

Ethical Considerations in the Care of Hospitalized Patients with Opioid Use and Injection Drug Use Disorders

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“Lord have mercy on me, was the kneeling drunkard’s plea.”
—Johnny Cash

The Diagnostic and Statistical Manual of the American Psychiatric Association defines opioid-use disorder (OUD) as a problematic pattern of prescription and/or illicit opioid medication use leading to clinically significant impairment or distress.¹ Compared with their non-OUD counterparts, patients with OUD have poorer overall health and worse health service outcomes, including higher rates of morbidity, mortality, HIV and HCV transmission, and 30-day readmissions.² With the rate of fatal overdoses from opioids at crisis levels, leading scientific and professional organizations have declared OUD to be a public health emergency in the United States.³

The opioid epidemic affects hospitalists through the rising incidence of hospitalization, not only as a result of OUD’s indirect complications, but also its direct effects of intoxication and withdrawal.⁴ In caring for patients with OUD, hospitalists are often presented with many ethical dilemmas. Whether the dilemma involves timing and circumstances of discharge or the permission to leave the hospital floor, they often involve elements of mutual mistrust. In qualitative ethnographic studies, patients with OUD report not trusting that the medical staff will take their concerns of inadequately treated pain and other needs seriously. Providers may mistrust the patient’s report of pain and withhold treatment for OUD for nonclinical reasons.⁵ Here, we examine two ethical dilemmas specific to OUD in hospitalized patients. Our aim in describing these dilemmas is to help hospitalists recognize that targeting issues of mistrust may assist them to deliver better care to hospitalized patients with OUD.

DISCHARGING HOSPITALIZED PATIENTS WITH OUD

In the inpatient setting, ethical dilemmas surrounding discharge are common among people who inject drugs (PWID).

These patients have disproportionately high rates of soft tissue and systemic infections, such as endocarditis and osteomyelitis, and subsequently often require long-term, outpatient parenteral antibiotic therapy (OPAT).⁶ From both the clinical and ethical perspectives, discharging PWID requiring OPAT to an unsupervised setting or continuing inpatient hospitalization to prevent a potential adverse event are equally imperfect solutions.

These patients may be clinically stable, suitable for discharge, and prefer to be discharged, but the practitioner’s concerns regarding untoward complications frequently override the patient’s wishes. Valid reasons for this exercise of what could be considered soft-paternalism are considered when physicians unilaterally decide what is best for patients, including refusal of community agencies to provide OPAT to PWID, inadequate social support and/or health literacy to administer the therapy, or varying degrees of homelessness that can affect timely follow-up. However, surveys of both hospitalists and infectious disease specialists also indicate that they may avoid discharge because of concerns the PWID will tamper with the intravenous (IV) catheter to inject drugs.⁷ This reluctance to discharge otherwise socially and medically suitable patients increases length of stay,⁷ decreases patient satisfaction, and could lead to misuse of limited hospital resources.

Both patient mistrust and stigmatization may contribute to this dilemma. Healthcare professionals have been shown to share and reflect a long-standing bias in their attitudes toward patients with substance-use disorders and OUD, in particular.⁸ Studies of providers’ attitudes are limited but suggest that legal concerns over liability and professional sanctions,⁹ reluctance to contribute to the development or relapse of addiction,¹⁰ and a strong psychological investment in not being deceived by the patient¹¹ may influence physicians’ decisions about care.

Closely supervising IV antibiotic therapy for all PWID may not reflect current medical knowledge and may imply a moral assessment of patients’ culpability and lack of will power to resist using drugs.¹² No evidence is available to suggest that inpatient parenteral antibiotic treatment offers superior adherence, and emerging evidence showing that carefully selected patients with an injection drug-use history can be safely and effectively treated as outpatients has been obtained.^{13,14} Ho et al. found high rates of treatment success in patients with adequate housing, a reliable guardian, and willingness to comply with appropriate IV catheter use.¹³ Although the study by Buehrle et al. found higher rates of OPAT failure among PWIDs, 25% of these

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failures were due to adverse drug reactions and only 2% were due to documented line manipulations.¹⁴ This research suggests that disposition to alternative settings for OPAT in PWID may be feasible, reasonable, and deserving of further study. Rather than treating PWIDs as a homogenous group of increased risk, contextualizing care based on individual risk stratification promotes more patient-centered care that is medically appropriate and potentially more cost efficient. A thorough risk assessment includes medical evaluation of remote versus recent drug use, other psychiatric comorbidities, and a current willingness to avoid drug use and initiate treatment for it.

Patient-centered approaches that respond to the individual needs of patients have altered the care delivery model in order to improve health services outcomes. In developing an alternative care model to inpatient treatment in PWID who required OPAT, Jafari et al.¹⁵ evaluated a community model of care that provided a home-like residence as an alternative to hospitalization where patients could receive OPAT in a medically and socially supportive environment. This environment, which included RN and mental health staff for substance-use counseling, wound care, medication management, and IV therapy, demonstrated lower rates of against medical advice (AMA) discharge and higher patient satisfaction compared with hospitalization.¹⁵

MOBILITY OFF OF THE HOSPITAL FLOOR FOR HOSPITALIZED PATIENTS WITH OUD

Ethical dilemmas may also arise when patients with OUD desire greater mobility in the hospital. Although some inpatients may be permitted to leave the floor, some treatment teams may believe that patients with OUD leave the floor to use drugs and that the patient's IV will facilitate such behavior. Nursing and medical staff may also believe that, if they agree to a request to leave the floor, they are complicit in any potential drug use or harmful consequences resulting from this use. For their part, patients may have a desire for more mobility because of the sometimes unpleasant constraints of hospitalization, which are not unique to these patients¹⁶ or to distract them from their cravings. Patients, unable to tolerate the restriction emotionally or believing they are being treated unfairly, even punitively, may leave AMA rather than complete needed medical care. Once more, distrust of the patient and fear of liability may lead hospital staff to respond in counterproductive ways.

Addressing this dilemma depends, in part on creating an environment where PWID and patients with OUD are treated fairly and appropriately for their underlying illness. Such treatment includes ensuring withdrawal symptoms and pain are adequately treated, building trust by empathically addressing patients' needs and preferences,¹⁷ and having a systematic (ie, policy-based) approach for requests to leave the floor. The latter intervention assures a transparent, referable standard that providers can apply and refer to as needed.

Efforts to adequately treat withdrawal symptoms in the hospital setting have shown promise in maintaining patient engagement, reducing the rate of AMA discharges, and improving follow up with outpatient medical and substance-use

treatment.¹⁸ Because physicians consistently cite the lack of advanced training in addiction medicine as a treatment limitation,¹² training may go a long way in closing this knowledge and skill gap. Furthermore, systematic efforts to better educate and train hospitalists in the care of patients with addiction can improve both knowledge and attitudes about caring for this vulnerable population,¹⁹ thereby enhancing therapeutic relationships and patient centeredness. Finally, institutional policies promoting fair, systematic, and transparent guidance are needed for front-line practitioners to manage the legal, clinical, and ethical ambiguities involved when PWID wish to leave the hospital floor.

ENHANCING CARE DELIVERY TO PATIENTS WITH OUD

In addressing the mistrust some staff may have toward the patients described in the preceding ethical dilemmas, the use of universal precautions is an ethical and efficacious approach that balances reliance on patients' veracity with due diligence in objective clinical assessments.²⁰ These universal precautions, which are grounded in mutual respect and responsibility between physician and patient, include a set of strategies originally established in infectious disease practice and adapted to the management of chronic pain particularly when opioids are used.²¹ They are based on the recognition that identifying which patients prescribed opioids will develop an OUD or misuse opioids is difficult. Hence, the safest and least-stigmatizing approach is to treat all patients as individuals who could potentially be at risk. This is an ethically strong approach that seeks to balance the competing values of patient safety and patient centeredness, and involves taking a substance-use history from all patients admitted to the hospital and routinely checking state prescription-drug monitoring programs among other steps. Although self-reporting, at least of prescription-drug misuse, is fairly reliable,²² establishing expectations for mutual respect when working with patients with OUD and other addictive disorders is more likely to garner valid reports and a positive alliance. Once this relationship is established, the practitioner can respond to problematic behaviors with clear, compassionate limit setting.

From a broader perspective, a hospital system and culture that is unable to promote trust and adequately treat pain and withdrawal can create a "risk environment" for PWID.²³ When providers are inadequately trained in the management of pain and addiction, or there is a shortage of addiction specialists, or inadequate policy guidance for managing the care of these patients, this can result in AMA discharges and reduced willingness to seek future care. Viewing this problem more expansively may persuade healthcare professionals that patients alone are not entirely responsible for the outcomes related to their illness but that modifying practices and structure at the hospital level has the potential to mitigate harm to this vulnerable population.

As inpatient team leaders, hospitalists have the unique opportunity to address the opioid crisis by enhancing the quality of care provided to hospitalized patients with OUD. This

enhancement can be accomplished by destigmatizing substance-use disorders, establishing relationships of trust, and promoting remedies to structural deficiencies in the health-care system that contribute to the problem. These approaches have the potential to enhance not only the care of patients with OUD but also the satisfaction of the treatment team caring for these patients.²⁴ Such changes will ideally allow physicians to better treat the illness, address ethical and clinical concerns when they arise, and promote enhanced participation in treatment planning.

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