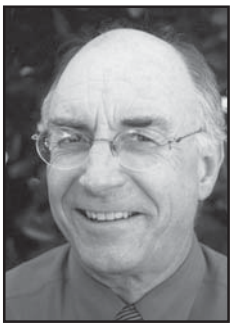
Editorial



Tony Townsend has been a general practitioner for 30 years. Although he has dabbled in medical politics, medical ethics, community-based teaching, university-based teaching, quality improvement and assessment, his passion remains clinical general practice. He is currently a full-time general practitioner in Whangamata.

Addiction

In my early years of practice I used to find dealing with addicted patients difficult and frustrating. Sometimes I still do. Among the reasons that I felt anxious when I saw the name of an addicted patient in my appointment book, or felt guilty when I knew that I had deliberately avoided raising the possibility of addiction with a patient, included a perception that addiction was not really an illness. It did not sit nicely with my understanding of the aetiology of biomedical disability. This was reinforced by many of my specialist colleagues' approach to addicted patients, which was often dismissive or even derogatory. Alcoholism, smoking, gambling, obesity, drug dependency and other addictive behaviours have been viewed very negatively by many of our medical colleagues. They complicate the management of patients' real medical problems and they are not amenable to our usual therapeutic armamentarium. This attitude has been hardened because many addicted patients are manipulative liars. This behaviour extends to concealing their addictive behaviour from their family and friends and even lying to themselves. Social stigmas and legal sanctions have been developed to try to control addictive behaviour. No real surprise that I had difficulties.

I have wondered whether my approach to patients with addiction would have been different if I too had experienced addiction, but I suspect that many addicted doctors are too involved in struggling with their own demons to constructively engage their addicted patients in strategies to achieve positive outcomes. It is likely that co-dependency often prevails. I am reminded of a GP I knew many years ago who used to smoke during his consultations. His practice attracted a large number of smokers.

I have also wondered whether younger doctors find it easier to care for these patients than I did. However, I suspect not, as a recent study by Rapley and colleagues showed that *'the intellectual, moral, emotional and practical difficulties that GPs currently face [in dealing with alcohol related problems] are quite similar to those faced by GPs from 20 years ago.*'[1] We now have better tools for identifying addictive behaviours, we have better management options and better community resources, but we still have a long way to go.

I think that what has helped me most in caring for patients who are struggling with addiction is the use of one of the fundamental tools of communication – empathy. I have tried to picture myself in the shoes (or often the bare feet) of the addicted patient. I cannot experience the hell that their life has become but I can better understand why they behave as they do. I saw two patients yesterday whose lives were controlled by addiction.

The first man had smoked heavily for 40 years. He had peripheral vascular disease (PVD) and was paying for Plavix because he believed that this would help to counter the effects of his smoking. This was contrary to all specialist advice that he had received. He was thin and had no other major risk factors for PVD. He was unable to work and I had previously explained to him why it was not appropriate for WINZ to pay for his Plavix. Over the course of a few consultations we started to talk about how he felt trapped and how bad he felt that his addiction was controlling his life and that virtually all of his income was going into paying for cigarettes and drugs 'to keep him alive'. Yesterday he proudly told me that he had stopped smoking and stopped taking Plavix for the previous two weeks. He was wearing a patch and he said that the hardest time was in the morning when he had to decide whether or not to put on another patch or have a cigarette. A patch had come off with sweat once and within half an hour the craving to smoke again was so strong that he nearly caved in. He put on another patch and was back in control.

The second patient was addicted to eating. She was in her mid-50s and told me that she had just been through a bad patch. Her relationship had fallen apart (due to her addiction), she had put on 16kg (now weighing in at 128kg), she felt guilty and depressed, including suicidal thoughts, but 'she was not that sort of person'. She told me how hard supermarket shopping was and how she would hide all the bad stuff under other things in her trolley. At meal times she would cover her bad food with salad so that she

couldn't see it and then eat it all. Her life revolved around eating and she was no longer in control. She realised that this problem had started at about age 13 or 14 and had been her demon ever since. She had dabbled with other addictive behaviours, gambling and drugs, but food was her downfall because she could not stop it completely. We talked about ways for her to start to gain control of her life. She came up with the idea of starting a support group for addicted eaters similar to AA, using the same 12 step plan. That might be helpful.

Each of these consultations was no longer than 15 minutes. I knew both patients well. We had previously established rapport and had already discussed issues to do with respect, judgement and safety. I did not feel manipulated, threatened, trapped or inadequate (all feelings that I had had in the past when dealing with addicted patients). I believe that the patients felt supported.

I am still not comfortable in dealing with those at the more difficult end of the addiction spectrum; those addicts who have no interest in confronting their addiction but simply want me to prescribe narcotics that they can sell to buy P or other related drugs. They appear to have lost any interest that they might have had in dealing with their problems and are bent on pursuing a path to self-destruction.

In this issue we have several papers that focus on addiction and discuss options that we can consider and incorporate into our own ways of dealing with patients whose lives no longer belong to them. It seems to me that most addiction is appropriately managed in general practice. It requires continuity of care, accessibility, compassion, trust and knowledge of co-morbidities. Aren't those the principles that define general practice?

References

1. Rapley T, May C, Frances Kaner E. Still a difficult business? Negotiating alcohol-related problems in general practice consultations. Soc Sci Med. 2006 Nov; 63(9):2418-28. Epub 2006 Jun 30.

Kiwis can fly

Congratulations to Nick Glasgow, a fellow of the RNZCGP, on his appointment as the new Dean of the ANU Medical School (ANUMS). His appointment was announced on 22nd February 2007 and the ANU Vice-Chancellor, Professor Ian Chubb said that Professor Glasgow's experience as the Foundation Director of the Australian Primary Health Care Research Institute (APHCPRI) and Associate Dean of the ANUMS Rural and Community Clinical School would play to the distinctive strengths of the medical school. 'Professor Glasgow brings substantial experience, as a clinician, a researcher and an educator, to the role, experience that will be of great benefit to our medical students.' What is even more important is that Nick is both a New Zealander and a general practitioner.