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Cite this article as:
Travis N. Rieder
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Health Affairs 36, no.1 (2017):182-185

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In Opioid Withdrawal, With No Help In Sight

A patient receives prescription opioids after an accident—and no support from his physicians as he weans himself off.

BY TRAVIS N. RIEDER

On May 23, 2015, my motorcycle was struck by a careless driver in a large van. My left foot was crushed, the great toe and first metatarsal shattered, while pieces of the first, second, and third metatarsals exploded out through the top and bottom of my foot. My first hospital stay lasted eight days. There, the orthopedic trauma surgeon saved my foot from the immediate threat of amputation and sent me home with a vacuum-assisted closure device for the wound, while the plastic surgeons figured out how to close the large hole on the bottom of my foot. After a week, I was admitted to a second hospital for a skin graft, but the surgery was aborted because of the size of the wound, and I was again sent home with a wound vacuum-assisted closure device. Finally, I was admitted to the limb salvage center at yet another hospital, where a team of surgeons performed a “free flap,” transplanting skin, fat, muscle, vein, and nerve from my thigh to my foot. The surgery lasted nearly nine hours and required five days in the intensive care unit plus another five days on the general care floor.

By the time I went home, I had been in and out of hospitals for more than four weeks.

I had been heavily medicated since the day of the accident—with varying degrees of success at relieving the pain—with both immediate-release and extended-release oxycodone, as well as intravenous morphine, fentanyl, and Dilaudid (hydromorphone). Having been opiate-naïve prior to the accident, I found this to be a confusing, dreamy, and sometimes scary time. Even when I was home between surgeries, I wasn’t really present for my family—either for my one-year-old daughter or for my wife, who was somehow holding our family and home together in the aftermath of the accident.

After the transplant surgery, my previous drug regimen was not keeping my pain under control, and the hospital’s pain management team was brought in to consult. The attending physician upped the dosage of oxycodone, added intravenous acetaminophen for two days, and prescribed gabapentin, a neuropathic pain medication. My pain was finally under control, so long as I continued to up the doses as I became tolerant—which my various doctors were always happy to do.

Tolerance And Physical Dependence

I know that some of what happened next was my fault: I’m well educated, and I should have been thinking more long term. But if I’m perfectly honest, I was just scared. The memory of those early days in the hospital was constantly present, and my life revolved around keeping my pain manageable; whenever I began to feel like I was losing control, I upped the dosage and informed my doctors, who wrote a new prescription. It never even occurred to me that I should be aggressively looking for the first possible moment that I could begin decreasing my medication, and no one told me to do so.

It was nearly August before my original orthopedic surgeon, at an x-ray follow-up, asked about my pain and not-
ed that I ought to think about getting off the meds. He seemed surprised that I was still taking such high doses, and his recommendation to back off had an air of admonishment about it. He did not, however, have any suggestions, nor did he mention that I might have difficulty quitting. He simply told me to call the plastic surgeon to get advice on weaning. The plastic surgeon advised what I now know to be a very aggressive taper, which involved dropping one-quarter of my daily dose of extended-release oxycodone and gabapentin each week for the following month and using the immediate-release oxycodone only when I absolutely needed it. My wife—a research scientist—was skeptical of the approach, but we assumed that my physician knew best. That night, I reduced my first dose.

A Glimpse Of Withdrawal

The first week of tapering I became nauseated, lost my appetite, and began to have difficulty sleeping. I spent most of my days lying on the couch, waiting for time to pass. When the symptoms began to improve around day six, however, I assumed that my body was becoming accustomed to this process.

But then it was time to drop the next dose. During that second week, I ate even less and began spontaneously crying. The crying was disconcerting by itself, but after a few days it would launch me into depressive episodes. Each day felt a little worse, and I began to believe that I would never recover. My body, my brain, my hormones—they all felt so profoundly broken. We called my doctor, who focused on the intestinal problems, advising stool softeners and lots of fluids. When I meekly pushed him about the immediate-release oxycodone only for the very first time in my life, he told me it might be time to go back on the meds now. When she asked if there was anything the doctor could prescribe to ease my symptoms, he said that he wouldn’t advise me on the matter any longer, as he was clearly out of his depth. Officially, he recommended that I go back on the meds and find someone else who was more comfortable dealing with opioid dependence. But the thought that the nearly three weeks of suffering I’d endured might have been for nothing, and that I might have to go through it again in the foreseeable future, was unbearable. I decided to stick to the plan.

After I took my final dose of opioids at the start of week four, I thought withdrawal might kill me. The nausea left me with goosebumps, and had several crying spells a day. The depression was crushing. My wife called the doctor again. He told her it might be time to go back on the meds. She asked if there was anything the doctor could prescribe to ease my symptoms, but he said that he wouldn’t advise me on the matter any longer, as he was clearly out of his depth. Officially, he recommended that I go back on the meds and find someone else who was more comfortable dealing with opioid dependence. But the thought that the nearly three weeks of suffering I’d endured might have been for nothing, and that I might have to go through it again in the foreseeable future, was unbearable. I decided to stick to the plan.

A Failure Of The Medical Community

No one will be surprised to hear that I was angry. Angry at myself, angry at my doctors, angry at the medical community. Just—angry. I had been hit by a van and undergone five surgeries, yet the worst part of the experience was my month in withdrawal hell. How could it be that my doctor’s best tapering advice led to that experience? And how could it be that not one of my more than ten doctors could help?

I have since learned about some strategies that help patients get free from narcotics. For instance, I now know about appropriate weaning schedules, such as tapering off each medication
separately, at a rate as low as a 10 percent drop per week. I’ve learned about Suboxone (buprenorphine and naloxone) as an alternative to methadone for weaning patients off narcotics, as well as a variety of medications for managing the symptoms of withdrawal, such as trazadone for insomnia and clonidine for restlessness. So why aren’t these strategies common knowledge among physicians? Shouldn’t they be?

It seems clear to me that they should. Physicians are the gatekeepers of medication for a reason: They are supposed to protect their patients from the harm that could come from unregulated use of those medications. Physicians, public health officials, and even the Centers for Disease Control and Prevention tell us that we are in the midst of an “opioid epidemic,” due to the incredible addictive power of these drugs. Yet when people become addicted to painkillers after suffering a trauma, the best advice they might get from physicians when coping with withdrawal is to go back on it to feel better. Can we really do no better than that?

**A Moral Principle For Prescribers**

I understand that I might have gotten unlucky and that many physicians could have done better by me as a patient. But no one should get as unlucky as I did. I believe each physician has a duty to prescribe only those medications that he or she can responsibly manage for the length of a patient’s need, including the treatment of foreseeable side effects. If a physician prescribes a highly addictive medication for pain management, with serious and predictable withdrawal effects, then he or she has a duty to see that patient through the weaning process as safely and comfortably as possible. Or, alternatively: He or she has a duty to refer the patient to someone who will be able to see the patient through that process.

I am an ethicist, and it seems to me that such a principle is well supported by bioethical reasoning. Indeed, this can be seen simply as a specification of the principle of nonmaleficence or the Hippocratic dictum to “first, do no harm.” By prescribing a drug that has predictable harmful effects without a plan for dealing with them, a physician is at least partially responsible for causing those harms.

Now, one could object that physicians cause harm all the time in this way, as many medications and treatments have harmful side effects that are accepted as the cost of care. Chemotherapy, for instance, certainly harms the patient, but we do not condemn oncologists for prescribing it.

The objection doesn’t stick, however, because we should condemn oncologists if there are methods for managing the side effects of chemotherapy that they do not prescribe alongside the treatment. Indeed, as our ability to treat certain chemotherapy-related toxicities has advanced, we have come to expect that cancer patients receive this care. In short, we already accept this ethical principle. If a physician opens up a patient to predictable harm—even for very good reason, such as saving the patient’s life—the physician must do what he or she can to minimize that harm.

**Structural Implications**

The medical system is organized in a way that makes it quite difficult for physicians to live up to their withdrawal care responsibility, as my experience illustrates.

The most obvious problem is educational. To responsibly prescribe opioids, physicians must have the relevant information concerning dosing, dependence, weaning schedules, and symptom management. There is mounting evidence, however, that medical schools are not making this a priority. Judy Foreman, in her powerful book *A Nation in Pain*, surveys the literature on medical education only to find that there is little to no formal training in pain and pain medicine in US medical schools. For context, she notes that Canadian-trained veterinarians receive, on average, far more education on pain than do US medical students.

Of course, pain specialists do receive
such training. Yet the two pain management teams from whom I sought help delineated their jobs as prescribing pain medication, not helping patients withdraw. Methadone clinics, meanwhile, deal largely with maintenance and detox programs for people with long-term addiction, not necessarily someone in my situation. In my case, the nonspecialists, the pain specialists, and the addiction specialists all failed to see routine withdrawal care as falling within their purview. Given the physiology of dependence, we know that a number of patients who are prescribed opioids will require this kind of care. As a community, we need to decide whose responsibility these patients become.

In team-based medicine, particularly when acute care has chronic implications, it is often unclear who “owns” the patient at any given time. Although I had a prescribing doctor, the fact that he was one of a dozen physicians who were seeing me might have diluted his sense of responsibility. This likely affected every aspect of my care, from education (whose job was it to teach me about the dangers of opioids?), to a general lack of coherent planning for dosing, monitoring, and ultimately withdrawing. Somebody must take responsibility for long-term pain management for patients like me, or many of us will simply fall through the cracks of the complex medical system and either suffer the harms of unsupervised withdrawal or wind up addicted.

Learning From This
The plastic surgeon who had been managing my prescriptions eventually apologized and admitted that he simply had not known how to deal with opioid dependence. I hope that he committed to learning more after this experience.

My goal is not, however, to change one doctor’s view about what he owes his patients. Instead, I want to start a broader conversation about physician responsibility for opioid-related harms, as well as the systemic forces that make it easier or harder for physicians to recognize and discharge their responsibilities. Opioid withdrawal isn’t minor. It’s not “just temporary” or “the price to be paid” for pain relief. It’s not morally innocuous. The moments that I was in withdrawal—all of the thousands of moments of genuine suffering—were the worst of my life. That kind of suffering matters, and its seriousness needs to be reflected in the way we deal with prescription opioids.

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