

The Humanistic Perspective of Nursing and Its Potential to Address the Opioid and Addiction Crisis

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Executive Summary

Registered nurses (RNs) are in the business of caring for people. While nurses are best known for providing care in hospitals, we also play other roles and work in other settings. Nurses care for people in their homes, primary care settings, health departments, schools, prisons, substance-use treatment centers, and psychiatric facilities. Licensed RNs may be educated at the associate or baccalaureate level, and they practice within a defined scope, which may vary by state. While nurses do fulfill medical orders, there is much more involved with the independent practice of nursing than most people likely realize. As the largest group of health care professionals, RNs bring a unique humanistic perspective and can play a critical role in combatting the opioid and addiction crisis in their communities, especially when they are practicing at their full scope of practice.

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Editorial Note

This report is part of a month-long awareness campaign and town hall discussion about the opioid and addiction crisis in Western North Carolina, visit go.wcu.edu/townhall to learn more.



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Nursing Philosophy

Nursing addresses the human response to health and illness and has very different philosophical underpinnings from the medical model, which predominates in the US health care system. The medical model is based on a biomedical perspective, which is often focused on disease and illness and involves use of a systematic method of collecting evidence to support the diagnosis of a disease or disease state.²⁰ The medical model defines health as the absence of disease or illness and is historically rooted in Rene Descartes's dualism, which presumes that the mind and body are separate entities.⁷

In contrast, the theoretical underpinnings that define nursing are based on principles of holism and humanism. Humanistic theory assumes human beings are holistic, ever-changing, multidimensional, and unique in their experiences.¹⁴ The relationship between the nurse and patient is partly based on the nurse's understanding that the patient's potential should not be limited to the absence of disease. Humanistic theory is one of many holistic theories that guide the practice of nursing. Holistic care moves beyond recognizing wellness as the absence of disease and provides a foundation of wellness as interconnection among mind, body, spirit, and environmental and social conditions. We are not claiming that medicine disregards prevention and wellness. Rather, we claim that reimbursement for health care services in the United States remains predominantly focused on treatment of illness rather than on preventive services. More often than not, the arsenal of treatment options used in the medical model includes surgery, procedures, and pharmaceuticals.

Nursing is also rooted in caring, with a strong emphasis on prevention and on promoting health and wellness. Nurses can, through their licensed scope of practice, engage in therapeutic nursing

interventions to support the human response across these domains. These interventions include fulfilling specific treatment modalities, educating patients and loved ones, and providing a therapeutic presence to demonstrate care and support for the patients, families, and communities we serve. For the most part, none of these services are directly reimbursable in our current health care system. Rather, nurses are often seen merely as labor costs, and they often feel the brunt of budget cuts.

In addition to practicing holistic care, the nursing profession has core values that ensure that nurses provide care that is ethical and patient-centered. These core values include autonomy, beneficence, nonmaleficence, and justice.² Justice can be interpreted as provision of care that is equitable and fair. When we speak about equity and justice, it is vitally important to consider the concept of need. In today's complicated and ever-changing health care system, providing people with the care that they need is not an easy task. Nurses are called on not only to provide individual care of patients based on justice, but to advocate a health care system that provides equitable care. In other words, an ethical principle that underlies the practice of nursing is ensuring people have access to the care they need.

In the changing landscape of health care, the nursing profession has been the most trusted of all professions, twenty years running.¹⁷ Based on the Gallup survey assessing ethics and honesty, nurses are more trusted than physicians, police officers, and teachers. Our guiding principles and philosophies have provided us with the desire and ability to connect with the people we serve. That connection has provided our patients with a sense of trust and comfort.

Nursing Practice

There is great misunderstanding within other health care disciplines and among the general public about the education of nurses and their scope of practice. To be licensed as an RN, nurses may obtain a nursing diploma, an associate degree, or a bachelor's degree (BSN). The fact that there are three different entry-level educational requirements for initial licensure represents historical changes in our education and

arguably a need to standardize initial educational requirements. Regardless of the entry-level education an RN obtains, a BSN is required to enter nursing graduate programs. With graduate education and additional training, nurses may also engage in advanced nursing practice, which provides them the ability to incorporate medical interventions into their nursing practice.

The scope of practice for advanced-practice nurses is regulated at the state level and varies. In all settings and levels, we interact with people who have substance-use disorders. The combination of philosophical underpinnings of nursing practice and broad education on physiological, psychological, social, emotional, environmental, and spiritual domains of health and the human experience warrant that nursing professionals be fully engaged in practice-based community strategies to combat the opioid crisis.

Health effects of The Opioid Crisis and Challenges of Treatment

The fact that so many individuals, families, businesses, and communities have been impacted by this crisis has heightened awareness regarding the growing number of overdoses and deaths related to the use of opioids. Every day, 130 Americans die from an opioid overdose.⁵ In addition to overdose, opioid use often leads to considerable morbidity, especially when the person self-injects. Nurses are often on the front line in caring for patients facing these consequences in settings ranging from the intensive care unit to the community.

For example, injecting opioids into the bloodstream also places the person at risk of contracting viral infections such as the hepatitis C virus and human immunodeficiency virus (HIV). These individuals are also susceptible to bacteria that can infect the heart valves, skin, bones, and brain. When bacteria grow on a heart valve, it is called infective endocarditis (IE), a severe illness that often leads to valve failure, heart failure, sepsis, blood clots, or strokes. Since the emergence of the opioid crisis, hospitalizations due to both opioid overdoses and IE have increased significantly at the state and national levels.

IE can seriously impact future health and even survival: about 20 to 40 percent of people who develop IE do not survive.⁹ North Carolina has seen one of the biggest increases in opioid-related inpatient hospitalizations, compared to other states.¹ From 2010 to 2015, it experienced a twelvefold increase in hospital discharges of patients with combined diagnoses of drug dependence and IE. The majority of these patients were under the age of forty.⁹ In 2010, the cost (in North Carolina) of hospitalizations related to IE and drug dependence was \$1.1 million. By 2015, the cost of these hospitalizations had skyrocketed to \$22.2 million, an eighteenfold increase.

Other challenges in providing treatment for these individuals include the need for high-cost care for patients with a history of intravenous drug use. For example, the treatment for IE includes intravenous antibiotics for a minimum of four to six weeks and requires the patient to have a special long-term device to administer these medications. In situations not involving substance use, these devices and the administration of antibiotics for treatment can be managed at home with the help of a home health nurse. Unfortunately, it is not safe to send a patient home with this type of device if they have a history of substance abuse: there is a significant risk the patient will self-inject drugs and overdose, or introduce bacteria or viruses into the bloodstream. Ultimately, these patients typically stay in the hospital for the full course of treatment, far beyond the length of time they would normally be required to remain hospitalized.

In some cases, antibiotics are ineffective at treating a patient's infection, and because of resulting damage to the heart valve tissue they will require a heart valve replacement. Individuals with a history of IE are at high risk of reinfection, especially when they continue to self-inject substances. If a new valve becomes infected, it typically needs to be replaced.

Beyond financial and treatment challenges, other complexities need to be addressed when caring for individuals with substance-use disorders in both the acute-care environment and community/primary

care settings. One such complexity that persists in the United States is the perception that addiction is a problem of morality and poor decision-making.

Understanding the Science of Addiction

The stigma regarding addiction as a deficit of morality has persisted despite compelling scientific evidence that supports the view of addiction as a chronic disease. In order to understand why a person might continue to use opioids even when severely ill, it is important to consider the neurobiology of addictive disorders.

New discoveries are unveiling the brain processes associated with the loss of control and compulsive drug use that accompany addiction.¹⁹ The National Institute of Drug Abuse defines addiction as a “chronic, relapsing disorder characterized by compulsive drug seeking, continued use despite harmful consequences, and long-lasting changes in the brain.”¹⁸ Sustained drug use disrupts brain chemistry and prefrontal cortex functions and results in an excessive response in the limbic system when exposed to cues that remind the affected person of drug use.⁴ These excessive responses are known as cravings, which are intense and powerful responses to such cues; cravings are a hallmark of addiction and lead people to seek drugs.¹⁶ Cues may simply be exposure to the drug itself, but they include anything that reminds the person of the drug: stress, friends they used drugs with, places they used drugs, or situations in which they would commonly use drugs.

The phenomenon of craving is similar to a sugar lover who is craving chocolate cake or a social drinker who is craving a glass of wine after a long and stressful day; but cravings for opioids are far more intense and for some individuals may be nearly impossible to overcome with willpower alone. The craving of a person with a substance-use disorder results in the release of pathological amounts of dopamine upon exposure to drug-related cues. This craving overpowers the person’s ability to be rational, and,

subsequently, seeking out the substance to which they are addicted is their top (and in some cases, only) priority.

These cues are not limited to opioid addiction, but also concern other types of addictions. For instance, use of tobacco products is highly associated with social or environmental cues, which play an important role in an individual's ability to refrain from use. Craving and its relationship to relapse have been well studied in addiction science. Many abstinence-focused recovery programs help the individual to identify the environmental cues that may trigger cravings (and lead to relapse). RNs can take holistic approaches and work directly with clients to help identify the cues that may trigger these responses and to help to develop positive coping mechanisms.

When patients with substance-use disorders abruptly stop using the substances, whether by choice or not (such as when they are hospitalized or incarcerated), they experience withdrawal, which can be extremely uncomfortable and painful and, in some cases, can result in life-threatening responses. People in acute withdrawal from opioids have dangerous physical symptoms, including increased heart rate and elevated blood pressure, which can lead to strokes and other cardiac events.⁴ Some of the physical symptoms that accompany opioid withdrawal include vomiting, diarrhea, changes in body temperature, anxiety, and sedation.

Hospitalized individuals with a history of substance abuse are fortunate to have nurses who fulfill the critical role of constantly assessing their responses during withdrawal and assist the medical providers in initiating treatment protocols. This is not necessarily the case when someone goes into withdrawal when in custody by law enforcement. Furthermore, even if someone receives supportive treatment in the withdrawal process, there are limited options for long-term treatment to support recovery.

Without appropriate education, health care providers may fail to recognize the impact of these physiologic responses on subsequent behaviors that manifest in many patients with a history of opioid use.

Such behaviors include using illicit drugs while hospitalized with severe illness.^{9,10,11} These patients might leave the hospital against hospital-staff advice because of their intense desire (some would argue need) for the drugs they crave. In many cases, access to illicit drugs while hospitalized may be provided by family and friends, that can even result in death. In response, some hospitals have employed abstinence-based policies specific to reducing the risk that the patient will use illicit drugs while in the hospital.¹⁰ Often, these policies prohibit visitation by family and friends, which presents its own ethical dilemmas regarding patient rights versus patient safety concerns.

These challenges present unique and complex dilemmas for nurses caring for these individuals; our code of ethics and underlying values support autonomy in decision-making and patient and family engagement, which is not always possible when these safety concerns are present. For individuals suffering from addiction, it is as if a switch has been turned on that cannot be turned off. It is essential that anyone caring for, or involved in policies that guide the care of, patients with addiction disorders have a sound understanding of the pathophysiology involved in addiction.

Treatment and Recovery

One of the philosophical approaches to treatment for addiction is abstinence, which is used in popular twelve-step programs. Abstinence is the complete cessation of drug use and has been accepted as the preferred model of recovery for many years. But more recently, harm-reduction strategies have been gaining momentum in combatting the opioid crisis.

Harm reduction refers to any strategies aimed at reducing the negative consequences of drug use and includes medication-assisted treatment (MAT), safe drug-consumption sites, safe needle-exchange programs, and naloxone training and distribution.^{3,6} MAT is being used primarily in community settings and includes the use of pharmaceutical therapy, counseling, and behavioral therapy to support recovery from opioid-abuse disorders. MAT has become one of the most important methods for treating opioid-use

disorder.⁶ Harm-reduction strategies can fulfill the core values of equitable and just treatment, in that they call for the nonjudgmental and noncoercive provision of resources and services, providing a voice to people affected by addiction.¹⁵ Efforts that support harm reduction should be implemented and supported in all communities; these efforts save lives and provide people with substance-abuse disorders access to the health care system, including substance-abuse treatment facilities.

Opportunities for RNs to help address the crisis

RNs can play valuable roles on behavioral-health support teams because of the important elements of assessment, planning, interventions, and evaluation of a person's response through a holistic lens. Nurses are probably best known for providing client education, but they can also perform other interventions, such as basic counseling and emotional support. Nurses can also help individuals identify ways to strengthen positive coping mechanisms. They can provide encouragement to identify client-directed goals and provide coaching to help the clients achieve their health goals. RNs can provide a number of cost-effective contributions to help combat the opioid crisis. They can provide evidence-based nursing interventions to augment medical interventions to support recovery for people suffering from addiction and substance-use disorders or to manage chronic pain. New changes in reimbursement to support improved patient outcomes are creating new roles for RNs providing care-coordination and care-management services to help address clients' educational needs and need to navigate the complex medical system, and they include roles for RNs addressing social determinants of health that may impede patients' ability to stay in recovery programs. For these individuals, an interdisciplinary, team-based approach to treatment, beyond merely providing pharmacological therapies, is needed.

Barriers to nursing's involvement

However, a number of market barriers limit the nursing profession's ability to help solve this crisis. One of the four key messages of a seminal report issued in 2010 by the Institute of Medicine called for nurses to be

able to practice to the full extent of their training and educational preparation.⁹ Nurse practitioners can provide high-quality care for individuals in primary care settings and offer a feasible solution to the growing need for health care providers in rural areas.¹³ Currently, in North Carolina, advanced-practice nurses are required to have a collaborating physician to oversee their practice. Other states allow full authority for nurse practitioners, who do not require oversight by or collaboration with a physician. Thus, policy changes are needed to allow advanced-practice nurses to practice to their fully defined scope of practice, which is, and should remain, defined by the Board of Nursing.

Prior to 2000 and the passage of the Drug Addiction Treatment Act, medication-assisted treatment for people with opioid-use disorders was limited to clinics administering daily methadone therapy. Since that time, a program has been established that requires practitioners who wish to prescribe buprenorphine (also known as Suboxone) to request a waiver from the Drug Enforcement Agency in order to prescribe this medication. The waiver program also limits the number of people to whom each individual provider can prescribe these medications. Included in this waiver program are specific training requirements for advanced-practice nurses and other non-physician prescribers that are more extensive than what is required of physicians. Nurse practitioners and physician assistants must undergo twenty-four hours of training, while physicians are only required to have eight hours of training based on an untested assumption that they receive this information in their medical training programs or are otherwise more qualified to prescribe these medications. Additionally, in states where nurse practitioners do not have full practice authority, their physician-oversight requirements also include a requirement that the physician hold a waiver to be able to prescribe these medications, further limiting access to these services by nurse practitioners. Training to provide MAT correctly is not the issue; rather, it is the inequity of requirements that limit other professionals from providing MAT, when they might otherwise provide additional access to this type of treatment for individuals, especially in rural areas.

Addressing Pain

In order to adequately respond to the opioid crisis, it is imperative that we address societal views on pain (and the overarching expectation that life should be pain free) and health care providers' approaches to assessing and managing pain. The historical events leading to the opioid crisis include a "perfect storm" of marketing of opioids by the pharmaceutical industry and the designation of pain as the fifth vital sign by the American Pain Society (APS), a recommendation that was subsequently adopted by the Joint Commission in 2000.¹² This recommendation to increase assessment and management of pain by the APS was based on racial and age disparities and was a move in a positive direction, aimed at providing equitable care to all people. The APS's recommendation changed health care evaluation of every patient in every care setting. However, the overwhelming desire to increase profits drove pharmaceutical companies to not only exploit this recommendation, but also to exploit health care providers' desire to alleviate human suffering. These realities are coming to light in the recent lawsuits by a number of states and their attorneys general against the manufacturers of opioids marketed during this significant period.

After the Joint Commission adopted pain as a fifth vital sign, quick and effective methods to assess pain based on patients' subjective experience became institutionalized. Most health care providers and systems incorporated a numerical pain scale, which allows the patient to designate a number that best represents their level of pain. Despite the intended utility of the numerical pain scale, this simple assessment tool has partly contributed to the overuse of opioids. When a patient designated a number that signified a high level of pain, that patient was often treated with what was being marketed as the most effective treatment option: opioids.

Pain is an inevitable part of being human and is not limited to physical pain. We also suffer emotional and spiritual pain, which are deeply connected with and impacted by physical pain. When we quantify pain, we try to simplify something that is highly complex and we fail to acknowledge unique human

responses to pain. When we simplify pain management with a pill, the chances of disastrous results can become inevitable.

We are not implying that people should languish in physical pain or that health care providers should tell people there is a necessary lesson to be learned from physical pain. Rather, we claim that alleviating the suffering of another person requires far more than asking them to assess their pain on a numerical scale and manage that pain with a pill. When we simplify a complex concept such as pain and simply try to eliminate it, we are practicing under a model of care that doesn't seek to understand, care for, or connect with a human being.

A more holistic approach yields far better results. Part of what a human being needs when they are in pain is connection to another human being. Our attachments with other human beings are crucial to our survival and ability to thrive. During difficult times when we are in pain, we need the support we find in relationships. At the core of nursing is our connection to our patients and our ability to perceive a patient's potential as far more than merely the absence of pain. Therapeutic presence and communication can help to alleviate the pain and suffering our patients endure.

Conclusion

There is no simple solution to the opioid crisis. If we have learned anything at all, it is that there is not a cure-all for those who are suffering in the crisis. On the contrary, the opioid crisis presents an opportunity to provide nonjudgmental compassion to the human beings who are suffering and to search for community-based, innovative solutions that provide people with an ability to connect to others and find the support they need. Improved access to health care, increased community outreach, better pain assessment, and education regarding pain management are just a small number of the approaches nurses are taking to combat the crisis. We are caring for patients with opioid-use disorders in every walk of our profession and our lives because caring is our business.

Footnotes

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Resources for further reading:

Advanced Practice Nursing: Policy priorities

<https://www.aanp.org/advocacy/federal/federal-issue-briefs/aanp-federal-policy-priorities>

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Medication Assisted Treatment

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