

Case Study: Learning From and Supporting Clinicians in the Field

Following are excerpts from an interview JBS staff conducted with an M.D. in Rhode Island. The interview was part of a series on Pharmacotherapy for Substance Use in the Primary Care Setting.

In the late 1990s, it came to my attention that a percentage of my chronic pain patients taking opioids were abusing them. A behavioral health specialist I was working with told me that in addition to methadone, there was a new office-based treatment for opioid dependence called buprenorphine. To become a qualified prescriber, I took the course, which was an eight-hour day of lectures.

With my first 10 patients, I was scared I would harm them or perhaps not help them. And in fact, a couple of my initial patients were insufficiently in withdrawal when I began the in-office induction, and it resulted in them vomiting on my shoes. Now I have a mantra, “You got to feel bad to feel good.” This learning experience reinforced for me the fact that buprenorphine was a safe, effective, and life-saving medication. That increased my comfort level dramatically.

I faithfully follow SAMHSA’s protocol (SAMHSA, 2004; SAMHSA, 2005; SAMHSA, 2016) of seeing the patient every day for the first four days and then once a week for the first month. I require all of my patients to attend 12-step meetings and/or therapy. The first meeting when the patient is in withdrawal or high is always the hardest.

At this point, I spend about 40 percent of my time as a family doctor and 60 percent of my time treating addiction. Mostly the latter are opioid-dependent patients, but I also have patients who have issues with alcohol, benzodiazepines, cocaine, and even methamphetamine.

The vast majority of my buprenorphine patients are also my family practice patients, but I always differentiate between the two types. It’s my habit to see my buprenorphine patients monthly, which is the standard of care nationally. I say to these patients, “You see me once a month anyway; why don’t I deal with you as the provider of care for your diabetes or COPD”—or whatever chronic or acute condition they have. The vast majority choose to have me as their primary care doctor as well.

The treatment of addiction can be psychologically challenging and demanding of the provider (and what’s hard are the patients with polysubstance use or those who have psychiatric problems, or who are struggling with heroin and who don’t want to be, or can’t be, stabilized on buprenorphine), but it is equally or perhaps even more gratifying than the family practice part. You get to stabilize the lives of people who have been thoroughly disrupted by drugs. The transformation that you see in patients is profound and wonderful.