Medicine of the Person
74th International Meeting
07th - 10th August 2024
UK - NORTHAMPTON

Conference ***2***

Dr Frédéric von ORELLI (CH)

08/08/2024

Translation: Kathy WEBB-PEPLOE

CONTINUITY OF CARE IN THE TREATMENT OF PAIN

Dear friends,

There are few symptoms as difficult to be objective about as pain. It is impossible to model it, to measure it or to describe it objectively. And yet, pain is absolutely real. It can completely paralyse us, break us, make us despair or fall into a depression. Pain signifies that 'something is not right.' 'There is a problem which needs to be resolved for me to feel well again.' In our supposedly enlightened and rational culture, we look for and are pleased to find a tangible organic cause, a guilty party to fight against, the same as in other disorders such as a rash, haemorrhage, diarrhoea or visual disturbance, or else the pain disappears on its own and we forget it. Pain has thus basically become a thing, explained and sorted.

And if the pain doesn't disappear? Or if it reappears on a regular basis?

Chronic pain where we haven't identified the cause is first and foremost a worry. We use any means to try and understand it, to limit it, to define its character and above all to work out what makes it worse or better or modifies it. It acquires a life of its own. In a way, we develop a relationship with it. When it gets worse, it can play a part in modifying our behaviour, it can even dominate it. It limits our freedom and that of our relatives. Pain becomes itself an illness in parallel with its underlying cause and can become more important than the illness causing it, in terms of its importance in my daily life.

In what follows, I would like to try and describe the important influences of this malady of pain on the person of the patient and what we can do to make it better and why it is so important that we don't give up. With the help of a few clinical cases, I will shed light on some of the problems which accompany chronic pain and the effect they have on treatment.

Pain is a stress

On 20th January just gone, in the last few metres of a magnificent morning walk, I slipped on some ice and fell on my right elbow. My shoulder joint was violently jolted. The consequence was severe pain in my shoulder and a quasi-paralysis preventing any movement: my thoughts: disaster: rupture of the rotator cuff, which would mean: orthopaedic consultation, operation, immobilisation for weeks, maybe a frozen shoulder, physiotherapy lasting for ever; in a fraction of a second, the whole drama of my experience of patients with this problem unrolled before my eyes. I carefully got up and I established that my bones were intact, I looked for my car keys and was relieved to find that I could drive with my left hand, and even use the automatic gear. What an idiot I'd been. I had brought with me crampons for my shoes as I suspected there would be black ice, but there they were in my backpack. Why had I taken one more step when I could see the ice glistening in front of me? It was so stupid, because I had just a few steps to go before reaching the car and everything had gone fine up until then. Pure stupidity. I was really an ass!

As far as the rest of me was concerned, I was in good health, but the pain rendered me a complete invalid. I was barely able to do any housework. I could more or less sleep, but any movement and I was in pain. To get dressed or undressed was painful. Brushing my teeth? Forget it! An electric toothbrush became necessary, etc, etc. The slightest awkward movement provoked shooting pains in my arm. I was not used to this.

I knew all too well that at my age, conservative management is advised for 6 weeks before seeing if one can or should operate. So, I waited, I got annoyed, and I stayed stressed. I didn't want to take painkillers given my sensitive stomach. The restrictions imposed on the slightest activities made me impatient and angry, angry with myself. I was glad that I didn't have to work, didn't have to do any sort of manual labour. I sensed that the uncertainty about the future weighed on me much more than the actual pain and disability.

Stress can make you ill: stress increases the heart rate and blood pressure. Stress contracts muscles (fight or flight), disturbs one's concentration, deprives one of joie de vivre. Calm and relaxation are absent because one can't find a comfortable position. My thoughts revolved around the shoulder, a future with a disability as an old man on his own.

Finally: appointment with the rheumatologist, a colleague known for his skill with ultrasound: my diagnosis was correct: rupture of the rotator cuff. Thankfully only one of the three tendons had ruptured. I could therefore wait before having an operation and have physiotherapy. The pain would pass. It would all get better, more or less, with conservative management.

My colleague suggested a cortisone injection. No, I didn't want that, I said. Certainly, it would lessen the inflammation, but it would slow down genuine healing. But that meant another four weeks of pain in spite of white cheese compresses recommended by the physiotherapist; on the other hand, I already felt less stressed, since I was no longer alone, I could unburden myself, relax, chat with the physiotherapist and have good reason to think things were improving. After another four difficult weeks, I ended up accepting treatment with cortisone and hyaluronic acid and I felt a rapid and marvellous improvement in the pain, which also made my physiotherapy exercises easier. The rheumatologist saw me three times, technically excellent. The physiotherapist offers me continuity of care thanks to her great professional experience. Only I can overcome the mistake of a thoughtless misstep. Today, I again feel well again.

Stress and pain – What is the relationship between the two ?

On the one hand, there are conditions of extreme stress which stop one from feeling pain. But this effect doesn't last very long and has nothing useful to add to the treatment of pain. Another question might be, is stress harmful? Or does stress itself lead to pain? Of course, it wasn't stress which caused the pains in my shoulder. I had a real muscular injury, and, as seen on the ultrasound, a reactive inflammation of the tendon of the biceps, which could completely explain the pains and the beneficial effect of injecting the painful areas with cortisone. But there is something else, which I had never become aware of. Several researchers have observed that patients suffering from rheumatological diseases (systemic lupus erythematosus, rheumatoid arthritis etc) feel far more fatigue, pain and inflammatory symptoms after emotionally difficult and stressful relationship difficulties, than after positive experiences. (Davis, M.C. et al. Journal of Pain 11, 2010). They were able to establish that in stressful situations, besides the clinical effects and the effects to boost performance, there are raised levels of pro-inflammatory cytokines such as neopterin and interleukins 1 and 6. So, stress in and of itself promotes inflammation. My stress was not helping me to heal at all. I was happy to have the good prognosis, the physiotherapy and the cortisone injection, which all contributed to reducing my stress levels. I will return to this later.

I want to move on to another case of a young patient suffering from pain:

'You don't want to get better!'

Alessandro, a 14-year-old boy at the time, injured his right shoulder in a fall while doing judo, probably dislocating his acromio-clavicular joint. As a talented young sportsman, he was immediately taken to see the orthopaedic surgeons, was operated and taken back to see them because of instability of the joint after the first operation. The joint was entirely rebuilt by another orthopaedic surgeon. Because of persistent pain, he was therefore operated for a third time, but his arm was no longer mobile, and he came to see me to have his pain treated. I saw him accompanied by his mother. He was remarkably silent, saying virtually nothing, completely overwhelmed and just allowing himself to be swept along by events. I learned that his parents were divorced and that he was looked after by each in turn, and that no-one really knew what to do in terms of his treatment plan. His parents thought he was being lazy and not cooperating and argued about how to punish him and what was appropriate treatment. The physiotherapist had doubts about his adherence, since the boy didn't want to do the exercises because of the pain. In the end, he was mostly reprimanded because he refused to do his rehabilitation. At school, he was falling behind because pain stopped him from concentrating, in spite of taking analgesics.

I diagnosed a typical frozen shoulder in an intelligent boy who didn't understand why he was constantly being made to do painful exercises which resulted in even worse pain. First of all, I had to convince his parents that his heart was in the right place and explain to them the time needed in rehab to recover from a frozen shoulder. I had to dissuade them from thinking that it was all just' psychological' and linked to their family situation, after the patient had assured me that he, in fact, had a good relationship with both of them.

Neural therapy, first weekly, then monthly, allowed him the ability to do the exercises. The boy regained courage and hope and was able to be supported at school as his pain was acknowledged. For 18 months, I was able to treat him and discuss any problems whether at home or at school, up to and including his choice of profession. He was even able to start swimming again, to do his favourite sport, at least for pleasure. All the family had to accept that not everything was easily achievable, that Alessandro couldn't be repaired like a machine and that he needed constant support.

The cooperation of patients with prescribed therapies, whether they are medicines or behavioural, depends a lot on our relationship with them. The philosopher Martin Buber says it well in 'Education': 'It is essential that the relationship is a true relationship lived by the doctor in touch with their soul, thus including both the practising teacher who conveys knowledge and the sympathetic and empathetic friend, which belong together to a relationship in dialogue.' It is difficult for us to ask the patient to behave in a way that we wouldn't if in their place.

Alessandro recovered full movement of his shoulder albeit with reduced strength and trained to become a nurse.

Another problem:

‘There is nothing to see.’ The invisible illness in the case of undiagnosed neurodivergence.

Madame Boss, 54 years old, single, has been working for the last 5 years in a window factory as the only secretary. She is shy and likes working alone. Before, she was an accountant, as she really likes numbers above all else. She calculates the price of the windows that have been chosen and draws up the invoices. In October 2010, she bites on a grain of barley and breaks a left lower molar, which had already had a filling. This results in violent pains in the mandible, then in the maxilla and as far as the region round the eyes. Her whole trigeminal nerve (supplying the face and the cheek) is ‘on alert’. The maxillo-facial surgeon takes out the rest of her teeth but the pain always returns as attacks taking the form of ‘atypical facial neuralgia.’ Neither the max-fax surgeon nor the neurologist manage to understand what has happened and they prescribe different medicines without success. The patient is exhausted by it all and is forced to go part-time at 70%, mainly because of her numerous appointments with doctors and therapists. She is depressed and starts psychotherapy and takes anti-depressants. At the end of three years, Madame Boss came to our clinic to continue her treatment. Our neurologists are also baffled as to what is causing it. I start by doing repeated injections of local anaesthetic in the region of the trigeminal nerve and the molar to relieve the effect of the scarring. We persevere, patiently, since the attacks are becoming less frequent. Moreover, the patient can shorten the duration of the attack by taking antimigraine medication, but she can’t stop it altogether. She draws a happy smiley face in her diary when she has a day without an attack. At the start, there were up to 30 unhappy smileys per month. We continue to look for causes. A colleague and friend finds that the dental scar is still active using kinaesthesiology. So, we look for a dentist who works holistically. And the dentist also finds a static problem with imbalance of the pelvis and treats her with a dental appliance and orthopaedic insoles. The attacks become less strong. Five years later, the attacks are much less frequent but still very severe. It was then that I retired.

Now the patient does not want another doctor doing injections in her face. She only takes migraine tablets (Maxalt – rizatriptan), which relieve the pain during an attack. From time to time, her boss says to her; ‘There’s nothing wrong with you, we can’t see anything.’ She is wounded by this and isn’t able to formulate a reply. After another two years, she takes planned retirement as she no longer has the energy required to work. She continues psychotherapy. In the Spring of 2024, the psychotherapist who did a course tells her that she has Asperger’s syndrome. That is to say a disorder on the autistic spectrum. She has absolutely typical symptoms. It explains many of her childhood experiences and her experiences at work; her solitary life with bullying at school because she didn’t understand the joke, her shyness in the company of others because she often couldn’t gauge their reactions. Her love of numbers and many aspects of her character are typical of this condition. She telephones me to talk about it and we find ourselves in a café.

She views the diagnosis as a deliverance. Was there an existential stress which prevented her recovery from her tooth injury? This diagnosis also explains her social isolation. I point it out to her, and she thinks that it is possible. In any case the intensity and the frequency of her attacks have lessened.

The lack of understanding of those around them is equally a problem for many patients suffering from headache and from depression, even without Asperger’s syndrome. They don’t present with any sign of tension, except maybe for deep ‘worry lines’ on their forehead and appear on the outside to be completely ‘normal’. The list of smileys helped the patient to document her suffering and to make it ‘visible’ in a certain sense, without having to give long explanations. Madame Boss wrote to me on 15th My 2024: ‘Neural therapy was important, for after 6 months of neural therapy, I had for the first time a day completely without pain, which gave me the hope of getting better which continues until now. Thank-you for having persisted and for having believed in my pain. From January 2013 until June 2018, you didn’t abandon me. I would probably not be here now.’ A moving admission.

Another problem linked to a painful illness is

Fear

Madame Bachmann is a 57-year-old intensive care nurse who has given heart and soul to working in the hospital for the last 30 years. She is single, sings in a choir, goes on bike rides and has tortoises in her garden. She tells of the tortoises laying eggs every year and then burying them. She has to dig them up so as not to need to sell them or kill the young.

She comes to see me because she cannot bear the pain in the soles of her feet anymore which has been tormenting her for about a year. From time to time, she has to take sick leave, when standing for any length of time or when walking become unbearable at work. The neurologist diagnoses a polyneuropathy of unknown origin and prescribes pregabalin. Otherwise, there is nothing to be done. It should progress slowly. The only physical sign in this slim, supple woman is a diminution of vibration sense in the left foot. But she is terrified of having to live in a wheelchair in the near future, for she won’t be able to walk anymore because of the pain. She doesn’t tolerate analgesia which makes her tired and has no effect at low dose. But the neurologist doesn’t know of any treatment to stop the progression of the disease.

The evolution of a polyneuropathy of unknown origin is not predictable and so the future is worrying. The fear experienced by this woman on her own, with good medical knowledge, is totally understandable. Thanks to neural therapy in the femoral arteries, we are able to temporarily calm down the pains. We are probably improving the circulation and the nerve conduction with this treatment. For a long time, she has also been having treatment for pains in her chest, which we attributed to costo-vertebral entrapment and treated by manipulation. Madame Bachmann does not view the relief of her chest symptoms or the improvement in her recurrent pains in her feet a simple pain-relief: she is alive again and regains her zest for life. We talk of her exhausting but fascinating work in intensive care, of her leisure time with the tortoises, the choir, the bicycle journeys through nature. She can free herself from anxiety and now make the most of life, even in retirement, in spite of the pains in her feet. The treatment is ongoing. The neurologist says that she was lucky to have started neural therapy early, otherwise the neuropathy would have progressed much more. I think that it was at least as important to be able to get rid of her fear. It is proven that fear can provoke and sustain a chronic stress reaction with inflammation.

Sticking to the path together

Frieda’s story shows to what point it is important to journey together on the road chosen by the patient. Frieda was born in 1979, she is single and is studying economic law. I see her for the first time in 2010 because of pain in her right leg following ankle erysipelas (surface infection of the skin). The erysipelas was successfully treated with antibiotics. The initial injury may have been due to mosquito bites. As the pain was not improving, she came to see me for treatment of her pain.

Other than abdominal cramp attributed to endometriosis, this woman was in good health and athletic. Below the right internal malleolus, she had a little oozing, painful wound which she had inflicted on herself with a nail during a pedicure. Bacteriological swab was negative. But following on from that she developed lymphoedema. We managed to keep the pain at a relatively manageable level thanks to analgesics and neural therapy, without getting rid of it completely. The patient had to walk with sticks and wear support stockings to maintain lymphatic drainage. Vascular examination didn't yield a cause for the lymphoedema. The little wound, in spite of good treatment, spread to become an ulcer the size of the palm of a hand. Without any further injury, an ulcer, nearly as big, also with lymphoedema formed in the same place on the left, below the malleolus, a few months later. The dermatologist she consulted recommended different ointments and creams, besides lymphatic drainage, without success. He finally advised that she have a skin graft from the thigh done by a well-known specialist in the university hospital at Zurich. Given her worry about her mother, and her studies, this solution was not a realistic option for this patient. Anyway, she wouldn't have agreed, as she would have had to stay in bed for two weeks and the very fact of lying down made her pains very much worse. She didn't think she would tolerate it.

In the course of our exchanges, the patient slowly revealed details of her youth. She grew up on her own with a mother who was divorced. They both had strong characters and argued a lot. She saw her biological father for the first time at the age of 8, while on holiday on the edge of a lake in Ticino. The father spent the whole of the first morning fishing, leaving her on her own. At midday, he wanted her to carry the bucket of fish home. 'What is it?' she asked. 'It's your lunch!'. To which the girl replied: 'I'm not going to eat these animals! I'm taking them back to the lake.' 'You can't do that!!' her father shouted at her. The girl: 'I'm doing it' and she tipped the fish back into the lake. Absolutely furious, her father put her in the car without explanation and took her back to her mother without saying a word during the six-hour journey to Germany. At the age of 16, she had a similarly traumatic experience with him and never saw him again.

For six years, we met for neural therapy, initially once a week, then every two to three weeks, and talked about many different things. Frieda learned to bandage her feet and keep the wounds sterile and to wear the contentious stockings in spite of the heat. Because of her persisting abdominal pains and her food intolerances, we did a test showing that she was sensitive to certain foods, and I recommended that she avoid milk, gluten and eggs as much as possible. The endometriosis was no longer a big problem. To our great surprise, the ulcers slowly got better and healed up, the pains disappeared and the lymphoedema was resorbed. In 2017, the patient completed her studies and is living with her partner, almost pain-free, while sticking to her diet.

Frieda had been subject to severe relationship trauma when young, lacking a father, and subsequently found it difficult to find her way in life with her mother. She was aware on an emotional level of her food intolerances, but she hadn't paid it sufficient attention. Children are particularly vulnerable to relationship trauma. Of course, we don't know all the factors which contributed to Frieda's illness and to her ulcers. The food intolerances clearly played a part in the problems with healing, even if we are unable to explain it. It needed our combined obstinacy in believing for many years that we could be successful, carefully protecting the ulcers from infection, sorting out the problems with her education and finally a willingness to bring order to her diet, in order to bring enough equilibrium in her body and in her life for healing to occur. A purely mechanical 'repair' with a skin graft at the university hospital would certainly have ended in disaster.

This was a good therapeutic relationship with active support, where no-one could have predicted the outcome. We had to keep encouraging each other to keep on the road we had chosen and to remain open to new possibilities. I didn't strictly speaking do psychotherapy with Frieda. The episodes with her father were treated as psychological injuries and we talked about her relationship with her mother. To be able to talk about these was very important to Frieda.

What is striking about these stories?

Pain and the process of healing is not entirely explainable by injuries or organic illness. They don't completely get better or they don't get better at all. They weigh on our existence. Even my acute injury seemed to have completely changed my life. I was lucky, it wasn't that serious. But I understood what it was to be suddenly dependant and how important reducing stress was. All the patients in my examples suffered added psychological pressures. Alessandro: the uncertainty and lack of understanding of his parents and his therapists, Mme Boss: the bullying and rejection because of her personality trait, Mme Bachmann: fear of becoming an invalid and Frieda: uncertainty because of problems with healing which felt as though they would last for ever with massive restrictions on her daily life and on her future.

Patients are subject to permanent stress. But can we establish why they needed treatment for such a long time whereas I healed in three months?

In some, our conversations revealed a stress linked to relationships in their early childhood. Was it therefore all psychological? Certainly not. Alessandro's stiff shoulder, Frieda's ulcers and also Mme Boss' facial pain had a neurological or dermatological basis. It is only the delayed healing which couldn't be explained solely by the complexity of the injuries. We cannot tell why one illness becomes chronic, and even less why a good relationship between a patient and their doctor makes chronic illness more bearable and can sometimes result in cure. Is this to do with a miracle? Paul Tournier observed almost 100 years ago that even with psychoanalysis and psychosomatic illness, man is not being treated as a whole person. He knew, from his own experience, that what is important in life, is relationships, relationships with your father, your mother, and, and, and… We heard it yesterday.

I kept thinking about this problem while I was preparing this talk. I happened to find some books from which I'd like to briefly share some ideas with you, for they present the results of important research which would have pleased Tournier.

One of the research groups is that of Professor Joachim Bauer at Fribourg-in-Brisgau. He is a psychiatrist and neuroscientist and most notably was the first person to describe interleukin 6. Bauer explains that in the newborn, there is not yet a consciousness of self. It is the contact with the environment, in particular the human reaction of people around them to cries or to smiles or to other vocalisation, which marks the formation of a 'neuronal network of self' in the frontal brain. It happens particularly in the first 24 months. It is thus that the small human being starts to recognise themselves as 'me' and to distinguish themselves from their environment and from other people after these first 2 years. This imprinting also involves so called 'high risk' genes for chronic disease such as for example coronary artery disease, Alzheimer's disease or cancer. We find more high-risk genes in patients with 'silent inflammation', such that we currently consider it an important factor in numerous chronic diseases. The biography of patients suffering from Alzheimer's disease, for example, may show an impressive picture with stress which is sometimes severe, or even severe trauma which could have 'weakened' the self as it was developing.

Other studies have also shown repeatedly that a new social activity, for example as a school caretaker, can result in a reduction in inflammatory activity of the high-risk genes (Fredrickson Barbara, Cole Steven et al. PLoS one, 2015).

The second group of researchers, led by Christian Schubert at Innsbruck, study immunological disorders which can lead to chronic silent inflammation.

Their psycho-neuro-immunological research was able to show that stress states and other emotional disturbances, such as mourning, separation, anger, can lead to permanent inflammation and even to allergies and intolerances, particularly in childhood and adolescence. It seems as though the body is equipped not only to defend itself against viruses and bacteria, but also against psychological trauma, with reactions similar to those of the immune system. Whence the term used to denote this field of research: psycho-neuro-immunology. Why are such traumas harmful? Why does pain heal less well if we have a preceding history? For that, we need to take a brief detour via the defence mechanisms of our body. When the attack is due to a virus or to a vaccine, the body activates its immune defences with T and B cells which form antibodies and set off an inflammatory reaction with activation of the sympathetic nervous system. Depending on how vigorous it is, it is accompanied by release of adrenaline, noradrenaline, cytokines and, a bit later, of cortisol, which leads to the sensation and behaviour associated with being ill with weakness, malaise, maybe fever and fatigue (sickness behaviour). This state is helpful in protecting us from extra stresses such as work or sport and to defend us against microbial attack by concentrating all our forces on fending off infection. The activation of the parasympathetic system and of cortisol sets off an opposing reaction which, once the danger is eliminated, initiates healing. The study of psycho-neuro-immunology now teaches us that it isn’t only viruses, bacteria, allergens or cancer cells which activate our immune system, but also psychological stress. We now know that prolonged stress, mental distress ahead of exams or the continuous practice of sport at a high level makes us more vulnerable to viral infection or causes troubles with wound healing. For a short period, the biological stress reaction is totally logical and beneficial to good health. But if the infection or the tissue injury, or even the psychological stress is prolonged, the constant flooding of cortisol becomes itself an attack on the body’s cells responsible for defence and so brings with it a weakening of the body as a whole. This is what we are calling silent inflammation. This effect can equally be demonstrated experimentally, particularly in wound healing.

The chronic somatic, cellular and humoral (antibody) response to a major psychological threat can for example result in more frequent allergies or explain psychologically defensive behaviour. It is impossible to say which particular conditions lead to dementia, multiple sclerosis, coronary disease or other chronic diseases. In contrast, we can try to understand, during the consultation, when a patient has had severe physical injuries or major relationship difficulties. We can then help the patient to confront them so as to reduce the chronic inflammation which eventually arises from them. In the same way, we need to notice those behaviours which recur in the life of a person, and which disturb their development as a complete human being, as a *person.* Tournier’s life is an example to us with the repression of his emotional life.

Tournier always referred back to the bible and to people like Martin Buber and many others to show that our attitude to the patient is often much more important than the techniques which we learn from books. It reveals to us the deep problems of the person we are meeting.

It is very important that psycho-neuro-immunology renders medicine of the person more understandable in terms of its physiological basis and confirms it as a physiological phenomenon. There are currently an incredible number of ‘body-mind’ methods, which are in part applied with a lot of success and can be very useful to us, even as we adopt Paul Tournier’s fundamental medical approach of personal relationship. I am thinking here of numerous psychological and psychosomatic methods, of hypnosis, of transactional analysis, of psycho-kinesiology according to Klinghardt, and many others. The thing which is decisive for us isn’t the method, but the fundamental attitude we adopt with our patients and the willingness to follow a common personal path which we are both passionate about. The application of a method is an objective approach ‘I – that’. Medicine of the person seeks the path of a personal relationship ‘I – thou’. Even if this isn’t always possible, not even close, we can evidence with our patients how gratifying success is for them and for us – generally after a certain time, along a continuum – and how it can lead to important discoveries.

Thank you for your attention.