

SEEING THE PATIENT THROUGH AN OPIUM HAZE

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The Problem

Opiate overdose deaths in the United States of America soared in the 1990s and worsened yet with the new millennium, causing the U.S. Center for Disease Control to declare this problem a new “epidemic.”¹ The opiates causing this problem came not from street corner drug dealers, but from the prescription pads of respected physicians in clinics and hospitals, including myself and my primary care trainees.

Two decades ago there was a marked shift in our medical standard of care concerning pain medications. In 1986 an influential medical author charged the medical community with inadequately addressing patient pain and overstating the potential harm of opiate medications.² It didn't matter whether a patient was suffering from bony metastases, or from unclear, poorly defined low back pain. In December 2000, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) promulgated new standards designed to ensure patients the right to appropriate assessment and management of their pain. They advocated that pain be “the fifth vital sign”. All patients, no matter their reason for visit, were to be asked about their pain during encounters.³ The pharmaceutical industry also contributed. In the 1990s Purdue Pharma advertised their long-acting oxycodone formulation as effective for most pain while being nearly addiction proof, recanting only in 2007 when they admitted guilt in court to misbranding the drug “with intent to defraud and mislead the public.”

Around 1990 we shifted from an environment in which it was rare for physicians to prescribe opiates (sometimes reluctant even in the case of terminal cancer) to an environment in which the standard of practice was to treat patients with any pain for as long as necessary with whatever doses of opiates were effective. Well-meaning physicians, by way of a groundswell shift in medical opinion, through overt administrative pressures, and trying to be patient-centered, contributed to this surge of opiate use.

Balint Initiates

In the United States, almost half of our primary care residencies conduct Balint groups.⁴ The Oregon family medicine residency where I teach has a long tradition of Balint training and we have settled into a stable rhythm with our groups. Each resident class of twelve has its own group with two co-leaders. The groups begin as they start their second year of residency training, after they have had the chance to experience the complexity and “weirdness” of some of their patient relationships. Through the group's first year, meetings occur monthly, increasing to twice monthly as the ever more mature physicians enter their third and final year of residency training.

I've been honored to help lead these groups for nearly ten years and am now leading my fifth group of residents. Through these training cycles a consistent pattern has emerged.

A new group begins. My co-leader and I give a brief introduction to the history and purpose of Balint work, explain the ground rules, take a deep breath, and ask who might have a case. An enthusiastic resident, Doctor A, ready to fully embrace the Balint process, soon steps forward: "I have someone," she starts. "Mr. Z is a 46 year old who first came to see me six months ago to get a refill of oxycodone for his back pain." The group collectively groans as the presentation continues. They know the case and the dilemma it presents.

While I've not formally kept track, my recollection is that in these initial group meetings, 100% of the cases presented involved the patient's use of opiates, as do over 75% of all the cases through the first year and 50% of the cases the second year. This pattern isn't specific to my residency. At Balint leadership forums I've attended, I frequently hear others discuss how their early trainee groups also are centered on patient opiate use as well.

These opiate-centered groups lapse into an all too painful pattern. As the case plays out, it becomes clear an unbridgeable impasse has been reached. Mr. Z thinks he needs more oxycodone. Dr. A worries he is taking too much. I can feel the tension in the group rise while I replay in my mind the likely scenario that played out during their last encounter. "Doctor", implores Mr. Z. "My back hurts so much you must increase my medicine dose or I won't be able to go on." Doctor A, with a rightful sense of uncertainty about the patient's pain, indeed about the whole situation, with the normal learner's feelings of inadequacy, experiences a growing sense of dread, just hoping to escape from the room without a shouting match. The progress of the visit stalls.

And the progress of our Balint group stalls.

Pain Reified

Chronic, non-malignant pain is defined as pain that continues beyond three months or beyond the ordinary duration of time that an injury to the body needs to heal.⁵ We have a poor understanding of why certain patients develop chronic pain. Often, their problems fit into the category of "medically unexplained syndromes" that we have always struggled to understand in primary care.⁶ The back injury suffered from a work fall, the whiplash of a rear-end car accident, diffuse myofascial pain, aching in the temporomandibular joint, or chronic daily headaches; for some, trauma heals with time and the pain dissipates. Others continue to show up in your exam room complaining of unclear but disabling pain for months and years after onset. We silently scratch our heads thinking about hyperalgesia while the patient insists they have a high pain threshold and that their current pain would be intolerable for anyone. Pain is absolutely subjective; like taste, "non est disputandum". Another person's pain simply can't be questioned.

While people experience somatic symptoms as a unified whole, our western medical mindset is to artificially separate them into bodily symptoms and psychological symptoms.⁷ Perhaps because they are simpler to understand, we bring the physical symptoms to front stage while relegating the psychological symptoms to dusty back closets with hopes they can be contained and ignored. Only those problems that have the

potential to be seen with an MRI scanner are considered real. Emotional health problems are subtly stigmatized as a sign of weakness. Patients themselves understand that to be taken seriously, their pain must be material, not a result of unseen emotional distress. In one of our recent Balint groups, the presenting resident illustrated his case with a mobile phone photo of his patient's abdomen. The patient had chronic pain that migrated to various locations around his trunk, unexplained despite intensive investigation. Now he had begun drawing on his torso with permanent felt markers, triangles and circles showing the location and intensity of his pain, squiggly lines demonstrating where the pain radiated. The shapes in the photo had an abstract intensity like prehistoric cave paintings. The patient had so desperately needed a physical manifestation of his distress that when it couldn't be identified with an MRI, he created his own metaphoric representation.

Opiates, of course, are an imperfect solution for any pain. They fix nothing. Rather, by activating mu-receptors in the brain, opiates allow pain to be masked and thus better tolerated. When your wrist fracture is being set, this is a good thing. But as with all medicines, there are time and dose-dependent side-effects. Drowsiness. Confusion. Constipation. The development of tolerance over time to a given dose. Euphoria. Dependence. Withdrawal when stopped. And of course, uncertainty. Most of what we know about opiate use comes from short term trials; very little research has been done on long-term effects. We don't know whether five years after starting daily opiates a patient's pain will be controlled, whether they will be more or less disabled, whether their life will be better or worse. In the 1990s we acquiesced to the opinion of influential medical experts, to the advertisements of Pharma and to the requirements of administrative oversight boards without good evidence to answer these questions. What we have done, then, is to take poorly understood patient problems and treat them with poorly understood chronic medications.

The countertransference of pain

For years our residents have intuitively understood there is something wrong with this. The fact that this single subject has so dominated our Balint groups means that it dominates their thoughts. They find themselves in an impossible situation: "On the one hand, if I don't go along with this patient's request for more opiates, I am a paternalistic, non-patient-centered doctor, insensitive to suffering. On the other hand, by liberally passing out oxycodone tablets, while making this patient happy, perhaps allowing them to feel good from day to day, hour to hour, dose to dose, it's likely that over months I will watch them turn into a lotus eater. I feel ever less like the healer that I entered this profession to become, and ever more like a drug dealer."

There is an even more insidious cognitive/emotional twist. Good studies show that a small percentage of patients purposefully misuse opiate prescriptions, either selling them or using them to get high. Because it's impossible to know which patient this might be, all patients become suspect. As Dr. A sat in her encounter across from Mr. Z a part of her probably wondered whether he wasn't playing her for a fool.

I'm convinced that this causes our early residents to feel a deep sense of moral distress they are unable to verbalize as such. Some express dread in going to their outpatient clinic, and many question their role in medicine. It's entirely appropriate, then, that resident Balint groups focus so much on patients who use opiates. These are the complex patients whose problems are poorly understood, the difficult patients who call the clinic at night looking for more relief. The Doctor, His Patient and the Illness was full of stories like these. The only difference is that in the 1950's GPs seldom prescribed morphine in this way.

Opium has a strong physical presence in our Balint group meeting concerning Mr. Z. A thick, hazy smoke of uncertainty and suspicion faces the residents like a wall, the shape of the patient vaguely on the other side. For the residents, it is all too easy to identify with the presenting doctor and her unspoken feelings of helplessness and inadequacy. She wants to help the patient, to "fix" him, only to find him too unclear to fix. It is too hard for the residents to identify with the shadow on the far side and quite easy to tag him as "the other". In some of our meetings we never get beyond this problem and end with the consensus that the patient be "fired", asked to not come back to the clinic. Empathy is numbed, narcotized. The Balint process appears to have failed – we depart with no better understanding of the patient (just one of "those" chronic pain patients) or the doctor-patient relationship. If I, as leader, push the group to see from the patient's perspective, I appear insensitive to the pain of the residents, risking my relationship with the group.

But of course, chronic pain patients do have a perspective. Despite the uncertainty and even the distrust, pain is always a symptom of another human's distress, of their suffering. Suffering has been defined as "the severe distress associated with events that threaten the intactness or wholeness of the person... Patients will continue to suffer until they no longer believe the disruption to be enduring, come to see the possibility of being whole again..."⁸ For whatever reason, the wholeness of chronic pain patients has been broken. They've lost so much hope that they prefer to be treated with morphine, the treatment of someone with a terminal illness. The root cause of their lost resilience is buried deep. Aggressively digging for it might create more pain. The resident has only two choices. She can accept the patient in all his unfixableness and sit with his suffering. Or she can deny his humanness and his suffering and turn away. This is even more painful.

And so I sit, month by month with my Balint group, now and then planting seeds that I hope might someday help them see Mr. Z as a fellow suffering human, always careful not to push too hard, to infer they are deficient healers because they sometimes want to turn away. In these groups, the interventions are mostly through example. I sit with the residents, listen to their stories, normalize their feelings of inadequacy, and empathize with their distress. I sit with them month by month, feeling the intensity of their suffering, waiting until they "come to see the possibility of being whole again." I hope they see how this might work with their own patients. I try to demonstrate one of the most important lessons of Balint work, that "listening is doing something".⁹ And over the months, it does do something.

The opium haze gradually draws back. It becomes less like an intervening barrier and more and more like an aura emanating from the patient. Gradually, the person within takes on more shape. The haze never completely disappears but we begin to tolerate it as part of the patient. Over time, fewer cases focus directly on opiates and more on other subtleties in the patient's care and context. In the first meeting in 2013 of our now 3rd year resident Balint group, a patient was presented who was mean-spirited and adversarial for no clear reason. She also used chronic opiates but the residents didn't dwell on this as they struggled to see who this person was. When the case was over, one of the residents reflected to the group: "It seems to me that most of our groups have something to do with opiates, but they seem to be getting more complicated."

Conclusion

A shift in the standard of pain care in the U.S. in the 1990s resulted in a high prevalence of primary care patients using opiate medications for chronic pain. For our primary care trainees, this presents a clinical challenge that flows over into their Balint groups, making it hard to see from the perspective of the patient. Through perseverance and time, Balint can be a special, safe place to sit with residents in their suffering, and thus model how they might sit with their patients. Eventually it promotes a more complete understanding of medically unexplained symptoms and a process for exploring root causes beyond the physical. It helps residents to understand that they're not deficient if they're unable to "fix" patient problems so deeply rooted that they can be spoken of only through bodily symptoms. These lessons are integral to helping our future GPs not harm their patients through inappropriate investigation and over-medication. Especially, Balint work allows modeling the healing lesson that listening truly is doing something.

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