Brace yourselves

"What can I do for you, Bob?"

"Doc, I need a note saying I can't work due to the pain from my accident. I sit at a desk and my neck starts to tighten after a while. Hey, Doc, why are you wearing that neck brace?"

My life with a neck brace has been interesting. Not only do many of my patients come in to complain about their accident symptoms while I listen semi-patiently—braced in, so to speak—but all of them want to know what happened to me. I need more time in my day to allow for the frequent retelling of my tale. It would be nice to have a video playing on the TV in my waiting room with a blow-by-blow of the accident, but I've got it down to one line: "Me, bike, car—bike finished last, me second, the car won."

Wearing a neck brace is not without some funny moments. My pillow has hit the floor numerous times as I go to tuck it under my chin while I replace the pillowcase. Same with the phone as I attempt the hands-free ear/shoulder cradle. Also, apparently, you look down at your belt to see the holes when you put it on, ditto with your jacket zipper (free neck brace tip—use a mirror). I didn't realize how often people say, "Hey, look at that," which holds a whole new level of difficulty if what they're looking at is above and to one side or behind you, particularly if you are in a car.

I have noticed that people don't look at me anymore; they only look at the brace.

I also find it interesting that the only people I meet in the real world who ask about my brace are people who appear to live on the street. As I walk past they often query, "Hey, what the F happened to you?" After a brief explanation they offer a sympathetic reply, "S, that's messed up," and then launch into their own story about when they got hit in a crosswalk or beat up and had to wear some sort of brace for a while.

But one observation in particular has really caused me to stop and think. I have noticed that people don't look at me anymore; they only look at the brace. While I was in a restaurant recently I got up to go to the bathroom. During the trip I counted 23 people who glanced at my brace, avoided my eyes, and looked away. It's as though they saw the disability but not the person. I found this process made me self-conscious and a little less confident. I found myself not wanting to walk past groups of strangers and started to avoid it if possible. I began to wonder if I have the same reaction when I see people with a disability. It was a sobering thought to consider that I was also guilty of only seeing the brace, crutches, wheelchair, etc., not the individual. Unlike many, I will soon be free of my brace and am now committed to seeing beyond the obvious and greeting those whom I meet with the eye-to-eye kindness we all deserve.

Lastly, I wonder if I will have a new craving for turtlenecks.

—DRR

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Stigma

(noun) A set of negative and often unfair beliefs that a society or group of people have about something. A mark of shame.

Even the word has an unpleasant ring to it.

I think methadone therapy is associated with stigma among physicians. Has this been aided and abetted by a lack of knowledge of methadone in clinical practice? Is it because addiction doesn't really fit our definition of illness and we see it as a lifestyle choice? There are other conditions that stem from how we choose to live our lives, from lung cancer and smoking to diabetes and obesity. My guess is that sharing a diagnosis of cancer or diabetes, from a public perspective, is much easier than admitting to being on methadone. Many patients are not comfortable sharing that openly or confidentially, even with me when I see them in the emergency department.

A Cochrane review of methadone in 2009 clearly elucidated its benefits in decreasing the risk of contracting HIV, hepatitis B and C, and overdose death. Successful treatment usually requires long-term therapy to decrease illicit opioid use and manage dependence. Patients on methadone are more likely to stay in treatment programs and not relapse than those who are managed in a drug-free or abstinence program. There is a best individual dose for methadone and we know that less is not better. Patients on moderate doses are more likely to be compliant and avoid illicit opioids than those treated with low doses. All these positive advantages are in addition to methadone therapy being compatible with normal activities at work and school. It is hard to suggest this is unworthy or ill-conceived treatment for the medical illness of opioid addiction.

Perhaps, because therapy is aimed to control but not cure opioid addiction, physicians are less accepting of methadone therapy. Treatment itself causes drug dependence. However, there are many other examples of long-term therapy that are very successful in improving patients' well-being without cure, from infliximab for rheumatoid arthritis to ramipril for congestive heart failure. But no stigma there.

My own perspective was significantly updated after a year on the College of Physicians and Surgeons of British Columbia's Methadone Maintenance Committee. Previously, my sliver of knowledge consisted predominantly of methadone's long half-life, toxic effects, and once-a-day dosing. What an eye-opening privilege to spend time with clinicians with extensive expertise in managing patients on methadone. They brought real-world practicality, compassion, and a deep awareness of the many challenges their patients face in addition to opioid dependence. These physicians showed me the breadth of complexity in providing care to these patients, and all without a sense of stigmatization. The focus was on how to provide the best care to a group of patients who are among the most challenging, diverse, and often vulnerable. Deft clinical acumen, sound knowledge of pharmacology and drug interactions, skill in psychiatry, social work, and maternal health—the list of medical topics covered when seeing a patient on methadone can be vast. It is not just about writing that special prescription for methadone—that makes up a minuscule part of the care process. Even with our many dedicated physicians, there are regions in BC that need more such skilled and authorized methadone prescribers. This shortage makes it harder for patients to get their care locally.

Methadone is a key piece to long-term care for opioid addiction.

Across Canada there is now tremendous focus on the amount of opioid prescribing by physicians and the increasing numbers of patients with opioid dependence. While we have to address the root causes and be leaders in minimizing harm from opioids, it is essential that we manage dependence well. Methadone is a key piece to long-term care for opioid addiction. Shame and stigmatization are not concepts that should come to mind when we think about this treatment regimen.

—AIC

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