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CONTRACTS WITH PEOPLE WHO INJECT DRUGS FOLLOWING VALVE SURGERY: UNREALISTIC AND MISGUIDED EXPECTATIONS

To the Editor:

We applaud Vlahakes' acknowledgment, in a recent editorial commentary,¹ of the importance of incorporating addiction medicine experts into the care of people with infective endocarditis caused by injection drug use. However, we take issue with his recommendations that surgeons pursue a contract with their patients who use injection drugs as motivation for them to remain clean.

The idea that a contract—an indenture between surgeon and patient—is enough to prevent illicit drug use is misguided. Substance use disorders have a complex pathophysiology, influenced heavily by comorbid psychiatric illness and socioeconomic factors. Treatment options are limited and often difficult to access. It is unrealistic to expect that a signature on a piece of paper, in a time of medical extremis, will insulate the patient against recurrent drug use. Even if the patient can grasp the gravity of prosthetic valve endocarditis, it is shortsighted to suggest that the potential for a disease will prevent use of drugs. Decades of neuropharmacology and neurobiology research demonstrate that drug dependence is defined by altered decision making. According to the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*,² the essential feature of substance use disorder is that “the individual continues using the substance despite significant substance-related problems.”

Other behaviors, such as smoking cigarettes or caloric dietary decisions, can also cause recurrent cardiovascular disease. In our review of the literature, we have seen no editorials by surgeons on the importance of contracts with diabetics or smokers to avoid future behavioral transgressions. A smoker who comes in with angina following cardiac revascularization will not be refused treatment. A

diabetic with high sugars who has acute sternal osteomyelitis with retrosternal abscesses following cardiac surgery will not be refused debridement and reconstruction surgery.

Instead of contracting with patients to compel them to avoid injection drug use, a more useful contract is between surgeons and other inpatient clinicians with medical, psychiatric, and substance use-related services outside the hospital to assist patients with the transition from inpatient to posthospitalization care. As shown in a recent review of injection-drug-use-related endocarditis cases at 1 Boston hospital, fewer than 10% of cases were referred to medication-assisted treatment programs for buprenorphine or methadone.³ With limited posthospitalization support, it is not surprising that several patients with injection-drug-use-related endocarditis use illicit drugs again. There is room for improvement, and our focus should be on getting our patients the addiction-related services they need.

People who inject drugs represent a vulnerable, marginalized population, often with fragmented health care. Contracts dictating the availability of future life-saving care have no place in the clinician–patient relationship.

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CONTRACT WITH THE PATIENT WITH INJECTION DRUG USE AND INFECTIVE ENDOCARDITIS: SURGEONS PERSPECTIVE

Reply to the Editor:

We read with interest both Vlahakes' editorial commentary¹ on the new American