



## Editor-in-Chief Pick August 2022

By Jeffrey A. Kline, MD

### The Real World

The simile of contrasts stated as “The difference between academic research and clinical practice is the difference between opera and real life” explains part of the value of this month’s POTM, ***“Just give them a choice”: Patients’ perspectives on starting medications for opioid use disorder in the ED*** by Schoenfeld et al. [This paper](#) should be mandatory reading for all emergency physicians at all levels, and I believe for all physicians. Using rigorous planning and qualitative methodology, the authors interviewed 27 persons with opioid use disorder to understand their opinions, beliefs and thought processes about opioid use disorder, suboxone and methadone, and about their experiences with health care providers. The work shows the beauty and the power of well-done qualitative research. This methodology provides a tiny bit of magical ability to read patients’ thoughts in a more-or-less systematic, nonjudgmental and transparent way. Keep in mind that about 1/3 of perfectly “normal” Americans believe that evolution never happened and bigfoot is real, while 7% believe chocolate milk comes from brown cows. With that consideration, Schoenfeld et al show that patients with opioid use disorder harbor many beliefs anchored in a reality that may or may not be the same reality for clinicians. For example, the authors summarized that “Most participants who had tried buprenorphine could explain that it had “blocking” properties and that these properties that would cause one to “feel worse” (precipitated withdrawal) if they were not yet in opioid withdrawal and could keep people from overdosing.” However, another participant believed “For Suboxone, you have to be able to be clean for two days and none of these people are going to be able to do that.” The paper goes on to emphasize that like just about all patients with any disease, folks with opioid use disorder want to have access to all options, in this case to choose between suboxone and methadone. Whether we like that or not as clinicians, that is the reality of our patients. The paper goes on to describe the importance of treating patients as partners, being nonjudgmental, and that relapse is part of the natural history of getting better. This paper serves as a model for the treatment of opioid use disorder, brilliantly illustrating the yawning chasm between the hard evidence required for clinical practice guidelines, and the real world. I would argue the same gap exists for the treatment of many other medical problems encountered in emergency care, including hypertension, diabetes, blood clots and any other substance use disorder.