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Misconceptions in Addiction Medicine

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Hunched, with his hands on his knees, rubbing his sweaty hands together anxiously, he sat staring at the ground. He was pleasant and answering my questions appropriately, but I knew something was off. Proceeding with the conversation, I asked the typical questions of any MAT visit follow up: Are you using your medications as prescribed? Is your current dosage still effective? How are your behavior health visits going? How, in general, are you feeling?

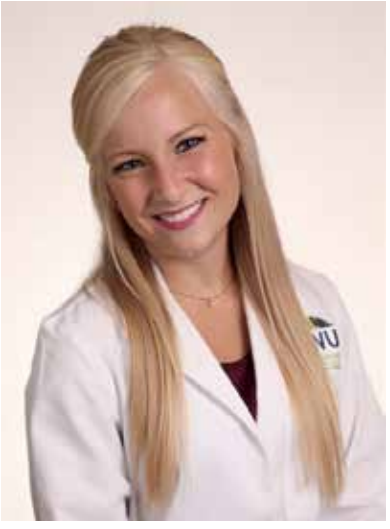
When I asked the last question, he looked up, locked eyes with me, and replied, "I've been extremely anxious this week and haven't been sleeping." After a brief pause, he continued, "I have been so stressed because at my last MAT visit, I forgot to report that I started taking my gabapentin again and I know I'm supposed to report all the medications I am taking. I am so sorry, please, please don't kick me out of the program. I have been so worried about it this whole week!"

John has been a patient of the community MAT (Medication-Assisted Treatment) program for almost two years. This was my first visit with him on my Family Medicine rotation and during my encounter I was shocked at how distraught and fearful he was of losing access to his Suboxone treatment. To us, as providers, gabapentin is more or less a medication we would rather see patients with chronic pain taking than any of the alternative options. Furthermore, we would never scrutinize a patient for taking this medication if they believed it helped. However, John didn't know this, he just saw his failure to report as a potential catastrophe to his finally, normal life.

As I learned more about John, I was saddened to discover he was another victim of medical negligence, suffering the consequences of the opioid crisis that has plagued our society. Several years ago, John suffered a traumatic amputation of the digits on his left hand after a snow blowing accident. Partial re-attachment of the second and third phalanges was successful, however he still suffered from terrible phantom pain. After the surgery he was prescribed Oxycontin. As he came to the end of his prescription, he was left high and dry; still suffering significant pain but without a means of relief, leaving him with no choice but to turn to the streets for pain management. He self-medicated with mostly heroin which was the cheapest at the time. His addiction cost him his job, his wife, and custody of his daughter. It is a tragic story of addiction, but John has grit. He knew he couldn't fight the cravings he had, but something had to be done. That's when he found the MAT clinic.

I'm embarrassed to admit, prior to this rotation I was biased. "Opioid addiction...they know it's wrong, it's ruining their life, why can't they stop? Suboxone treatment – aren't they just exchanging one addiction for another?" I was naïve. However, I think it's safe to assume that many medical students and even physicians are naïve in their knowledge surrounding this topic. It wasn't discussed in my medical school courses and if that's true across the board, then this is a fault that should be changed across the country.

About a month ago, I attended a talk on addiction medicine, specifically Suboxone treatment. During this talk, I had a moment of enlightenment and also a feeling of sheer guilt. The speaker



made a phenomenal reference that I feel is necessary to share.

First of all, we have to understand what constitutes addiction. The American Psychiatric Association describes addiction as "a complex condition, a brain disease that is manifested by compulsive substance use despite harmful consequence". The key here is "…brain disease". Initial introduction of an addictive substance and continued use cause changes in the brain's wiring leading to intense cravings and make it hard to stop despite negative consequences. Therefore, addiction is a *disease*. That's a hard, cold fact. Then why is it so difficult for us to treat it like one?

When attending this talk, the speaker compared Suboxone to albuterol - polar opposites you would think, but the further he broke down this comparison the clearer the world of addiction treatment became. Here's the scenario – you have two patients: one is a teenage female complaining of breathing issues, and the other is a teenage

male complaining of heroin use. Your female patient reports, "Doctor, I have difficulty breathing every time I try to run or exercise. I hate it. It's keeping me from being able to participate in sports with friends and I feel left out!" Easy – you prescribe her an albuterol inhaler and tell her to take a few puffs before she exerts herself. Your male patient reports, "Doctor, I tried heroin several months ago with some friends. I know I shouldn't have done it and it was supposed to be a one-time thing, but now I can't stop using or thinking about using. I've even started stealing money from my parents to buy more and the school is threatening to expel me!" Easy – you prescribe Suboxone and instruct him to take his prescribed dose daily. Both patients return a month later. You ask your female patient how she feels, "I'm great Doctor, I take a couple puffs before I exercise, and I feel *normal*." You ask your male patient how he feels, "I'm great Doctor, I haven't used in a month, yet I feel *normal*."

You succeeded as a physician, you helped both of the patients with their disease. But here's the mind-boggler, would you ever make your asthmatic patient stop taking their albuterol? Are they suddenly just going to cure themselves one day? Probably not. Then why is there implicit bias present when a patient is on chronic Suboxone therapy? Why is the culture to wean them off a substance, for a chronic disease, that makes them feel *normal*? Did they too just cure themselves overnight? You wouldn't take albuterol away from an asthmatic so why take Suboxone away from an addict? Seems simple when you spell it out this way, but like I said before, I wrongly thought Suboxone was indeed just exchanging one addiction for another.

Suboxone is a combination medication of buprenorphine and naloxone. Buprenorphine is a partial agonist at opioid receptors, which means it causes lower activation as well as binds tighter and longer than true opioids themselves. As the dose increases, its analgesic effects reach a plateau and it starts to act as an antagonist. Therefore, buprenorphine does not produce the same *high* and it is much harder to overdose on than your typical opioids. Additionally, due to its tight binding affinity, if a user was to take another form of an opioid medication on top of their Suboxone dose, no high would occur. The second ingredient, naloxone, is a full opioid antagonist, it binds to opioid receptors and blocks them from being activated. It, however, is inactivated in the gut and instead is an added ingredient to keep users from misusing Suboxone via snorting or injecting. For a provider to prescribe such medication, a Drug Addiction Treatment Act (DATA) wavier is required which is accomplished by completing an eight-hour continuing education class. Overall, this medication is a great option for long term treatment of opioid addiction. It provides minimal abuse as well as overdose potential coupled with enough activating action to prevent withdrawal and cravings.

"My views on addiction and chronic Suboxone treatment have been forever changed and I, without a doubt, plan to attain my DATA waiver to help patients like John."

Back to John. Seeing the pleading in his eyes when he begged me not to kick him out of the MAT clinic solidified for me the true impact this medication can have on a patient's life. In fact, John was now head mechanic at the local auto shop and had full custody of his thriving, five-year-old daughter. A simple guy with a medical disease, taking a daily treatment, that makes him function like his normal self is a medical success, wouldn't you say?

My views on addiction and chronic Suboxone treatment have been forever changed and I, without a doubt, plan to attain my DATA waiver to help patients like John. As family physicians, we are first line in this ongoing war against opioid abuse. We have an opportunity to make a tremendous difference in many lives; I urge everyone to put aside any bias they might have, educate themselves, and take time to obtain a prescribing waiver. Together, let's spread more *normalcy*.