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## Commentary

### WHY WE DO WHAT WE DO—DELIVERY OF BUPRENORPHINE AND THE TREATMENT OF OPIOID ADDICTION

At first glance, there is nothing unusual about the article by Bell and colleagues [1]. The Introduction notes that 'there is limited evidence of the effectiveness of maintenance treatment without observed dosing'. One simply assumes that the authors were interested in seeing how unobserved administration of buprenorphine compares with the traditional way of doing things—whether patients will do as well. I was surprised, therefore, to read the authors' hypothesis that 'retention in treatment would be superior in the group randomized to unobserved dosing, as the requirement to attend a clinic for supervised administration of medication would be a deterrent to remaining in treatment'. What are they saying? Are they asserting that the way we have been treating patients is not in their best interests and that clinic attendance may actually be a *deterrent* to remaining in treatment? What the authors postulate appears to go against the long-standing precept that 'more is better' in terms of more services, treatment and clinical supervision being better in terms of longer retention, reduced drug use and improved functioning [2–4]. Most researchers and clinicians would presume that the group attending clinic more often for observed dosing would do better [5]. A lunch-time informal survey by showing of hands among investigators at the UCLA Integrated Substance Abuse Programs showed that the overwhelming majority (13 : 1) felt that way; a lone cynic thought patients might learn bad habits from other patients at the clinic.

As it turned out, the two groups performed 'strikingly similar' in clinical outcomes, except that the cost for the unobserved group was, as predicted, significantly less. At this point, we could expect the authors to suggest that we should reconsider our current treatment approach, to grant greater latitude and reduce requirements for clinical contact. I was even more surprised when I came upon the first sentence of the discussion: 'Refuting the trial hypothesis, attendance for observed dosing was not a deterrent to remaining in treatment during the first 3 months.' What we have been doing so far is not so bad after all—perhaps we do not have to revamp our treatment approach.

However, adherents to conventional addiction medicine could hardly take comfort in the outcome of the

study and the way the results were framed in the treatment context. In the United States and in many other countries the idea of requiring clinic attendance has always been thought of as contributing to more positive outcomes. Requiring patients to attend clinic more frequently has been advocated as an intensification of therapy [6]. The idea has been so ingrained that it is embedded in virtually all treatment practices and official requirements [7]; it was even legislated as a provision for approval of buprenorphine for treatment of opioid addiction in the United States [8,9].

Perhaps the issue is not so much about whether required clinic attendance is good or bad for patients, but about why we do things the way we do. Could it be that at some level we recognize that requiring frequent clinic attendance is a burden on our patients but we make these requirements for other than research-based reasons? Perhaps we do not trust our patients enough, perhaps with good reason, or perhaps traditional treatment approaches are overly reflective of societal expectations more than based on scientific rationale. Even if we clinicians consider these matters consciously, we are unlikely to engage patients in the process. We do not say to our patients that we understand it is a burden to attend clinic, but that it is necessary because society wants us to adhere to certain expectations in order to improve outcomes, ostensibly, to exert control, or for whatever reason. In the final analysis, we can only do what 'Big Brother' lets us do according to regulatory mandates. In that context, the real message is that we believe addicts are sick and need help but they are also sinners and must suffer a little, whether by required clinic attendance or supervised dosing or providing urine samples; but that 'suffering' may not be entirely bad. While the first principle of medicine is that the patient's best interests are paramount, sometimes the needs of the greater society conflict with the physician's judgement about what is best for the individual patient. This is particularly pertinent to addiction, which affects not only the individual, but society as a whole. In such cases it is perhaps also our responsibility to convey to our patients that giving consideration to societal needs is an integral part of their recovery, because in the end they will have to live as a member of that same society with its structured mandates, laws and expectations.

**Keywords** Buprenorphine, clinic attendance, opioid, opioid addiction, treatment, treatment outcome.

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