Caring for Ms. L. — Overcoming My Fear of Treating Opioid Use Disorder

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Ms. L. always showed up 10 minutes early for her appointments, even though I always ran late. Her granddaughter would rest her cheek against Ms. L.'s chest, squishing one eye shut, and scroll through Ms. L.'s phone while they waited. After reviewing her blood sugars, which Ms. L. recorded assiduously in a dog-eared blue diary, we'd talk about smoking cessation. That was a work in progress. "There's just nothing like a cigarette," she'd sigh. "Don't you ever start," she'd admonish her granddaughter, kissing the top of her head.

One day, I knew something was wrong the moment I opened the door. Ms. L. was alone. Sweat dotted her lip and forehead. She closed her eyes and looked away, and tears fell onto her lap. "I need help," she whispered, and it all came out: she had taken a few of the oxycodone pills prescribed for her husband after a leg injury, then a few more from a friend. And like a swimmer pulled into the undertow, she was dragged back into the cold, dark brine of addiction. I tried to hide my shock. I'd known she was in recovery from opioid use disorder (OUD), but it had simply never come up. She hadn't used in decades.

"No one can know that I relapsed," she said. "If my kids find out, they won't let me see my granddaughter." She wanted to try buprenorphine and was frustrated to hear that I could not prescribe it. "Why not?" Annoyed, she rocked in her chair. "I just want to feel normal again, and I know you. I don't want to tell anyone else."

I evaded her question: "I don't have the right kind of license to prescribe it," I said. "Let me refer you to a colleague."

But my incomplete answer gnawed at me. In truth, the reason I didn't have a waiver to prescribe buprenorphine was that I didn't want one. As a new primary care physician, I spent every evening finishing notes and preparing for the next day. Every Friday I left the office utterly depleted, devoid of the energy or motivation it would take to spend a weekend clicking through the required online training.

But more than not wanting to take on the extra work of prescribing a medication for OUD, I did not want to deal with patients who needed it. I knew that for some people with substance use disorders, the relationship with the drug can eclipse all other relationships, leading them to push away family, friends, and caregivers. I had witnessed patients waiting for prescriptions antagonize secretaries and nurses, seen patients try to manipulate toxicology screenings, and heard voices raised in exasperation at colleagues through thin clinic walls. Addiction, according to the American Society of Addiction Medicine, "is characterized by . . . impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response."[1] Already overwhelmed, I did not want to take on patients with needs that I did not know how to meet.

One of my colleagues started Ms. L. on buprenorphine treatment. When I saw her again for her diabetes, a space had opened between us. Then she didn't show up to her next appointment. I called her and sent a letter, but she didn't show up to the next one either. Months passed, and then a year.

The night I found out that Ms. L. had died of an overdose, a heavy, wet snow was falling throughout the city, dampening the sound of traffic. In the quiet,

I was clicking through the usual computer screens, preparing for clinic in the morning. I saw Ms. L.'s name and stopped. I read the text twice, three times, and then again: "brought in by ambulance . . . unable to revive her." At first I felt horror and revulsion at the thought of her lifeless body on a gurney. Then, profound sadness. I thought about her husband, her children, and especially her granddaughter. I wondered how silent their house must be that snowy night, without Ms. L.'s brassy laugh floating through the hallways.

But it was the shame that kept me awake, listening to the plows pass through the streets. This shame didn't just burn red and hot in my face — it burrowed thick and leaden into my chest and stomach. What if I had treated her myself, instead of referring her? I don't flatter myself that I could have provided her better care — I had complete confidence in my colleague. But Ms. L. and I had had a relationship. She had trusted me. And I'd turned her away.

In the ensuing months, I earned my waiver to prescribe buprenorphine. I still harbored apprehensions about caring for patients with addiction, but I also knew that I could not turn away another Ms. L. I now care for a small panel of patients with OUD. It has not been easy, and I could not provide this care without the support of colleagues with expertise in addiction and social work. I quickly grasped the pharmacology of buprenorphine therapy, but learning how to manage other aspects of addiction care, particularly for patients in early recovery, has been formidable.

One patient, Ms. J., has coexisting alcohol use disorder, chronic pain, and severe anxiety. I have practiced harm reduction for years — maximizing oral therapies in a patient with diabetes who declines to take insulin, for example. But navigating the gray shades of harm reduction in caring for Ms. J., who uses alcohol on an almost daily basis and takes several sedating psychiatric medications in addition to buprenorphine, is an entirely new calculus for me.

Beyond these difficult therapeutic questions, many of my patients with OUD have complex social needs. Before Ms. J., I had never cared for a patient whose visitation rights with her children were predicated on her continuing therapy with me. A few of my patients have had difficulties following clinic guidelines; implementing behavior contracts had not previously been a common part of my practice, and learning how to use them with kindness and respect remains challenging.

Colleagues with years of experience managing substance use often advocate: "Everyone should get waivered. OUD is a chronic disease just like any other — when a patient comes in with hypertension, you don't say, 'Oh, I don't treat that.'" This comparison does not capture the whole picture. Of course OUD is a chronic disease and should be managed in primary care as such. But it's also true that patients with addiction often have acute psychosocial needs. OUD can utterly shatter a life; I have never seen hypertension have such an effect. If we do not recognize, name, and talk about the social issues that must be addressed when caring for patients with OUD, we do a disservice to both patients and caregivers and create a significant barrier to more providers getting waivers. I know, because I was one of them. Everyone in primary care should get a waiver, but that is not enough. We must also advocate for team-based behavioral health and social work resources in every primary care setting to support patients and providers in managing all aspects of OUD, just as we have developed team-based protocols for managing hypertension.

Caring for these patients has become the most meaningful part of my practice. Ms. J., who has tested my clinical judgment almost weekly, has also inspired me with her persistence and courage through a grueling recovery. Buprenorphine has allowed her to feel "normal" — at least most days — and to focus on her sons. Providing some sense of normalcy for patients whose lives are roiled by overdose and estrangement is the most profound therapeutic intervention I've engaged in as a caregiver. I did not know what Ms. L. meant all those years ago when she said that she only wished to feel normal again. I wish that I'd listened more closely. I wish that I had not been afraid.

Patients' initials and identifying characteristics have been changed to protect their privacy.

Disclosure forms provided by the author are available at NEJM.org.

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1. Definition of addiction. Rockville, MD: American Society of Addiction Medicine, April 19, 2011 (https://www.asam.org/resources/definition-of-addiction).

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