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Responding to Unexpected Urine Drug Test Results: A Phenomenological Approach

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Abstract

As a response to the opioid epidemic in the United States, the Centers for Disease Control and Prevention (CDC) published the *CDC Guideline for Prescribing Opioids for Chronic Pain* in 2016. This document served as a means to reduce risks and address harms of opioid use by recommending that clinicians conduct periodic urine drug testing for patients on chronic opioid therapy. As an unintended result of this recommendation, providers began using unexpected urine drug test results as a reason to dismiss patients from practice, both out of concern for their patients' wellbeing as well as their own legal risks. Using Husserl's and Heidegger's phenomenology, we argue that this science-based, black-and-white practice does not heed the patient as a whole person. Instead, we recommend a more contextual, patient-centered approach that can help us to better understand and manage patient needs in such contexts.

Keywords

Martin Heidegger, Edmund Husserl, opioid epidemic, medical ethics, chronic pain

Pain is difficult to treat. Although there may be lab or imaging tests and physical assessments to support a diagnosis of pain, pain is largely subjective. There has been concern in the healthcare community that this could lead to under-reported and undertreated pain (Pozza et al., 2021). The President of the American Pain Society, James Campbell, addressed this in 1995 by introducing pain as the fifth vital sign, further emphasizing the importance of routine pain assessments (Campbell, 1996). Consequently, various assembly bills, professional organization recommendations, and treatment guidelines were modified to stress the importance of effective

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pain management (Pozza et al., 2021).

The emphasis on pain as the fifth vital sign had unfortunate and unintended consequences. Rather than drawing attention to the need for improved assessments, many healthcare professionals and organizations emphasized the importance of treating pain, often overzealously (Baker, 2017). This led to inappropriate use of opioids, with steadily increasing numbers of opioid prescriptions, and consequently, the development of the opioid epidemic in the United States (Baker, 2017). In fact, from 1999 to 2014, over 165,000 Americans died from opioid-related overdoses; in 2011, it was estimated that more than 420,000 emergency department visits were due to opioid misuse and abuse (Dowell et al., 2016).

In some regards, the pendulum has swung the other way, with providers now fearful of prescribing opioids, both out of concern for their patient's wellbeing as well as their own legal risks related to doing so. In 2016, the *CDC Guideline for Prescribing Opioids for Chronic Pain* recommended routine urine drug testing to reduce the patient's risk of toxicity and drug-to-drug interactions, mitigate medical and legal problems, and better ensure patient compliance (Dowell et al., 2016). However, providers are increasingly using unexpected urine drug test results as grounds for patient dismissal (Florete, 2018). While this protects the provider from a legal standpoint, it raises serious ethical concerns, as it does not take into consideration the factors and life circumstances that may be involved in the patient utilizing drugs other than opioids in the first place. Using Edmund Husserl's and Martin Heidegger's phenomenology as our background, we argue that this practice does not heed the patient as a whole person nor is it attentive to the situational context (Husserl 1913/1989; Heidegger, 1987/2001). By applying phenomenology, it becomes clear that providers should avoid dismissing a patient solely on the basis of an unexpected urine drug test. Instead, providers can use a phenomenological lens to better understand the patient's experience and respond in a manner that delivers contextual, patient-centered care that respects the patient as a whole human being.

Overview of Phenomenology

In order to apply phenomenology to the issue at hand, we need to get a sense as to the general impetus of this way of doing philosophy. The motto of phenomenology is encapsulated in the pithy saying by its founder, Edmund Husserl, that we need to "get back to the things themselves" (Husserl, 1900/2001, p. 50), which means that we need to philosophize in a way that respects how things show up in their everyday contexts, rather than approaching all entities from the strictly scientific perspective. Husserl was responding to the movement of naturalism in the early 1900s "that recognize[d] as real (*wirklich*) only the physical" (Lauer, 1965, p. 9). When naturalism is applied to medicine, Husserl argues, we get "scientific medicine [that] results from the utilization of insights belonging to purely theoretical sciences concerned with the human body, primarily anatomy and physiology. These in turn are based on those fundamental sciences that seek a universal explanation of nature as such, physics and chemistry" (Husserl 1911/1965, p. 149). Purely from the perspective of science, the human body can be understood as a physical object that functions according to the principles of physics and chemistry. Husserl's word for this aspect of the human body as a material object is *Körper* (Husserl 1913/1989, p. 152ff). While Husserl notes that "no reasonable person will doubt the objective truth or the objectively grounded probability of the wonderful theories of … the natural sciences" (Husserl, 1911/1965,

p. 74), he thinks that this way of approaching the world does not and indeed *cannot* do justice to the way in which we experience the world in our everyday contexts. Since the natural scientific approach leads to a "dogmatic one-sidedness" (Husserl 1935/1996, p. 19) in that there is a myopic focus on objectivity, he develops phenomenology as an attempt to describe the world as it appears in everyday contexts, thereby paying credibility to the subjective factors of experience. Pain as a subjective experience plays a significant role in his analysis, which is the most obvious place to start when it comes to the opioid crisis.

From a phenomenological perspective, pain cannot be approached from a merely objective, scientific stance. Instead, the proper initial question is: "what is it like to experience pain?" Husserl provides the following commentary on this very question as follows:

> If the hand is pinched, pressed, pushed, stung, etc., touched by external bodies or touching them, then it has its sensations of contact, of being stung, of pain, etc. … my Body's entering into physical relations (by striking, pressing, pushing, etc.) with other material things provides in general not only the experience of physical occurrences, related to the Body and to things, but also the experience of specifically Bodily occurrences of the type we call *sensings*. Such occurrences are missing in "merely" material things. (Husserl, 1913/1989, p. 153)

What Husserl is getting at is that the experience of sensing the world cannot be explained by merely appealing to the body as object; rather, any robust discussion of pain needs to deal with it as a subjective sensation. Commenting on this, Saulius Geniusas states, "Pain biology, if successful, can shed light on the neurophysiological mechanisms that, presumably, accompany pain experience. However, irrespective of its practical utility, pain biology cannot clarify the nature of pain experience" (2020, p. 1-2). This is why Husserl makes a distinction between the body as physical object (*Körper*) and the body as lived body (*Leib*), the latter of which "refers to my own existence, to my experiences, perceptions, and feelings as they are lived" (Aho, 2018, xvi). In fact, Husserl makes it clear that the primary investigation of phenomenology is "phenomena," "the most general essential character [of which] is to exist as the 'consciousness-of' or 'appearance-of' the specific things, thoughts (judged state of affairs, grounds conclusions), plans, decisions, hopes, and so forth" (Husserl 1935/1996, p. 15). From this perspective, a description of pain has to do with one's consciousness of pain and the ways in which pain alters one's world. An analysis of *Körper* can provide meaningful scientific insights into the human body, but an attentiveness to *Leib* opens us up to the lived experience of the person, which may not only help us to understand another's experience of pain, but also a person's broader overarching goals, life plans, values, etc.

Husserl's most famous student, Martin Heidegger, utilizes this distinction between *Körper* and *Leib* to elucidate the ways in which humans are different from merely objective entities in his Zollikon Seminars, which were a series of lectures given to health professionals with the attempt to show that, despite the obvious successes of scientific medicine, "the central characteristic of being human cannot be approached by natural science" (1987/2001, p. 27) and, therefore, the practice of medicine requires methodologies that go beyond those found in the natural sciences. Heidegger makes it clear that his approach does not entail an "abandonment of science, but on the contrary [a means of] arriving at a thoughtful, knowing relationship to science and truly

thinking through its limitations" (1987/2001, p. 18). Phenomenology of healthcare, from a Husserlian-*cum*-Heideggerian perspective, complements scientific knowledge with an approach to care that attempts to understand and respond to the patient as a lived body, rather than as merely a physical object. As Heidegger is talking primarily to psychiatrists in these seminars, he begins his discussion with the example of sadness to highlight his overarching point as to the limits of science and the need for human connection:

> How do we measure sadness? Evidently, one cannot measure it at all! Why not? If one approached sadness with a method of measuring, the very approach would already be contrary to the meaning of sadness … As far as sadness is concerned, it can only be shown how a person is affected by it and how his relationship to himself and the world is changed. (Heidegger, 1987/2001, p. 82)

Heidegger's point is that the experience of sadness from the perspective of the patient cannot be understood from a merely scientific perspective, a discussion that allows him to extrapolate towards the topic of pain. In noting that health professionals have a better sense scientifically as to what might *cause* pain, he states "yet, a layman's experience is probably closer to the phenomenon of pain" (Heidegger 1987/2001, p. 84). This is because the experience of pain can only be heeded by engaging with the lived body of the patient, rather than merely the body as physical object. Instead of a black-and-white scientific approach to pain and access to pain relief, a Heideggerian approach calls for providers to think through how pain is affecting a person holistically, thus leading to a different relationship with the world.

In order to help providers engage in these more holistic approaches to patient care, Heidegger makes it clear that they must heed the uniqueness of each patient and he does so by commenting on the phenomenon of "bodying forth" [*Leiben*]. He states, "the body is not … [merely] a corporeal thing, but each body, that is, the body as body, is in each case my body. The *bodying forth* [*Leiben*] *of the body* is determined by the way of my being" (Heidegger, 1987/2001, p. 86). This concept of bodying forth is helpful in that it recognizes living as a unique unfolding for every individual. In the context of pain, this means that certain individuals are able to tolerate and cope with pain effectively, but others are unable to do so and thus require more aggressive treatments. In order to assess their patient's capacity for tolerating or coping with pain, providers should build a relationship with the unique person in order to determine their character and "measure up" the patient's pain capacity. Heidegger discusses our myopic understanding of measurement to make this point. From a scientific perspective, to measure is to provide objective exactitude via the use of tools. But, there is also the type of measuring that occurs in relations to humans where we determine if others "measure up" to our preconceived understandings, given the information we are given. Heidegger states, "All measuring is not necessarily quantitative. Whenever I take notice of something as something, then I myself have 'measured up to' [*anmessen*] what a thing is. This 'measuring up' [*Sich-anmessen*] to what is, is the fundamental structure of human comportment toward things" (Heidegger, 1987/2001, p. 100). Measuring, in this sense, is a matter of holistic assessment. When we are attempting to determine if a patient should indeed be provided access to opioid medication, Heideggerian phenomenology would recommend a holistic, relational approach where we engage in communication to determine the patients' experience of pain as it is related to their life as a whole.

Generally speaking, Husserl and Heidegger help to provide a means for health professionals to attend to their patients as persons rather than as merely bodily objects. This provides us with an appropriate springboard to think through the experience of chronic pain, which is often the reason patients seek opioid therapy (Chou et al., 2020). Research has shown that patients seek opioid prescriptions often to treat chronic physical pain, but that other factors are common, including seeking to get high or experience euphoria, to improve sleep, to relieve depression, sadness, nervousness, or anxiety, and to deal with bad memories (Weiss et al., 2014). A holistic approach in which we explore the phenomenology of the patient can provide a means to explore the reasons as to why the patient is seeking medication so that the provider can determine the best course of action.

Phenomenology of Chronic Pain

Logically, then, it makes sense to first seek to better understand the phenomenology of patients with chronic pain *before* responding to unexpected urine drug test results. After all, patients with chronic pain are those most frequently managed with chronic opioid therapy and undergoing urine drug testing. In their article, "The World of Chronic Pain: A Dialogue," Martin Kusch and Matthew Ratcliffe describe Kusch's experience with chronic and debilitating jaw pain through a phenomenological lens. Kusch was prescribed opioids to manage the pain, but his overarching story provides a holistic perspective as to the experience of chronic pain more generally. Admittedly, the experience of a single patient with chronic pain cannot be generalized to all patients with chronic pain (Kusch & Ratcliffe, 2018). However, their discussion can inform healthcare providers of the possible effects of chronic pain and highlight experiences beyond the physical pain that reflect that patient as a whole human being through *Leib*. Their discussion emphasizes two key features of chronic pain: (1) that chronic pain affects how a person relates to others and anticipates behaviors from others and (2) that chronic pain is "concretely focused, and yet, at the same time, all-encompassing" (Kusch & Ratcliffe, 2018, p. 61).

When dealing with chronic pain, Kusch describes his relationships with others as fundamentally altered: he was unable to relate cognitively or emotionally to anyone without simultaneously thinking of himself as a sufferer. He began to distinguish between those who supported him through his suffering with those who did not. Moreover, the depth of his prior relationship (or lack thereof) did not necessarily predict the level of support he received. In the process, his perception of his world changed (Kusch & Ratcliffe, 2018). Whereas he previously viewed medical doctors as those who could fix or repair a physical ailment, with a moral obligation to help, he ultimately began to distrust healthcare providers for failing to alleviate his pain even after he made them privy to such inner worries (Kusch & Ratcliffe, 2018).

Kusch and Ratcliffe (2018) offer interesting insight to the "self-infantilization" that can occur when someone is in chronic pain:

> Demoralizing long-term pain and increasing doses of opiates made it impossible for me to think clearly: my higher—self-reflective and self-corrective—functions became more and more restricted. This created an area for archaic, primitive, infantile cognitive, and emotional patterns. It led me to see the medical doctors as a father figure, and to build up expectations that only a father could possibly have fulfilled. The fear of losing the

> doctor—what will I do if he refuses to treat me any longer?—also had irrational elements that are best explained on the basis of the equation of the doctor with the parent. (Kusch & Ratcliffe, 2018, p. 65)

As Kusch was prescribed higher doses of opioids to control his pain, his higher-level cognitive abilities became impaired. Furthermore, his desperation and suffering led him to revert to a state of dependency, this time on his healthcare providers. Ultimately, this positioned the provider as an authority figure. Kusch also observed the provider gaining authority through ritualized assessments and an overarching objectification of the patient experience. With complaints of pain, patients are asked questions such as "On the [numeric rating scale] scale from one to 10, what is the intensity of the pain? Is the pain drilling, dull, or stabbing? And how often does it occur?" (Kusch & Ratcliffe, 2018, p. 66). This approach objectifies the patient experience and fails to shed light on the deeper experience of living with pain. At the same time, this superficial questioning leaves very little time for the patient to express themselves as more than just *Körper*.

Fredrik Svenaeus (2015) also sought to understand pain from a phenomenological perspective. He describes several of the experiences and interpretations of living with pain, similar to Kusch. He points out that the same tissue damage can yield varying experiences of pain from individual to individual. Because of this, it is not sufficient to focus solely on "pain" *per se*. Rather, the concept of suffering may be better suited to address the experiences of pain. Svenaeus (2015) refers to the experience of chronic pain as both a physical and emotional experience leading to severe distress. First, pain signifies distress and calls for immediate action. But over time, pain can affect a patient's entire life experience. Pain can inhibit the patient from performing activities that they previously enjoyed.

Additionally, Svenaeus (2015) describes that pain is not simply objectified in the mind of the patient. Instead, it is lived in the human experience, again more reflective of suffering. He describes this suffering as follows:

> Still, this suffering, I believe, is most adequately described as a kind of bodily resistance and modulation displaying itself at the heart of consciousness and human experience. That is: an awareness of a body that is mine, but yet alien, since it resists and disturbs, rather than supports, my ways of being conscious and directed towards the world. (Svenaeus, 2015, p. 113)

Here, Svenaeus (2015) describes how pain is an alienating process whereby the body becomes more intolerable and foreign. The patient loses control of one's bodily experience. Consequently, patients try to block or escape unrelenting pain and eventually become "prisoners in [their] own bodies" (Svenaeus, 2015, p. 115). Drawing from Elaine Scarry's *The Body in Pain: The Making and Unmaking of the World* (1985), Svenaeus (2015) summarizes the torture that ensues with chronic pain where torture indicates an active experience and deliberate violation. This torture causes a breakdown of language that further threatens the patient's ability to express one's pain and more thoroughly understand it for oneself. And while some may find an escape through other tasks and work, there is some pain that is so debilitating that patients can find no escape and suffer needlessly (Svenaeus, 2015).

Havi Carel explains how life-altering chronic pain can be by talking of the change in one's experiential structure of the world, which Husserl and Heidegger would refer to as *Leib*. She states, "the opportunities, possibilities and openness of one's life, activities, and goals are closed down" (2016, p. 68). The result is a "life altered" (Carel, 2016, p. 64) to such an extent that one loses "the subtle feeling of 'I can' that pervades [one's] actions" (Carel, 2016, p. 90). And this loss of the sense that one can easily navigate the world can lead persons to seek ways of escaping it through, for instance, alcohol or marijuana—or, in some cases, illicit drug use.

Responding to Unexpected Urine Drug Test Results from a Phenomenological Approach

Understanding the basic tenets of phenomenology and especially the phenomenology of chronic pain, we can further investigate the appropriate responses to unexpected urine drug test results. First, let us assume that the patient is truly in pain, rather than drug-seeking. After all, as pain is largely subjective, a healthcare provider should adopt a *prima facie* trust in their patients' declaration that they are in pain. Second, we must keep in mind that chronic pain is not merely a physical experience as it also leads to tremendous suffering that can affect a patient's relationships, experiences, and interpretations of the world. The patient may feel alienated in one's own body, imprisoned and unable to escape the pain, thereby leading to a feeling of being tortured and unable to articulate their experience. Finally, pain threatens the patient-provider relationship because of a breakdown of patient communication, thereby threatening patient autonomy (Rentmeester, 2018). Thus, providers need to respond to the patient as a unique individual to attempt to understand the phenomenon of pain. This, however, is not the typical way in which doctors approach patients who seek pain relief.

Again, from the 2016 *CDC Guideline for Prescribing Opioids for Chronic Pain,* urine drug testing is intended to reduce the patient's risk of toxicity and drug-to-drug interactions, mitigate medical and legal problems, and ensure patient compliance (Dowell et al., 2016). When reviewing urine drug test results, providers hope to find results consistent with the medication(s) being prescribed and an absence of other medications and illicit substances. Ultimately, there are two overarching ways in which urine drug test results may be unexpected. First, the medication(s) expected to be found was not detected, or second, medication(s) (or other substances) that was not expected to be found was detected.

In the case that the medication expected to be found was not detected, the healthcare provider should first take into consideration possible causes of the negative test (Dowell et al., 2016). There is a slight possibility of a false negative result in which the patient was taking medication regularly and as prescribed, but this was not reflected on the test (although an in-depth analysis of test interpretation itself is beyond the scope of this paper). More often, the test is deemed to yield a true negative result where the patient truly is not taking the medication prescribed. In this case, the provider must consider the reason for this. If the urine drug test does not confirm that the patient is taking the medication prescribed, the most concerning threat is that the patient is diverting medication, that is, redirecting the medication that was prescribed for another person's use. It is well known that opioid medications have street value. In fact, Mutter et al. (2023) found steadily increasing street value of prescription opioids over the last several years, particularly as the number of opioid prescriptions has decreased. Patients may feel compelled to divert their own opioid prescriptions for personal financial gain. On the other hand, patients may be

diverting medications to their own relations (with or without understanding the risks of doing so). Understanding their own experience, this could be in an attempt to alleviate another person's pain and suffering. Although it is considered unacceptable from the provider's perspective to divert medication, to truly accept the patient's pain, worth, and dignity as a human being requires that the healthcare provider continue to care for their patient. Despite that, it would still be reasonable to no longer prescribe opioid medications. Instead, healthcare providers may look to alternative treatments with less likelihood of diversion and misuse, which we will discuss below.

The other possibility in the case of a negative urine drug test result is that the patient is taking the medication themselves but not as prescribed. Again, assuming the patient is truly in pain, providers can seek to better appreciate the patient's experience from a phenomenological perspective. In consideration of the suffering and desperation that results from chronic pain, healthcare providers should take an empathetic approach and consider why the patient is not taking the medication as prescribed. The patient may have run out of medication early because there was a recent flare-up or injury for which they relied on more medication. There may have been a different activity that they were required or chose to participate in but caused them increased pain. This may include going on a family outing or working longer hours. As Havi Carel (2016) pointed out, given the life-altering effects of chronic pain in which one's activities become difficult or impossible to participate, medication can allow them to regain joy and a sense of purpose by restoring their activity and level of function. It can help patients to better cope with their pain, allowing them to enjoy their favorite hobbies and be productive, as long as the prescription is appropriately allocated such that it doesn't lead to crippling cognitive effects that Kusch experienced from being on roughly 25 pills per day (Kusch & Ratcliffe, 2018, p. 63). At the same time, patients may not be taking medication prescribed because their pain is routinely undertreated, in which case consistently more aggressive treatment could actually enhance compliance and alleviate their suffering. If this is not felt to be the case, then the healthcare provider can again look to alternative treatments (Dowell et al., 2016).

In the case that other medications or illicit substances are detected, the healthcare provider must consider the reason for this. From a phenomenological perspective, the healthcare provider can understand how chronic pain can affect higher-order thinking, judgment, and language, as discussed via Kusch's commentary above. This may have been an unintentional omission of a prescribed medication on the part of the patient. If this is deemed to be the case, then the healthcare provider should discuss the risks and benefits of concomitant therapy. If it is not deemed to be safe to continue both, a discussion should be held with the patient in which they weigh the benefits of one therapy over another and agree upon a modified regimen.

Another possibility is that the patient intentionally omitted this information, whether it is a medication being prescribed by another provider or an illicit drug. Similar to the previous scenarios, the healthcare provider must consider the phenomenology of chronic pain and the patient's perspective. Again, it is important to consider why a patient would omit such information, seek other medications, or partake in illicit substance use. Empathizing with the patient's situation, one must consider if the patient is self-medicating to treat the pain that, again, could warrant more aggressive treatment by the provider. Perhaps they are looking to return to normal functioning. Perhaps they are looking for an escape from the unrelenting torture that Svenaeus (2015) described. Regardless of the reason, this situation warrants further discussion of

what the patient is experiencing to better understand that unique patient. Depending on the situation, this may also present an opportunity to treat the pain more aggressively or to discuss the benefit of addiction resources and refer the patient to these services.

In each of these scenarios, it is important to consider the patient's experience from a phenomenological perspective. Healthcare providers must recognize that pain is not only a physical experience but also an emotional experience marked by suffering. In acknowledging the patient as a worthy human being, it is only ethical to maintain a patient-provider relationship to demonstrate support and understanding of the patient's dignity and worth. Granted, the plan of care may take on different shapes. If it is felt that opioid medications are still reasonably safe and beneficial to the patient, the patient and provider may agree upon the conditions to continue them. Often, the medication may be continued, expectations can be reiterated, and the patient will be required to undergo more frequent urine drug testing to ensure compliance. If it is not felt that opioid medications are appropriate after an unexpected urine drug test result, the healthcare provider may look to a plethora of other therapies to manage pain. In short, along with nonopioid medications, the patient and provider can collectively decide upon physical therapy, psychological counseling, acupuncture, massage therapy, chiropractic treatment, weight loss and increased physical activity (Payne et al., 2010), along with heat, ice, and interventional procedures. If drug abuse is suspected, the patient should also be referred for counseling and addiction services. This more holistic approach aligned with phenomenology recognizes the complexities of the issue, as opposed to the black-and-white sort of thinking that has become commonplace in which providers automatically refuse patients due to unexpected urine tests.

In addition to the phenomenological experiences already discussed, dismissal from practice for an unexpected urine drug test result would reasonably lead to numerous other consequences. It would likely result in negative stigma, untreated pain, and further suffering for the patient. Inadequately treated chronic pain can negatively affect a patient's quality of life and is associated with poor mental health, anxiety, depression, and sleep disturbances; it also leads to impaired activity and ability to work and is a leading cause of disability (Dowell et al., 2022; Office of Disease Prevention and Health Promotion, 2022). In fact, Dowell et al. (2022) estimate that chronic pain costs between $560 and $635 billion annually when considering lost productivity, disability, and direct medical costs. Dismissing a patient from practice following unexpected urine drug test results could also lead to missed opportunities to discuss and encourage the person to participate in substance abuse treatment. For those patients who struggle with substance abuse, it may further compromise patient safety as they feel more compelled to obtain opioids from alternative—and unregulated—sources, further exacerbating the opioid epidemic. Because of the widespread and all-encompassing effects of pain, it is not surprising that a significant proportion of suicide victims experience chronic pain (Dowell et al., 2022). Chronic pain can affect nearly every aspect of a person's life, and treatment of this demands compassion and concern that goes beyond a single test result.

Conclusion

While the aim of pain as the fifth vital sign was to better assess the patient's pain, it ultimately led to overzealous treatment and consequential development of the opioid crisis. In turn, providers have turned to dismissing patients from practice based on unexpected urine drug test

results in an effort to maintain patient safety and protect the healthcare provider from legal issues. This fails to honor the patient as a human being and reduces the patient to a mere test result. Instead, the provider should use a phenomenological perspective to understand their patient's experience with chronic pain and respond to unexpected urine drug test results accordingly. Beyond the physical pain, the provider should also recognize that the patient might be drowning in an emotional experience, laden with desperation, grief, and suffering. Their relationships and worldview may be disrupted. And they may feel alienated from their own body or have difficulty communicating and understanding their own experiences. Not only can dismissing the patient from practice have devastating consequences for the individual patient but it can also lead to major social and economic consequences as a result of untreated pain. It is imperative that healthcare providers avoid dismissing patients from practice based solely on an unexpected urine drug test result and, instead, respond to unexpected urine drug test results with empathy and compassion, supporting their patient to alleviate their suffering while simultaneously honoring humanity. In conclusion, we should heed Husserl's adage that "merely fact-minded sciences make merely fact-minded people," thus reminding us of the need to practice holistic care as providers (1936/1970, p. 6).

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