LETTER FROM NEW ENGLAND **David Loxterkamp**

No mission without the marginalised

Giving up on opioid users is not an option: the stakes are too high, as failure pulls down a circle of people

In the 44 years since it became the 19th American medical specialty, family medicine has never faced such challenges and uncertainty as it does today. The hours have lightened, our pay improved, and the future has never seemed brighter. But our sense of identity and purpose have splintered like light through a prism: who we are depends on where we stand.

Increasingly, family doctors stand outside the obstetrical wards, inpatient units, and emergency departments where we once belonged. We insist on seeing patients in our medical home but not in theirs—nor in nursing and boarding homes where the less fortunate are placed. We have pared our practice from the care of all patients to the care of adults, to insured adults, to insured adults without psychosis or chemical dependency. But is this what we trained for? Can this kind of work—so safe and controlled—really sustain us intellectually and morally? Should we not ask what our communities need of us and what of this work we are willing to perform? This may be the litmus test of the so called patient centred medical home: who is welcome there; who we are prepared to receive.

For the past 30 years I have practised in a sleepy, picturesque, deeply rooted community that has remained remarkably unchanged for two centuries. Then, 10 years ago, I began caring for patients and families whose lives were ravaged by opioid addiction. I was so ill prepared for the task that I failed to recognise an epidemic at my doorstep. Until then, I practised in the manner and scope in which I had been trained. And failed to understand that my small community was a loose federation of smaller communities. Yes, I nominally belonged to various groups: young professionals, those "from away," my faith community, and the busy life of the school. But only marginally did I intersect with the "back to the landers," retirees, merchants, artists, and activists. Or with other communities—the alternative students and the homeless, mentally ill, disabled, or addicted people—that are equally important to the wellbeing of the larger community. Our paths never crossed. I never saw them, even as I treated them in the emergency department and my office.

Then I responded to a call to the emergency department where a friend's daughter was withdrawing from heroin. More calls came from teachers, ministers, and neighbours. I began to seek out the training I sorely lacked. After buprenorphine became available, I offered it to our opioid addicted patients and developed a counselling programme to support its use. Our patients stabilised, but few made the lifestyle changes needed to sustain their sobriety. They were now dependent on buprenorphine and, increasingly, on a polypharmacy of benzodiazepines, stimulants, and marijuana to medicate their emotions. Broken promises at home, at work, and among friends kept their lives reeling out of control. I cannot honestly say who, if any, we helped during those early years.

Now our practice has enrolled about 80 addicts in our treatment programme. We treat them in groups facilitated by a doctor and therapist and become their de facto parents. We reinforce the tenets of healthy recovery: self responsibility, honesty, separation from drug abusing friends, abstinence from alcohol and marijuana, and the expectation that they can and will taper off buprenorphine within two years. It all sounds so straightforward. The reality is that years of absent parenting, self destructive coping skills, poor self esteem, and apathy have created an almost insurmountable challenge.

Last Father's Day I asked the group members if they had been in touch with their dads. A few never knew theirs; most told tales tense with anger and resentment. Not a single member had called or sent a card. The odds for recovery are stacked against them.

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Addicts are overwhelmed by debt, mental illness, and dysfunctional relationships. Week after week they bring news of yet another eviction, conviction, lost job, or newfound skeleton. Or fall in with their old chums to drink, divert, or buy off the street. But giving up on them is not an option: the stakes are too high. Failure never shatters one life but pulls down a circle of friends, an extended family, and the next innocent generation.

In caring for marginalised people, we see that the sources of human happiness are universal. We learn the limits of our need to define, order, and control reality. And how to relinquish the reins of recovery to those who are really in charge. Addicts are the experts on the court system, price of street drugs, dangers of a criminal lifestyle, and the long shadow cast by domestic violence and familial dysfunction. Thus, the group's educational value is worth the price of admission. The other bonus is peer support, which drives every 12-step programme.

Self sufficient patients require less of the doctor's investment. Disease management is amenable to structures and standards. Clinical checklists and numeric scales shield us from the pain and struggle of disintegrating relationships and self destructive lifestyle choices. In the clinic we created, competent medical care does not really require a doctor; a midlevel practitioner, first year resident, experienced medical assistant, or computer will do.

During training, doctors need indigent patients to hone their skills. Though we graduate and move on, the poor and destitute still need us. Are we too far removed to see that the need is reciprocal? Family medicine has no mission without the marginalised.

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