

CASE AND COMMENTARY

Should the Location of a Patient's Home Inform Physicians' Opioid Prescription Practices?

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Abstract

This case-and-commentary examines whether and when prescribers should authorize prescription opioid refills and questions whether and how a patient's living in an area with a high number of overdose deaths should influence that decision. Clinical social work perspectives presented in the commentary inform a multidisciplinary, team-based approach to this decision that is holistic and nondiscriminatory and that prioritizes the ethical value of self-determination.

Case

Mr W is a 51-year-old man who had a successful partial colectomy 5 days ago for severe diverticulitis. He is tolerating by-mouth intake and is passing stools, and his pain levels are becoming more manageable. Dr M, Mr W's surgeon, gives the "go ahead" for Mr W to go home. Ms K, a nurse, instructs Mr W about how to take care of his surgical wound, and he is discharged to his home with oxycodone and acetaminophen for pain and docusate sodium and polyethylene glycol for constipation. A clinic follow-up appointment is scheduled for one week.

During the follow-up appointment, Mr W reports, "I'm feeling better. I used all the pain meds. May I get a refill?" Dr M authorizes a 5-day refill of the oxycodone and refers Mr W to his primary care physician for follow-up.

Dr M later wonders, however, whether she should have authorized a refill for a patient living in an area of the city struggling desperately with regular deaths by opioid overdose.

Commentary

Many prescribers have experienced Dr M's moment of reckoning. Anxiety concerning opioid prescribing—triggered by overdose reports, professional liability, and regulatory limits—suggests that what looks like a simple clinical decision is actually fraught with ethical complexity and uncertainty.¹ The social work perspective is useful to apply to this case and would entail looking at the prescribing decision in the context of personal and **environmental factors** in the patient's situation. Honoring his right to self-determination

while also identifying possible risk factors and educating him about potential misuse and overdose are essential components of this holistic approach.

What Would a Social Worker Consider?

A better understanding of Mr W needs to draw on biopsychosocial and holistic perspectives often used by clinical social workers. The **biopsychosocial model** includes social and psychological factors in a patient's situation. Holistic domains have been variously defined, but one holistic framework categorizes behaviors into 4 domains; environmental, psychosocial, physiological, and health related.² Also considered are an individual patient's emotional, social, spiritual, and psychological responses to these domains. Because biopsychosocial factors and holistic domains tend not to fit neatly into biomedical models of thinking about a patient's needs and vulnerabilities, they can complement biomedical approaches in disease management and prevention for good patient care.³

Incongruence in the patient presentation seems to be the most cogent factor in the prescribing decision, and it is one that requires more exploration to understand. In Mr W's case, considering a possible personal or family history of substance use disorder is warranted, and Dr M should also establish whether the prescription he's looking to refill is Mr W's first opioid prescription. If it is not, she might closely evaluate whether his more recent opioid prescriptions have been used responsibly. Since Mr W requests a refill after saying he feels better, Dr M might also ask him about this apparent incongruence in a nonjudgmental manner. A clinical social worker would also explore whether anyone in his household uses opioids and for what purpose. Engaging with Mr W and establishing rapport, a social worker could also nonjudgmentally probe into any recreational use of substances by Mr W. Recreational substance use could include illicit or nonprescribed pharmaceuticals and would be a factor to consider in prescribing decisions.

After assessing these empirical dimensions of Mr W's history and present needs, a good care team might try to determine whether it's clinically helpful or ethically appropriate to relate his personal history to demographic data about **overdose trends in his community**. If Mr W's health record and the state's prescription drug monitoring program reveal that he has had multiple opioid prescriptions in the past or multiple prescribers, Mr W's opioid use patterns could suggest that he is addicted and in need of addiction therapy or is diverting his opioid supply.

Looking at Mr W's case more broadly, Dr M could ask whether he also used up his constipation medicine as directed. (This speaks to a patient's compliance and self-regulation.) Again, given that the patient reported feeling better, what was his reason for asking for more opioids? Was he underreporting his pain? The physician would need more time than a follow-up visit usually allows to get answers to these questions, but these are the questions that need to be asked and answered for Dr M to resolve her concerns about this patient.

Clinician Humility and Patient Autonomy

While a heightened index of suspicion can be helpful in Mr W's case, Dr M should also consider that denying Mr W a refill of his opioid prescription could be unjust to him. As a clinician, she has a duty both to assess Mr W's risk of opioid misuse and to maintain a positive view of the patient and his intentions. All clinical social workers strive to hold a strengths-based view of patients. This means starting an encounter or relationship with

patients based on an assumption that they express their needs genuinely and that we are obligated to respect their right to and capacity for self-determination. The National Association of Social Workers (NASW) code of ethics calls for social workers to “respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals.”^{4,5} How might this tenet be applied in Mr W’s case?

Mr W states that his pain has diminished but also expresses a need for continued pain relief and requests a refill on his medication. Educating Mr W about overdose fatalities in his community is important. Does Mr W know that the area in which he lives has a high rate of opioid addiction and overdose due to fentanyl and other opioids? Dr M could ask about his experience of living in that area. Is there a public conversation about the opioid crisis and the overdose problem? But regardless of data showing that an area of a city in which a patient lives has many overdose fatalities, it would be right to question how this data should inform a team’s response to a specific patient.

We suggest that Dr M’s respecting Mr W’s right to self-determination means maintaining the focus on his expressed need, helping him advocate for himself, and offering therapies for pain relief other than opioids. It is also important for her to highlight her concerns for him, given the high rate of opioid overdose fatalities in his community and his critical need to recover from surgery while mitigating his risk for opioid dependence. Using Mr W’s responses to her questions about opioid misuse in his community as guiding tool—and accepting that Mr W is telling the truth about his experience—Dr M can decide to treat based on his individual needs, knowing that she has highlighted her concerns about the area in which he lives. Finally, respecting Mr W’s self-determination also means that he retains the right to accept or decline Dr M’s treatment recommendation.

Nondiscrimination

In order to identify the correct course of treatment, a strong understanding of the patient being treated or prescribed for is more important than where the patient lives. Many communities are suffering greatly from high rates of opioid overdose fatality and opioid use disorder (OUD) associated with both illicit and prescription opioids. Physicians are understandably confronting fears about prescribing. However, a prescriber making pain treatment decisions involving opioids solely based on location opens the door to consciously or unconsciously considering other factors such as race, gender, age, **ethnicity**, immigration status, or sexual orientation. These factors can lend themselves to bias and discrimination that create health inequities. Studies show that race does have an influence on opioid prescribing; for example, minorities receive **lower-quality pain care** over the lifespan than whites.⁶

Marginalized groups and individuals have needed people to call out discrimination and oppression, and the field of social work has answered that call. In its pursuit of social justice, the field of social work is uniquely attuned to the many ways people in our society have been mistreated due to discrimination and oppression. The NASW code of ethics ethical standard of discrimination 4.02 states:

Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical ability.⁴

The AMA *Code of Medical Ethics* aligns with social work in this regard,⁷ as stated in Opinion 9.6.6, Prescribing and Dispensing Drugs and Devices:

In keeping with physicians' ethical responsibility to hold the patient's interests as paramount, in their role as prescribers and dispensers of drugs and devices, physicians should: a. Prescribe drugs...based solely on medical considerations, patient need, and reasonable expectations of effectiveness for the particular patient.⁸

Pain management is individual, and no one person has the same tolerance level or response to medications as another. Prescribers can only work with the information they are provided with, and not all patients will give an accurate account of their history of medications or substances—over the counter, prescription, or illicit drugs. Unfortunately, the Centers for Disease Control Guideline for Prescribing Opioids for Chronic Pain, published in 2016, does not provide specific guidance on opioid prescribing for acute pain. It states that because chronic pain treatment with opioids can begin with acute pain treatment, physicians should limit initial opioid prescriptions by prescribing “no greater quantity than needed.”⁹ Physicians are left to interpret this guideline based on their training and experience, while navigating varying regulations and restrictions imposed by states and payers.

Interdisciplinary Teams

In treating pain—and in many other areas of health care—physicians leading an interdisciplinary team with a variety of professionals, including social workers, can help provide better care, reduce costs, and improve health across populations.¹⁰ Social workers play a critical role on health care teams by contributing their skills and expertise in looking at the whole person within the context of that person's psychological and social environment.¹¹ Social workers know that strong communication and engagement skills are needed to educate patients and help them advocate for their needs.^{10,12}

Returning to Mr W, Dr M or a social worker should educate Mr W on specific safeguards, such as safely storing and disposing of opioids and the risk of overdose, and, as previously discussed, on overdose trends in the community. This approach respects the value and worth of patients but allows them to consider their behavior in the context of their environment more critically.

Social workers and other health care specialists can provide not only useful perspectives on patients, but also support and care coordination, especially for pain care.¹⁰ A social worker making follow-up contact with Mr W to do a brief assessment could assist Dr M by either confirming or allaying her concerns. As a part of a care team, social workers can step in and engage the patient in his or her care in ways that may require time and skills that the physician may not have.¹³

Conclusion

Some might easily think that Mr W might not have needed additional opioids or that he only needed a day or two additional supply. Dr M's limiting of the amount of follow-up opioids for Mr W to a 5-day supply was prudent; an even smaller amount would reduce risk even more. Mr W's case is just one patient scenario of many involving opioids and pain, and each one presents its own set of questions for physicians. There are few simple answers when it comes to opioids, but, in general, physicians are no longer approaching opioid prescribing in the same way as in years past. Prescribing opioids thoughtfully, based on a holistic view of patients, with respect for their self-determination; using risk mitigation tools; and utilizing and leaning on the strengths of

other specialists within health care teams can further good pain care as well as help curb the opioid crisis in all our communities.

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Editor's Note

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