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To prescribe or not to prescribe... (in chronic pain... and elsewhere...)?

Prescrire ou ne pas prescrire (en douleur chronique... et ailleurs...) ?

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Abstract

Most medical doctors close a consultation by a drug prescription, even if some doubts exist about the treatment efficacy. The aim of this paper is to open a discussion on the questions underlying this urge to prescribe and to make some proposals for the clinical practice. Firstly, the psychosocial factors which may question the relevance of the prescription will be discussed. These elements (unrealistic treatment expectancies, distrust or anger against caregivers, multiple earlier treatment failures, or a relatively balanced situation) might threaten potential treatment benefits but may be difficult to identify and take into account. Secondly, some caution has to be made if the clinician decides to prescribe despite these psychosocial contraindications. It is then important to discuss with the patient the meaning of the treatment, its concrete aims and its practical modalities. Finally, observing that concluding a consultation without any prescription might be very uncomfortable for the caregiver, asks questions about the symbolic meaning of the prescription: need for the patient to be mothered, need ''to keep up'' for the doctor, biomedical reference frame observance. We conclude that, in spite of the anxiety raised when no prescription is made, the absence of prescription might paradoxically reopen the therapeutic process. Observing that pain may resist to the treatments allows a move towards broader objectives than symptom control. Such a change is possible only if it is recognised that the biological and psychosocial conditions of efficacy of the treatment are not, or will never be, optimal.

Keywords: Prescription; Chronic pain; Acceptance; Biopsychosocial model; Doctor–patient relationship

Résumé

Pour de nombreux médecins, clôturer une consultation par une prescription médicale va de soi, parfois malgré des doutes sur l'efficacité du traitement. L'objectif de cet article est de discuter quelques questions soulevées par le caractère presque automatique du geste prescripteur, en dégageant quelques pistes pour la pratique clinique. Les facteurs psychosociaux susceptibles de remettre en question la pertinence d'une prescription sont discutés. Ceux-ci (attentes inadéquates des patients, méfiance ou colère vis-à-vis des soignants, accumulation d'échecs thérapeutiques, situation d'équilibre) menacent le bénéfice potentiel d'un traitement mais peuvent être difficiles à identifier et prendre en compte. Les précautions à respecter si le médecin décide de « prescrire malgré tout » sont abordées : discuter avec le patient le sens du traitement, ses objectifs concrets et ses modalités pratiques. Enfin, le constat que ne « rien » prescrire à l'issue d'une consultation peut générer beaucoup de malaise chez le médecin soulève la question de ce que peut symboliquement représenter l'acte de prescrire : besoin de « maternage » du patient, besoin « d'être à la hauteur » du soignant, alignement sur la norme implicite du cadre biomédical. Nous concluons que, malgré les craintes que peut susciter une non prescription, celle-ci est paradoxalement susceptible de relancer le processus thérapeutique. Le constat de la résistance de la douleur permet d'évoluer vers des objectifs plus larges que le contrôle du symptôme. Cela n'est cependant possible que moyennant la pleine reconnaissance que les conditions biologiques et psychosociales d'efficacité du traitement ne sont pas suffisamment présentes.

Mots clés : Prescription ; Douleur chronique ; Acceptance ; Modèle biopsychosocial ; Relation médecin–malade

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1. English version

1.1. Introduction

The prescription, defined as a ''therapeutic recommendation made by a doctor'' or a ''formal and detailed order listing what should be done'' (Larousse dictionnary), is an extremely current medical act. The reflex of closing any consultation by a prescription (of a drug, rehabilitation, or even a technical gesture) is indeed firmly fixed in most of us. However, we may sometimes – or even often – have a doubt, more or less consciously, about the real usefulness of the prescribed treatment. It could therefore be interesting to wonder whether the ''prescription reflex'' is always relevant, what motivates it, what it leads to, in other words the *meaning* it conveys, in the patient's mind as well as in the prescriber's. Likewise, we can wonder about what goes with our doubts facing the prescription.

The aim of this paper is to open a discussion on these questions and to propose some useful recommendations for the clinical practice, but without closing a debate which may raise more questions than it may solve. We will first discuss about the clinical factors which should prompt caution before writing a prescription, then about a few principles to be respected if the decision to prescribe is taken, and finally about questionning the symbolic aspects of a prescription or a non-prescription (defined here as refraining from doing recommendations generally considered as having a therapeutic aim).

This debate finds its roots in our daily practice, with patients suffering from stubborn chronic pain (chronic pain syndrome). Such clinical situations are met by many general practitioners or specialists, in private practice or among pluridisciplinary teams. Any persistant pain induces deep and lasting modifications of the person's functioning in the three registers of the biopsychosocial model: alteration of the nociceptive system (especially by neuronal plasticity resulting in sensitization and ''pain memory''), emotional, cognitive and behavioural modifications, relational and occupational problems. These modifications install vicious circles contributing to the resistance of chronic pain to traditional therapeutic approaches and make out of it a disease on its own (the ''chronic pain syndrome''). In these situations where the patient's frailty is linked to a whole of biopsychosocial factors, either drug or technical means, as well as rehabilitation, allow in the best case an only moderate reduction of pain, and still even more modest repercussions on quality of life at long-term. However, it is still very difficult for clinicians to resist the ritual of the prescription and to distinguish whether they use it as an end or as means. Would it be pertinent to change attitude? What would be the consequences of an abstention? Which are the underlying anthropological presuppositions behind the prescription act? Let us underline that these questions, particularly present in chronic pain consultation (maybe putting the algologist in a position of priviledged witness of certain difficulties), concern numerous other clinical situations.

1.2. Clinical factors inciting to reservation

Our medical training tought us to be prudent in those situations where the drug prescription is associated with a significant physiological risk: contraindications, renal or hepatic insufficiency, side effects, pharmacological interactions... It can be assumed that besides these biological risk factors, psychosocial risk factors also exist, likely to compromise the effects of a treatment. We will arbitrarily distinguish four categories.

1.2.1. Inadequate expectancies

Inadequate expectancies are particularly frequent in many patients. In most cases, it represents a claim for complete recovery or a hope of relief more important than reasonably obtainable. A patient expecting the definitive disappearance of pain may reject a transcutaneous stimulation meant to releave him only temporarily. Likewise, a patient expecting complete relief will refuse a treatment reducing pain by ''only'' 50%. And yet, many patients do not express their expectancies, or they are even not really conscious of the reasons why they reject a treatment. Many references in the literature show that the expectancies (of the doctor and of the patient) should be considered as an influential variable in responses to treatments [6,9,11]. Identifying the prescriber's and the patient's expectancies should be a preliminary condition for any prescription, inviting – in case of excessive, inadequate or even often missing expectations – to an adjustment of the objectives or even to renouncement of drug prescription. Simple questions like ''What do you expect from the consultation?'' or ''What are your objectives in coming here?'' allow to obtain precious information, provided that the quality of the link opens enough space for the patient to speak with confidence.

1.2.2. Distrust or anger against caregivers

Many patients will betray more or less indirectly (for example through comments such as ''my mother *too* was badly looked after'') the existence of significant distrust or anger against caregivers. These feelings can easily be explained through an often hectic medical and surgical history [1]. How can a doctor be trusted when prior contacts with the medical profession were experienced as disappointing? The reasons of these disappointments are diverse, often including the feeling to have been a victim of a mistake or of ''ill-treatment'', or to have been denied in the pain felt (''The operation was successful, it is impossible that you to still feel pain''). But anger and distrust may also be the expression of an older scenario of relations, repeating itself on the ground of the present events. Our capacity to stand back, to hear what is underlying anger, is then requested. It is not an easy exercise, especially in the repeated confrontation to situations of patients' (and ourselve's) unsatisfaction. We are at risk, indeed, to often be the target of the patients' frustration and to make a first degree interpretation of their anger, without understanding that this anger is actually not really intended to us. Contributing to the fact that the patients feel listened to in the suffering of a