

I woke to find myself stuck somewhere between sleep and wakefulness, a liminal zone, a threshold between dream and reality. Drifting in and out of consciousness, my dreams came with me, events and people on the ward merged into a hallucinogenic thriller where events in the present affected not only the future but also the past. With hindsight, my choice of watching the film *Tenet* the night before going in for brain surgery, with its themes of time travel and a race to avert international disaster, may not have been ideal.

Earlier that year I was diagnosed with a pituitary adenoma and, after careful discussion with my team of endocrinologists and neurosurgeons, decided to have surgery to remove it. Generally considered a safe surgery, I expected to be in hospital for less than a week and was reassured I would need only simple analgesia after the first few days. Of course, I should have considered the additional 'risk magnifier' for medical personnel. Based on experience, this suggests that if the patient is a member of the medical profession anything that can go wrong with a procedure, generally will.

Sure enough, during surgery I had the rare complication of a CSF leak and then, to add insult to injury, developed an even rarer and aggressive 'ventriculitis' (no, I hadn't heard of it before either), an infection like meningitis but more focused within the ventricles in the brain. This caused headache, confusion, photophobia, and a fever with rigors that came on just as they were attempting to remove my lumbar CSF drain, which was a tad inconvenient.

FROM PAIN TO EUPHORIA

Here I need to qualify that rather dry description of a 'headache' as I really don't believe that does it justice. It was an excruciating pain rendering me unable to speak, open my eyes, or tolerate even the touch of my wife's hand. This led to the clinical team throwing the analgesic section of the BNF at me and I was given increasingly more heroic doses of oxycodone up to a

total of 80 mg in 24 hours (the equivalent of 160 mg of morphine) on top of paracetamol, naproxen, and dihydrocodeine.

To my embarrassment now, I remember as the pain built, I considered my experience of managing chronic pain in the community. I practiced breathing exercises and even remember reaching for my phone to play a meditation before the onset of rigors meant I couldn't press the buttons and I admitted defeat welcoming the opioids with open arms.

I don't honestly remember much of the next 48 hours, my level of consciousness fluctuated as the antibiotic equivalent of Domestos was poured into my veins but I subsequently rallied enough to emerge into a psychedelic combination of infection and opioid side-effects including delirium, hallucinations, sedation, and mood swings that were played out in a screenplay that would have done Christopher Nolan proud.

As the antibiotics continued to do their work, I was able to cut down the doses of opioids and reacquaint myself with reality. It was during this phase, shortly after a chunky top-up of oxycodone that I experienced my next opiate effect. Lying in my hospital bed with the pain receding I was filled with an overwhelming sense of wellbeing, finally all was well with the world and the next few hours were spent in a state of near-total bliss.

This may well have been because I was feeling better but I now recognise in that afternoon a near-perfect example of opiate-induced euphoria. How wonderful it was to be out of such awful pain (and how scary it was to consider it returning). This created the perfect pharmacological carrot and stick of motivation to continue to use opioids and it is no surprise to me that a significant portion of surgical patients end up becoming long-term users of opiates.

AVOIDING DEPENDENCY AND ADDICTION

One may think that as doctors our knowledge and experience might afford us some protection but the likelihood of our developing a substance misuse disorder actually exceeds that of the general population, with opiate

use coming second only to alcohol. Perhaps this should come as no surprise when considering that psychological health plays an important part in predicting those who are more likely to experience substance misuse. In early 2018, Mind surveyed 1066 GPs in England and Wales and found 40% reported significant mental health problems, add this to similar rates of burnout and you have a powerful driver for not only the descent into addiction, but subsequent relapse.

Critically we also have privileged access to controlled drugs, its sobering to note that primary care doctors are the most common source of opioids for non-medical users and perhaps this accounts for why both GPs and anaesthetists top the list of 'high risk' specialities likely to develop an addiction.

It's easy to vilify opioids but there is no doubt that they are highly effective analgesics in the management of acute pain; however, we must be honest with both ourselves and our patients and discuss not *only* the analgesic effects but *all* of the effects, including the euphoria and the more psychedelic effects that may reinforce use and increase the risk of subsequent dependence.

When it comes to surgery, informing patients on the potential side effects before they need opioids as well as giving guidance on reducing and stopping them after any procedure is vital. Early identification of risk factors and the use of interventions to equip patients with self-management skills can reduce post-operative use of opioids and ultimately avoid the drift into dependence and addiction.

My experience in this opiate-induced liminal zone has enabled me to reflect on the thresholds crossed between doctor and patient, and provided a valuable insight into the impact of these powerful drugs. It has been a humbling experience that has emphasised my own fallibility and vulnerability, not just despite, but perhaps because of, being a doctor.

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