NARRATIVE
ESSAYS

Scope of Practice: Expansion in the Midst of the Opioid Epidemic

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An unexpected text interrupted my dinner prep. I glanced down at my phone and expected to see a neighbor inquiring about child ferrying. Instead, I read a text from my family medicine residency colleague stating "Not sure you are aware but the patient on naltrexone has died." I was scheduled to work in the office the next day and she was thoughtfully trying to prepare me.

A small gasp escaped from my mouth and my observant 9-year-old daughter noticed. She asked what was wrong and I dismissively stated, "Nothing, just a text about a patient."

She saw through my veneer. "Is the patient okay?"

I was unprepared for the text and her questions and did not know how to respond. I did not have the chance to think before she asked, "Did someone die?"

I raised my head and nodded yes.

Her young innocent eyes closed and she offered a prayer for this person she did not know.

"Please God help her find her way to heaven."

Moved by her spontaneous blessing I realized I could not and should not protect her from my emotion. A few tears trailed down my face. "Don't cry," she stated anxiously. It was too late, I could not make the tears retreat.

"Was she old?" She asked.

"No, she was very young, and very sick. She was a mom and a daughter and a friend."

And with that my daughter came over and gave me a hug.

"That is really sad," she offered.

"Yes it is," I echoed back.

I should not have been surprised. After all, the statistics were stacked against my patient. Reports of increased death from overdoses and the opioid epidemic flood my email inbox every day. I know the tsunami of problems this issue has brought to our society. But up until that moment the numbers were faceless. This woman, now part of the statistics, was real to me. She brought her whole, vulnerable self to us several months ago, and for that brief period of time we cared for her as a real person.

My first tangible memory of her as a patient is from when I learned that one of our residents had agreed to prescribe injectable naltrexone for the patient's mother, a clinical nurse, to administer. She had received a few scripts before I knew he had been writing it. As clinical director of the office, I was angry. This medication requires protocols and systems of support that we had not developed. I had never prescribed this medication and neither the resident nor the supervising physicians of those visits had really thought through the scope of his prescribing decision. When residents push medical boundaries that I have never encountered I jump into a defensive mode. My mind starts to think "we can't," and "we should not." To my knowledge, no family physicians in our system were offering medication for opioid use disorder. My tired, overwhelmed brain did not want to think about expanding into this territory.

Thankfully, the resident was bold enough to challenge me. He pushed me to consider why we should offer this option to this patient and he shared her story. She came to us as a new patient nearly 2 years into recovery from heroin use. She boldly left her life in the metropolitan area to escape the context that had suffocated her. In her new setting she was living with her 4-year-old daughter and her mother. The patient clung to this treatment as her source of strength to pursue her new life. The more the resident shared with me, the more compassion I felt for her. My mind shifted from the "cannot" into the "how can we" mode. Fueled by her story, I challenged him to research the protocols and come up with a patient agreement so that we could administer the treatment safely and continue to support her recovery journey.

He did the research and we agreed on a protocol that involved our nursing and behavioral health team. The

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patient also agreed to the plan and confirmed understanding of the most important piece of the treatment: the increased risk of overdose if she were to return to using opioids at the same dose she had been on previously. Caring for her was not easy. Her physical and mental health needs were complex. However, true to the tenets of family medicine, it was fulfillment from the doctor-patient relationship that drove the desire to care for her even in the most difficult of circumstances.

In September, after being on naltrexone for over 30 months, the patient stated she felt like she had gotten to a place in her life where she no longer needed the medication to help keep her in recovery. Documentation in the chart again adequately stated the risk of overdose if she were to return to use. Her death was reported a few weeks later.

The day after I received the text I was sitting in my office reflecting on the impact this one woman had in our practice. Throughout the day more tears were shed as our charge nurse, behavioral health consultant, and numerous physicians stopped by to make sure I was informed of her death. With each conversation I was aware of their individual connections to the patient and her story. We cared for her as a team, and together we grieved.

I cannot escape the reach of the opioid crisis. Sorrow from this patient's death blankets me and provides me with certainty. Every time I see this patient's daughter's name on our schedules, I remind myself that we are choosing to lean into discomfort and accept addiction as a complex chronic illness that needs to be included in our scope of practice. The faculty and staff in our office agreed to align one of our annual goals around designing office protocols to manage opioid use disorder. We understand that there are not enough psychiatrists or addiction specialists to bear this burden alone. Driven by benevolence and social justice, I know I must expand my scope of practice and engage. One resident and one patient helped me to deeply understand this.

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