conference of Family Medicine Residents and Medical Students July 28-30, 2022 – Kansas City, MO. AAFP. https://www.aafp.org/dam/AAFP/documents/events/nc/congress/2022/restricted/Resident%203.pdf. Published 2022. Accessed October 11, 2022.
7. James K, Jordan A. The Opioid Crisis in Black Communities. J Law Med Ethics. 2018 Jun;46(2):404-421. doi: 10.1177/1073110518782949. PMID: 30146996.
8. Moradi M, Esmaeili S, Shoar S, Safari S. Use of oxycodone in pain management. Anesth Pain Med. 2012 Spring;1(4):262-4. doi: 10.5812/aapm.4529. Epub 2012 Apr 1. PMID: 24904812; PMCID: PMC4018705.
9. The origin and causes of the opioid epidemic. Georgetown Behavioral Health Institute. https://www.georgetownbehavioral.com/blog/origin-and-causes-of-opioid-epidemic. Published August 14, 2018. Accessed October 11, 2022.
10. Ravi A. Providing Trauma-Informed Care. *American Family Physician*. 2017;95(10):655-657. https://www.aafp.org/pubs/afp/issues/2017/0515/p655.html. Accessed October 11, 2022.

11. Recommended Curriculum Guidelines for Family Medicine Residents: Substance Use Disorders. AAFP. https://www.aafp.org/dam/AAFP/documents/medical_education_residency/program_directors/Reprint277_Substance.pdf. Published 2021. Accessed October 11, 2022.
12. Residents seek trauma-informed care, street medicine training. AAFP. https://www.aafp.org/news/education-professional-development/2022-nc-resident-congress.html. Published August 11, 2022. Accessed October 11, 2022.
13. Rosenberg A, Groves AK, Blankenship KM. Comparing Black and White Drug Offenders: Implications for Racial Disparities in Criminal Justice and Reentry Policy and Programming. J Drug Issues. 2017;47(1):132-142. doi: 10.1177/0022042616678614. Epub 2016 Dec 21. PMID: 28966392; PMCID: PMC5614457.
14. The story of syringes. National Museums Scotland. https://www.nms.ac.uk/explore-our-collections/stories/science-and-technology/syringes/#:~:text=Scottish%20doctor%20Alexander%20Wood%20is,Francis%20Rynd%2C%20to%20a%20plunger. Accessed October 11, 2022.
15. Scher C, Meador L, Van Cleave JH, Reid MC. Moving Beyond Pain as the Fifth Vital Sign and Patient Satisfaction Scores to Improve Pain Care in the 21st Century. Pain Manag Nurs. 2018 Apr;19(2):125-129. doi: 10.1016/j.pmn.2017.10.010. Epub 2017 Dec 15. PMID: 29249620; PMCID: PMC5878703.
16. Substance use disorders. AAFP. https://www.aafp.org/cme/all/substance-use-disorders.html. Published October 4, 2021. Accessed October 11, 2022.
17. Timeline of Selected FDA Activities and Significant Events Addressing Opioid Misuse and Abuse. U.S. Food and Drug Administration. https://www.fda.gov/drugs/information-

drug-class/timeline-selected-fda-activities-and-significant-events-addressing-opioid-misuse-and-abuse. Published October 4, 2022. Accessed October 11, 2022.

18. Trauma-informed care. AAFP. https://www.aafp.org/about/policies/all/trauma-informed-care.html#:~:text=Trauma-informed%20care%20(TIC),that%20is%20inherently%20patient-centered. Published December 13, 2021. Accessed October 11, 2022.
19. Trickey E. Inside the story of America's 19th-century opiate addiction. Smithsonian.com. https://www.smithsonianmag.com/history/inside-story-americas-19th-century-opiate-addiction-180967673/. Published January 4, 2018. Accessed October 11, 2022.
20. Understanding drug overdoses and deaths. Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/epidemic/index.html. Published February 14, 2022. Accessed October 11, 2022.
21. Van Zee A. The promotion and marketing of oxycontin: commercial triumph, public health tragedy. Am J Public Health. 2009 Feb;99(2):221-7. doi: 10.2105/AJPH.2007.131714. Epub 2008 Sep 17. PMID: 18799767; PMCID: PMC2622774.
22. Werle N, Zedillo E. We can't go cold turkey: Why suppressing drug markets endangers society. *Journal of Law, Medicine & Ethics*. 2018;46(2):325-342. doi:10.1177/1073110518782942
23. What is the U.S. opioid epidemic? HHS.gov. https://www.hhs.gov/opioids/about-the-epidemic/index.html. Published October 27, 2021. Accessed October 11, 2022.

24. Wood E, Elliott M. Opioid Addiction Stigma: The Intersection of Race, Social Class, and Gender. Subst Use Misuse. 2020;55(5):818-827. doi: 10.1080/10826084.2019.1703750. Epub 2019 Dec 23. PMID: 31868067.
25. Zwick J, Appleseth H, Arndt S. Stigma: how it affects the substance use disorder patient. Subst Abuse Treat Prev Policy. 2020 Jul 27;15(1):50. doi: 10.1186/s13011-020-00288-0. PMID: 32718328; PMCID: PMC7385978.