Hospital Care of Patients with Substance Use Disorders: A Conflict of Loyalties

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Throughout our first year of residency, we have been confronted by the extreme challenge of caring for individuals with substance use disorders (SUDs) in the hospital. We now reflect on the conflicts we face alongside our patients, with particular focus on stimulant use disorders, as well as possible paths forward.

Every healthcare worker in Sonoma County can attest to the incidence and severity of SUDs in our community. Unfortunately, our culture and practice still falls short of equitable care for these individuals. We now know that SUDs are closely tied to a history of trauma; yet, in our training we've been made accomplices to punitive practices like unconsented urine drug testing and strip searching that are antithetical to trauma-informed care. We routinely see patients' visitation rights revoked, belongings confiscated, and treatments restricted based on an SUD diagnosis. These forms of carceral practice and punishment are both ineffective and unacceptable.

This is a particular challenge when working with patients living with stimulant use disorders, namely methamphetamine and cocaine addiction. These patients are some of the sickest we see in the hospital. In order to receive treatment in the hospital they have little choice but to forcibly go through withdrawal, an experience that often drives conflict with staff and premature discharge. When healthcare providers moralize SUDs or treat disease as a personal failing, we further retraumatize patients and neglect our duty to provide evidence-based treatment. Patients leave healthcare encounters feeling isolated and powerless, even less prepared to engage in recovery services.

An increasing body of evidence explores treatment and harm-reduction for amphetamine use disorders: bupropion, naltrexone, stimulant replacement therapy, improved cardiac screening, contingency management, to name a few. In the absence of clear inpatient guidelines, though, SUDs are often relegated to an outpatient issue — this, despite often being the underlying driver of their hospitalization. Disappointingly, our hospital is slashing funds to our vital Substance Use Navigator program and has not embraced the newest evidence in the treatment of stimulant use disorders. Refocusing attention and resources on medication-assisted approaches in conjunction with mental health supports and community care is vital to addressing the crisis of stimulant use disorders in our patients.

We as healthcare workers cannot care for patients in this violent system without sustaining moral injury ourselves. We are forced to confront dual loyalties– to our patients' well-being and to our institution and professional norms. In attempting to navigate the conflict between these loyalties, we often sacrifice our well-being, risking burnout. Looking further, we're made to feel powerless in resistance to a healthcare system constructed on economic over patient-driven incentives.

The outlook isn't hopeless though. As the next generation of doctors, we are moving forward from a culture of shame and abuse. We do our best to find the time to hold space for our patients' individual needs and bridge them to appropriate services. As part of our training, we're becoming comfortable offering medication–assisted treatment (MAT) in the hospital and on discharge. Together, we are organizing to advocate for patient policies and practices that better align with our values.

Despite the exhaustion and moral fatigue engendered by residency, we refuse to dampen our sense of justice. We stand committed to pushing ourselves and our system to provide equitable healthcare for the most vulnerable among us.

Published in SMLMA July 2023 *News Briefs*