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letter to the editor

Prescription for Progress: Mediating Opioid Education and Awareness for Physicians

Manasicha Wongpaiboon, MS | Nicole Uthuppan | Shermeeka Hogans-Mathews, MD

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To the Editor:

Opioid use disorder (OUD) has led to increasing overdose deaths in the United States. As primary care physicians (PCP) navigate the landscape of OUD treatment, the use of medication for opioid use disorder (MOUD) has significantly reduced withdrawal symptoms and relapses as compared to other treatments. The recent learner research article by Cecilia Nguyen and Grace Kubiak, "Evaluating Barriers to Opioid Use Disorder Treatment From Patients' Perspectives," was of particular interest to us.[1] We commend the authors' abilities to highlight the multifactorial drive behind seeking and continuing OUD treatment and identifying the barriers to care in vulnerable populations that impact treatment outcomes. We would like to offer potential solutions to barriers to MOUD care that include increasing MOUD providers and OUD/MOUD training in medical education and decreasing stigma.

Future MOUD curricula integrated into both undergraduate and graduate medical education would be instrumental in reshaping the perspective of learners and reduce disparities in MOUD treatment. Studies have shown that OUD stigma is decreased regardless of intervention type when medical students are subjected to both contact-based or didactic lecture surrounding OUD, OUD diagnosis, and decisions to treat.[2] Incorporating clinical and systems learning sessions that address clinical skills and MOUD treatment into standard medical school curricula, including clinical rotations and preceptorship sites is key. Awareness and education allow for early MOUD exposure to future physicians, thus exponentially increasing the number of physicians entering practice with increased MOUD competency and comfort.

A multifaceted and culturally sensitive approach is crucial to dismantle stigma surrounding MOUD. Furthermore, provider stigma can exacerbate these challenges. A retrospective medical record review revealed significant disparities in incarcerated patients: White inmates were prescribed MOUD four times more than Black inmates despite twice as many Black inmates diagnosed with OUD.[3] The causes of this notable imbalance may be multifactorial, and may include insufficient training in culturally competent care or historical distrust of the health care system by patients. By fostering supportive and nonbiased care, providers can contribute to normalizing MOUD treatment and addressing systemic inequities.

MOUD provider shortages are often due to the ambivalence of PCPs which include the presumption of workload increase without adequate relief.[4] Limited appointment availabilities may hinder PCPs from quickly accommodating patients who are ready to start treatment, while others find stigmas at institutional levels stymie implementation and their drive to practice MOUD. PCPs anticipate low patient engagement, and therefore low patient yield, which further discourages MOUD adoption. However, embedding OUD screening protocols in routine visits to provide PCPs with an accurate count of patients, while leveraging help from

nonphysicians to streamline initial appointments and alleviate stress can counter hesitation. Increasing reimbursement rates for MOUD provision can encourage patients to seek care while also compensating physicians.

In addition to implementing systems-level changes to counter workload, MOUD treatment curricula inclusion, provider training, and stigma reduction can all play a significant role in decreasing OUD disparities and streamlining MOUD treatment. We anticipate further research and development in this field and hope the authors' recommendations will serve as a platform for further endeavors in the realms of MOUD and primary care.

Author Affiliations

Manasicha Wongpaiboon, MS - Florida State University College of Medicine, Tallahassee, FL

Nicole Uthuppan - Florida State University College of Medicine, Tallahassee, FL

Shermeeka Hogans-Mathews, MD - Florida State University College of Medicine, Tallahassee, FL

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