Preparing Physicians to Treat Addiction (PPTA)
Interview Results

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Background

The University of Kansas School of Medicine-Wichita's Department of Psychiatry and Behavioral Sciences and the Department of Population Health were awarded funding for Preparing Physicians to Treat Addiction (PPTA) by the Sunflower Foundation's Kansas Fights Addiction program. The purpose of PPTA is to improve access to substance use disorder (SUD) care in Sedgwick County, Kansas.

Methods

Staff from the Department of Population Health completed an extensive review of the academic literature to understand barriers and facilitators for physicians to provide care to those with SUD. The literature review informed development of an interview script that was used to conduct 26 interviews with physicians, residents, and medical students to understand barriers and facilitators to treating SUD locally in early 2024.

The interview script included 30 items, nine of which were demographic data. Two items assessed perspectives of the extent that SUD is a problem in Sedgwick County (prevalence, consequences, and proportion of patients with SUD), and three items that assessed how to address the local problem of SUD. One question prompted participants to describe various SUD resources and how to increase knowledge of these resources. Five items addressed what SUD services respondents currently offer, what services they are willing to offer, and what would make them more willing/ comfortable/confident to offer SUD services. Participants were asked what prevents them from offering other SUD services and, within their field, how they could help someone with an SUD. Finally, three items assessed stigma and bias by asking respondents about their experiences with people with SUD, under what circumstances people with SUD experience bias, and if they believed people with SUD were responsible for their disorder. This report highlights quotes from attending physicians, residents, and medical students that were representative of interviewees' responses to questions and comments.

Results

Twenty-six attendings, residents, or medical students in Sedgwick County, Kansas participated in an interview. Participants represented a variety of years in practice, fields of medicine, age, gender, and race.

	Percent	Frequency
Years in Practice		
< 5 years	38%	10
5-9 years	15%	4
10-14 years	12%	3
15-19 years	12%	3
≥ 20 years	23%	6
Field of Medicine		
Family Medicine	19%	4
Other	33%	7
Internal Medicine	19%	4
Psychiatry	5%	1
Pediatrics	10%	2
Surgery	10%	2
Obstetrics and Gynecology	5%	1
Average number of SUD patients seen each month		
0 patients	15%	4
1-10 patients	38%	10
> 10 patients	46%	12

	Percent	Frequency
Age		
< 35 years	31%	8
35-44 years	46%	12
45-54 years	4%	1
55-64 years	15%	4
≥ 65 years	4%	1
Gender		
Male	38%	10
Female	62%	16
Race		
White/Caucasian	65%	17
Black/African American	19%	5
Asian American/Pacific Islander	15%	4
Hispanic, Latino, or Spanish origin		
No	96%	25
Yes	4%	1

The following results offer representative responses to most interview questions.

Do You Believe That People with SUD Are Responsible for Their Disorder?

Most interview participants described SUD as a multi-faceted disorder, with multiple factors contributing to development.

- *Yes, people contribute at every step along the way. There are always choices to be made, but does that mean that a person is the main contributor, or how much of a contributor were they? I think there are a lot of gradations there.*

- *I'm not prepared to remove any personal responsibility at all from all cases of substance use disorder. But that being said, I think in most instances, there are very complicated social, biological factors that have led to the situations that people are having with their medical condition.*

- *…I feel like there's a lot of factors at play there…. We're talking about pain medicine substance use disorder. They hurt their back, they take some medicine… it's easy to get kind of down the rabbit hole before you realize you're down there. And so, you're not intentionally doing it or choosing to feel like crud. You're kind of there before you realize it, and then it's hard to get back out.*

- *I don't blame anyone for having allergy to apples, for example. And same way, I don't blame people for having a substance abuse disorder… we're all genetically predisposed to certain things, and some of us are more easily influenced because of that. And then, of course, we can't take away the environmental aspect of it, too.*

- *I don't think they've caused their disorders. I'm a big believer in the case of adverse childhood events like trauma building up to a picture that leads people to feel like that's the best choice for them. And then we get to this point in their treatment where them taking accountability is part of them getting better….*

Regardless of who or what is responsible for the development of a SUD, some respondents simply reported that SUD needs to be treated, like any other medical condition. Some specified that it is the responsibility of the person with a SUD to seek treatment.

- *I feel like it's a disease… it should be treated like diabetes or heart disease or any other psychiatric disorder.*

- *I believe that they're responsible for the treatment of their disorder, but I don't agree that they are responsible for the disorder themselves.*

Do You Think That People with SUD Are Weak Willed?

Most respondents reported that individuals with SUD are not innately weak-willed.

- *…a substance use disorder is not a means of willpower. It is a means of coping behavior, for the most part, of past traumas, abuses, or the way that they are dealing with their current world. I don't think it has anything to do with their will.*

- *No, I don't think so. I think drugs are highly addictive. It's like the one thing that'll sever a parent-child relationship or mother-child, or damage it a lot. And that's probably one of the strongest bonds in this word, and women will leave their kids or not be able to have custody of them because of the power of drugs over them.*

- *I think that people who have substance use disorders generally have fairly strong wills, in the sense that they will do very difficult things in order to continue being able to use, in order to continue to avoid withdrawal…. Somebody can hit a really far foul ball in a baseball game. You don't get any points for that, but it doesn't mean you're weak. If you can hit a far foul ball 400 feet, just point it in a different direction, that's a home run.*

- *I believe they're weak because of the circumstances they were raised in and the dysfunctional family… because they have no self-esteem and they don't have any confidence in themselves, and then they look weak in the end. They did not start weak.*

- *No, I think they have a disease that's difficult to control, and we don't have resources for them like we do for other conditions.*

- *Once you're in that spot, you're in a real bad spot, and it's really, really hard…. I think the majority of people, it's not something that you can just decide, 'I'm going to not do this anymore' and then now you don't.*

- *…Addictions are hard. I mean, if people could just kick addictions, I think everybody would… so I don't think it's a weak-willed thing. But it definitely takes some discomfort. It definitely takes effort. It takes time.*

Under What Circumstances Do People with Substance Use Disorder Experience Bias?

Participants reported that people with SUD experience significant bias, especially in medical environments.

- *Under every circumstance… interacting with the healthcare system… social stigma attached with, 'you brought this on yourself' kind of attitude.*

- *I might not necessarily intentionally, but unintentionally, in the back of my mind, how reliable is this patient going to be? What kind of behavioral issues are they going to have?... to show up and be on time, to adhere to instructions…?*

- *I think they get a negative bias from healthcare staff in trying to determine if they're truthful in their symptoms.*

- *Most of the bias seems to be related to frustration because it's so hard for physicians or for medical providers to navigate where this person is in their care, where they are in their treatment, where they are in their desire to have more drugs. And so, things that people don't understand, or are afraid of, can make them very frustrated.*

- *…the medical community has a huge bias…comes from just a lack of understanding of what they're dealing with, what SUD really… it is a complex disease of the brain…. Somebody with SUD needs help in a lot of ways…. As soon as a healthcare provider believes or thinks that somebody has SUD, they*

will pretty much drop them from their practice… or they're really unable to talk frankly with them…because the provider, they just don't have the information or the ability, or the language to talk about it.

- *There's a certain set of feelings when you see somebody that has an addiction issue…I think there's a predisposition towards being addicted to this, but in your mind, when you see somebody that has an addiction to narcotics, methamphetamine, you're thinking, 'this is a weak-willed person. This is a person that has no self-control.' It's almost something that's kind of hardwired into your mind, that people that have addiction issues doesn't have enough self-control because I don't have addiction issues, and I have self-control.*

- *I have to kind of check my biases before seeing these patients to remember that a lot of this they can't help… maybe not getting the full resource or complete workup, or time spent with them, or empathy…. Some people are leaving AMA from the hospital, and I don't know, you get burned by enough of those…so then you don't have empathy necessary left for the next situation….*

Participants commonly reported a prevalent perception that someone with a SUD is in medical environments solely to seek drugs.

- *…for sure in a healthcare setting…especially in pain management. When people present to the ER, a lot of people may think that they're just drug-seeking, when in fact, this person may really be in pain.*

- *… I do think one thing that doctors have not been so aware of is that people with substance use disorder do have a lower pain threshold, which means that they do truly have more pain that other people… they're not just always drug seeking, but that they may actually have more pain than the average patient.*

- *'Anyone who comes in and is overdramatizing their pain is drug seeking.' No, that's not right!*

- *They're completed judged, and profiled, and looked down [on]… They can be in pain, and we don't give them pain medication for million reasons. We don't believe them. We believe they're addicts. We're scared to give pain medication because we see doctors going to prison because of that.*

- *Their behavior leads people to be very biased against them… I can spot a meth addict very easily, so that leads me to be biased against them because their behavior is obvious.*

There is a recognition that this can lead to a shift in the patient-physician relationship and a lack of communication.

- *…there's a big stigma around substance use disorder, where people view it as something that can be controlled rather than just a biological condition. And I think a lot of people are scared to seek help or admit that they have substance use disorder because of that stigma and… people view them as being weak or out of control, or something that they can control themselves, which is just not true. It is biological.*

- *I think that a lot of them don't even tell us about it because they're scared about the stigma or getting in trouble or something like that. But I see it amongst even my colleagues and peers all the time. It's very apparent- they get treated differently.*

- *…folks who are the 'frequent flyers'… people that are really, really struggling with their addiction continually coming back to the hospital or even in the outpatient setting. I feel like [physicians] kind of just get tired, I guess, of treating them over and over again for the same thing.*

Moreover, this perception of consistent drug-seeking behavior is reportedly associated with a dulling of empathy toward, or stigmatization of, people with SUD.

- *…[they] are ignored, their basic needs can be ignored… [one frequent patient] fell down in the entry way [of an ED]. And the doors were shutting on her over and over, and security was able to get her. It was awful, but staff was not helping in the meantime. I was like, 'What is happening here? Is this what we do? Is this the norm?*

What Are the Best Ways a Non-Addiction Medicine Physician Can Help Someone with a SUD?

Participants reported several activities that non-addiction medicine physicians can help someone with a SUD.

See the Patient as a Person

- *Not stigmatizing people if they do tell you that they're struggling with a substance use disorder… making sure that people know that you're a safe provider or a safe person to disclose that information to is going to be just important in general, especially for this type of issue that's so highly stigmatized.*

- *Address the medical components, and that means asking questions about known risks and complications and side effects for their substance use. So like, 'Opioids cause constipation. Oh, you're using fentanyl. Are you getting constipated from it. Can I help you with that?' so addressing the medical parts of it. Also, just kind of validating. Physicians have this kind of inherent power or authority or legitimacy kind of infused into them. And so, when they offer that to other people who are marginalized, they feel seen, they feel heard, they feel valued.*

- *…Go in with an open mind in the sense of not labeling, trying to …get past your mind's need to label or categorize that patient, and learn the language to not say, 'oh, this is an addict.' This is somebody who is taking drugs and they've lost the ability through their body chemistry being altered to say, 'You know, enough is enough.' So, I think educating yourself as a provider is key.*

Engage the Patient; Acknowledge, Talk, and Listen

- *Well, recognizing that there is a problem… somebody that they happen to see, their ER physician or their surgeon telling them, 'This is a problem.' I've had that conversation with a few patients who didn't really recognize that they had a problem.*

- *I mean, especially in primary care, I feel like everyone should be an addiction medicine physician… it's a common diagnosis…I feel like that would be saying you're a primary care physician and don't treat heart failure…. Anybody can start that conversation.*

- *… and this is hard, and bringing it up with the patient. I think sometimes [patients] will have a problem, and [the physician] is just kind of not saying anything or kind of be like, 'oh, well, you shouldn't drink that much.' But one of the hardest things is acknowledging and bringing it up with the patient… but I think part of it is acknowledging it and bringing it up, and saying, 'Hey, I think this could be a problem. Let's talk about that.'*

- *…not just kicking back to the curb, but really, really addressing and providing resources immediately upfront.*

- *Being able to have open dialogue with your patients and talking regularly about substances. 'How much alcohol do you drink?' and when they say 'occasional.' 'Well, what's your occasional?' so that way, you can really get into it… and then also seeing where they're at. Do they want to change? Because if a patient doesn't want to change, it's going to be an ongoing conversation… providers can have that type of open dialogue, be willing to go deeper into a dive to truly understand where their patient's at.*

- *At a bare minimum, I would just ask that they not be terrible to them… recognizing that someone with a substance use disorder still needs healthcare, and that their substance use disorder probably means that they need more healthcare than if they otherwise didn't have a substance use disorder, and that treating them poorly doesn't improve their health outcomes.*

Screen and Briefly Intervene

- *So SBIRT, right? Screening, brief intervention, referral to treatment.*

- *…in medical training, we're taught about history and physical… one of the things we ask is recreational drug us, IV drug use, all these things as well. And so that's part of our screening. A lot of times, it's mentioned, we talked about and then kind of glossed over, unless it's pertinent to why they're specifically here. So, a lot of times, it's glossed over.*

- *Motivational interviewing, cognitive behavioral therapy, strengths-based perspective… it's brief intervention… we want to be able to help patients get to where they want to be, if it's again, brief.*

Integrate Behavioral Healthcare Workers in Clinic

- *…having behavioral healthcare workers within our clinic, a text away, makes it easier for us to say, 'You know what? I can start the conversation, and I have somebody to spend time with that patient to develop the conversation a little bit more,' and make more of an impact on that patient's life, and helping them to get through whatever situation they're going through.… If more clinics move towards an integrated approach for medicine… it will empower clinics to address this issue and others.*

Prescribe Medication Assisted Treatment and/or Refer

- *We can prescribe buprenorphine.*

- *Just get them to the treatment… if you talk to them long enough, no matter what the viewpoint is, nobody usually has a problem initiating care and getting them to the people who do care…and if we could just do that better, I think that would be huge.*

- *I would just simply say learning MAT is one option. Learning about the places around Wichita and Sedgwick County and even some outside of Sedgwick County that can help people with substance use disorders. And that way, if they can't do it themselves, they know how to refer the patients to the right place.*

- *The best way, outside of learning how to prescribe it yourself, which isn't hard, would be to refer somebody to a treatment specialist where they can get that care.*

Bring the Patient's Primary Care Physician into the Conversation

- *One of my roles is to include the primary care doctor in the discussion and issue. Whenever I see somebody who I think is maybe seeking or showing behaviors that are concerning to me, I always just call their primary care physician because they know that patient more than I do….*

- *Get them to somebody who [can help them] deal with this problem… don't ignore it, 'this is not my responsibility.' Either you do something about it, or you call the primary care doctor about it.*

Why Have You Offered MAT?

- *Because most times people don't get the help that they need, or it takes too long. So, if I can give them something to help start facilitating… most likely, once they leave ER, go back and drink again, go back and drink again. If they're asking for help and they're willing to, then yeah, I'll prescribe it to them. And there are times where I will ask them.*

- *…there's such a paucity of people being able to provide it. And I think also, patients feel comfortable with their primary care physicians because we know them, and… now that the regulations have been lifted, have a great opportunity to be able to intervene and help people because we built that relationship of trust with the patients.*

- *Life-saving benefit. Mostly that.*

- *Because I think we need to… all these people are dying in bunches and we're just ignoring it. I feel like it's a crisis, so just trying to do our part.*

- *Because we're aware of people who need the help and know that it can make a difference in their lifestyle. And longevity as well.*

Why Have You Not Offered MAT?

- *…I would love to start… I had talked to my partner about this for our teen clinic, doing it because I don't think there's really anyone doing it for teens…. I just don't think we have the capacity at the time when I was approached about it to open the floodgates to ER referrals of teens.*

- *…I guess I was just really uncomfortable trying to get to that information [with my patients].*

- *I don't think I would be interested in getting training to do it because I just want to focus really where I am.*

- *We don't because we don't follow them with it [like a primary care provider would].*

Physician's stigma about people with SUD is associated with poor access to care and poor health outcomes. How do we reduce this stigma to prompt attitude and/or behavior change among local physicians regarding people with SUD?

Exposure to People with Lived Experience of SUD

- *…that exposure to people with lived experience, and listening to them tell their stories was really helpful…I'd say that's probably the only way that I've ever seen people effectively address stigma, you come face-to-face with the people who have the condition that you're afraid of… then you go, 'Oh, this is just a person, like me. We're just two people.'*

- *Having more of these patients and meeting them and hearing their story… when you can hear people's lives or their aspirations, it really helps you to see them as a person and not as their use disorder and whatever else is going on medically.*

- *…it could easily be someone who's a lawyer who's using substances, it's not necessarily this vision you have in your mind of someone who uses substances.*

- *Compassion. Simple compassion. Look at the patient and see, what if that patient was your mom? What if that was your son?*

Training and Education

- *I think reducing stigma comes back to early training and education…I think all of us learning to be better about using destigmatizing language, person-first language… it takes time to break those habits and retrain that.*

- *Education on helping physicians identify [SUD] as a disease and not a moral problem… focusing on their behavior being a symptom of the disease and not it being a defect of morality.*

- *I think the more educated [physicians] can be about what things really are, the less their biases will influence their decision making.*

Having Champions

- *From a clinic or organizational perspective, I think having kind of ground floor champions among the provider core is helpful…there needs to be a kind of sustained championing from the upper levels of the organization to say, 'This is our community. These are our people. This is important for us to be a part of.'*

How Do We Improve Access to SUD Care in Sedgwick County?

Establish Trust with Patients

- *We need to have that …starting point of a conversation on substance use. 'I'm your doctor, and here's what that means. I don't want to tell anybody else. I don't get to tell anybody else, but there are some exceptions to that, if there's a safety issue or whatever. But you need to know that this is a place where it's okay to tell the truth. Whether you're using it or not, I want to be your doctor.' And then emphasizing the idea that people who use drugs especially need a physician.*

- *…to watch a doctor kind of shut his laptop and then slouch in his chair next to a patient was just like the most beautiful interaction… Sometimes, all you need to be validated, and to be heard, and to be respected, and be treated with dignity when sometimes the people you love the most, sometimes those bonds are broken from this disorder… and for your doctor to [say], 'you still showed up today, and that means you want to work with me, and that's what I'm here for.'… That was powerful.*

Refer

- *Finding people to refer them to… you have to make it in the areas where they are, easy to get in.*

- *…the number of people I get in my [medication assisted therapy] clinic, for instance, who are referred there from a physician is close to zero. Most people are either told about it by a friend or a family member, or they just Google it, or they're told by their probation officer or something like that… there's not enough access to treatment.*

- *Maybe we just have to better about when they're in your ER all the time, or even your office and wherever… it can't just be like, 'no, there's nothing wrong with you, go.' Just trying to recognize it as 'we need to get you the right resource.'… If you don't want them to keep coming back all the time, then we need to address it properly, or we're not getting anywhere.*

- *Getting those people that we know about in appropriate care…getting access to the medication. We can get them to a provider when they need to be seen, which I think is the most key for these patients.*

Need More Providers

- *We definitely have to increase the number of people treating…primary care can do this… if we can get people comfortable with that and give people the resources and support, then hopefully we can increase the number of providers.*

- *First, we'd probably need better mental health care, and I think that goes very much hand in hand with having providers who specialize in substance use disorders, like mental health providers as well as medical providers who are also able to prescribe….*

- *I think we're going to need more physicians that have the knowledge and the desire to treat them. And like I said, that's probably something where you start at the root, in residency, and go from there.*

- *We need more doctors doing methadone clinic…because the volume- there's always wait lists.*

- *Being willing to do the effort on your own part to make sure you feel confident in what you're able to prescribe and what you're able to help treat them with is a lot of it.*

- *…because substance use and mental disorders kind of go together so much, I would create a new mental health hospital…. I would increase the number of providers, psychiatrist providers.*

- *More trained behavioral health consultants.*

We Need Prevention

- *I tend to view this disorder as a coping disorder and as a way to deal with mental health issues of any kind…the mental health component of majority of the illness that we treat nowadays are underlooked before somebody develops a problem…we wait until you're fully addicted to something to try to intervene.*

- *… make the pipeline smaller by helping people stay connect to the things that are important to them.*

- *Individual placement and support… it's a job placement intervention for people with mental health problems…putting people in a job, not just giving them job training or helping them find a job, but putting people in a job is a dramatically effective way to help people with mental health problems because it identifies that a person…needs something to do.*

Systems Changes Needed

- *…primary care physicians, general internists, general physicians do not get much training, very limited training in psychiatric illness…a six or four week rotation in psychiatry, and it's very hard for them to learn very much from that.*

- *Primary care is actually seeing a decrease in reimbursement rates as well… so again, that forces primary care physicians to address that by increasing their volume… then their quality of care unfortunately has to take the hit…. They only get paid to see a patient once a month…if a patient recurrently comes back…there's not very high billing codes for that.*

- *Transportation is a thing that's kind of hard for a lot of people…. that is always the hindering factor of everything….*