

Interview



Douglas Drossman

President, Drossman Center for the Education and Practice of Biopsychosocial Care, DrossmanCare; Drossman Gastroenterology, DrossmanCare; President, Drossman Consulting; Professor Emeritus of Medicine and Psychiatry, University of North Carolina (UNC) School of Medicine; President Emeritus and Chief of Operations, Rome Foundation; Former Co-director, UNC Center for Functional GI and Motility Disorders, North Carolina, USA

Q1 You have previously spoken about the brain-gut interactions that appealed to you, but was there a particular event or person that encouraged you to pursue a career in gastroenterology?

My interest in gastroenterology came because I always had an interest in the psychological aspects of medical illness and, unlike other subspecialties that are number driven (e.g., cardiac physiology, pulmonary function, electrolytes with renal disease), there are no numbers in gastroenterology. We take a history and assess symptom patterns, quality of life, and other psychosocial features. Of course, there is endoscopy and I always liked that. In fact, as a fellow I would interview the patient before the exam and try to predict who would have a normal endoscopy (*vis-à-vis* functional) and who would have an ulcer or IBD. But to truly understand the disorder you have to understand the patient and that relates to the history you hear from the patient. That fit well with my interest in mind-body interactions from

my mentor, George Engel, who trained me and coined the term 'Biopsychosocial model'. So, it became a perfect combination because George was also an excellent interviewer. I trained with him in psychosomatic (biopsychosocial now) medicine and then went into gastroenterology. That was how I evolved the work in the functional gastrointestinal (GI) disorders (FGIDs) and brain-gut interactions (DGBI) very early on (in the 1970s), before anyone was really interested. Once I became a GI fellow, I was mentored by Don Powell, the GI Division Chief, who taught me how to 'play the game' of academics: how to publish, write grants, and give presentations. That convinced me to stay in academics and use my skills to help develop the field that led to the Rome Foundation and my work in communication skills.

Q2 In the recently published study you co-authored, entitled 'A survey of gastroenterologists in the United States on the use of central neuromodulators for treating irritable bowel syndrome', what



"There needs to be more studies to show that the patient-provider relationship improves health status, health outcomes, reduces unneeded procedures, and costs."

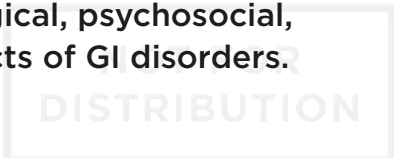
were the key messages you and the other researchers were trying to deliver?

First of all, I wanted to increase awareness of the value of using neuromodulators. That survey came after we did a Working Team report at the Rome Foundation in December 2018, which was a comprehensive review of the neuromodulators for GI problems, particularly painful conditions. That 2018 article has become a highly quoted publication. One of the major messages was to change the term from antidepressants, anti-anxiety, and antipsychotics to neuromodulators. We proposed that in the paper and that has rapidly taken hold because it avoids the stigma of using these medications for DGBI and not psychiatric problems. It's very analogous to how, in 2016, with *Rome IV* we changed the name functional GI disorders to disorders of brain-gut interaction. It's more scientifically based and avoids stigma. So, the key message is the awareness and legitimisation of using neuromodulators. As a side note, we call the GI drugs peripheral neuromodulators when they act on the enteric nervous system.

Another message is that these drugs are effective. There have not been sufficient studies in patients with GI disorders but enough empiric and consensus evidence to show benefit and we can borrow from other painful medical conditions where studies have been done.

The third message is that good clinicians can learn to broaden their repertoire from the usual 10 mg amitriptyline to higher doses and a wider spectrum of medications including the antipsychotics. It's the sense of dualism and stigma that leads to fear of learning how to use them. That was shown in the survey data. Personally, and throughout the Rome Foundation and my educational programme, DrossmanCare, I now run workshops to teach GI doctors how to use them.

You currently have more than 500 publications and over a dozen associated with your name for your research in the clinical, epidemiological, psychosocial, and treatment aspects of GI disorders.



What do you believe to be the current gaps in literature and what topics merit greater attention?

That's easy. There needs to be more studies to show that the patient-provider relationship improves health status, health outcomes, reduces unneeded procedures, and costs. That's the only way to convince the insurers to reimburse at least equally for face-to-face time compared to procedures. In the USA, the discrepancy is very large. Why spend an hour talking with a patient and make 250 USD when you can spend an hour doing 3 colonoscopies and make 3,000 USD! Patient centred care needs to be taught and reimbursed in the USA and the world. We have just released an article in *Gastroenterology* (online now); a Rome Working Team Report on communication skills and the patient-provider relationship. Part of that was an evidence-based review that demonstrated that good communication skills can improve patient and provider satisfaction, improve symptoms, and reduce costs. More studies like that may change medical school and residency curricula to teach communication skills and incentivise clinicians to learn more about these skills. Then, in time, unneeded procedures and reimbursement for services will fall in line. I also think we can develop good training programmes to teach doctors to communicate with patients better and then show that those courses are associated with patient and physician satisfaction and behavioural change in the practice. The Rome Foundation and DrossmanCare are doing these programmes now.

Another gap, as we noted above, would be to study the impact of central neuromodulators on improving the more severe DGBI.

What was the mission you set out to achieve when you founded the Rome Foundation?

At the time (the 1980s), functional GI disorders were not well understood, not well studied, not well taught, and were even trivialised. Diagnosis was made by exclusion of other disorders and the patients were thought to be psychiatric. So, my mission, personally and professionally, was to reverse all of that. Another mission was to put the FGIDs on the map, so to speak. The development

and unique application of symptom-based criteria changed the way we diagnosed these disorders. Once it was accepted by the U.S. Food and Drug Administration (FDA) and other regulatory agencies, the Rome Foundation criteria were required for clinical trials and that opened the door to more research. Now patients can be studied around the world with the same symptom features, something that didn't exist before. We began by developing the criteria, but we had other goals: to educate clinicians on these disorders and our working teams, and subsequent editions of *Rome II*, *III*, and *IV* have done that. We wanted to encourage research and our research institute is doing that. Finally, we wanted to bridge the gap between doctors and patients and our communication skills programme is doing that. Ultimately, we want to help patients. The overall mission is: "To improve the lives of people with disorders of brain-gut interactions." There are four objectives: to promote global recognition and legitimise DGBIs; advance the scientific understanding of their pathophysiology; optimise clinical management for these patients; and develop and provide educational resources to accomplish these goals.

What are the most significant changes you have seen in the field of gastroenterology during your time working within the field?

First of all, I came into training in the 1960s and endoscopy was just beginning. Without question, diagnostic and therapeutic endoscopy has been a game changer for GI disorders. Then, for those who had negative studies, as I noted above, the use of symptom-based criteria gave the DGBIs (previously FGIDs) a home starting in the early 1990s. Prior to that everyone with GI symptoms and negative endoscopy were thought to have IBS. Now we have a classification system of 33 disorders and that has allowed for more specific treatments targeted towards patients. A third change over the last 10 years has been the more recent field of neurogastroenterology, or the science of brain-gut disorders. This evolved by blending the work of clinicians and scientists in motility with those working in FGIDs and then adding the work of epidemiologists, basic scientists, psychologists, and dietitians. This is a more integrated and effective way to study these patients.

In your preface of the book you co-authored, *Gut Feelings*, you mention an aim is to deliver a “learning experience” and to “optimize the patient–doctor relationship.” What are the biggest challenges to this in clinical practice?

The biggest challenge to optimising the patient–doctor relationship begins with abrogating mind–body dualism and replacing it with the biopsychosocial model. Once we can teach the biopsychosocial understanding of DGBI and reduce the stigma attached to patients, both doctors and patients can partner to optimise the patient–doctor relationship. The next challenge is to teach clinicians and patients how to communicate with each other in a collaborative and patient-centred fashion. The third challenge, as I noted above, would be to incentivise this process by training doctors and rewarding them for doing it.

I believe that the uniqueness of this book is that it is a collaboration between a doctor and a patient. That can go a long way to meeting these challenges. The book gives a joint perspective on the patient–doctor relationship. I’m not sure that has ever been done before; at least not in gastroenterology. I was fortunate to have Johannah Ruddy as my patient. Her experience motivated her to clearly articulate in written and spoken word her transition from illness to wellbeing. From that, we began working together, doing communication training programmes and researching and writing peer-reviewed publications. So, the learning experience is for doctors to understand the patient’s world and for patients to understand how doctors work. The book also contains an easy-to-read compendium of all the DGBIs, a mini *Rome IV*, So patients or healthcare providers can quickly learn about these disorders.

You have described your latest focus of research as “patient–provider communications.” What are the latest advances in this field and where else can we expect to see your attention lie in the future?

In the last 2–3 years I’ve developed a collaboration between my educational programme, DrossmanCare, and the Rome Foundation to

“Without question diagnostic and therapeutic endoscopy has been a game changer for GI disorders.”

create a curriculum: ‘What Do You Hear?’. This has seven components: production of videos to teach communication skills; presentations and symposia; full day workshops at medical centres and other educational venues; Train the Trainer programmes to teach key opinion leaders in the field to run communication skills workshops; publishing educational materials in peer-reviewed journals on patient–provider communications; having a visiting scholar programme so interested providers can observe our patient care methods on site; and having a research programme to demonstrate the effectiveness of this curriculum in improving outcomes. My goal is to not only to increase learning but to also create a legacy by training others to continue our goals and objectives

What advice would you give to a younger-self or aspiring gastroenterologist looking to establish themselves in the near future?

I’ve learned a few things along the way.

If you do research or teaching, search from within to find what turns you on. Learn what gives you meaningfulness and use the interest and energy that ensues to build your career. Too many young GI doctors rely too much on what they are being told to do. I know that is difficult because new GI fellows are often asked to start doing research and to publish before they know what they want.

Learn to network. Find collaborators, join the societies, and learn from others, e.g., young investigator programmes.

Get a mentor. Often the most productive clinicians, educators, and scientists had mentors to guide them and to be there when things were not going well; to help provide direction. I had two and it helped immensely in building my career.

Enjoy what you do. Find the gratification and go with it. Too many young gastroenterologists can burnout because they haven’t found a satisfactory path. If you are having trouble, get advice. ■