This is a resident case log of a patient encounter in which an "Aware Medicine topic" was central.

Saying No to Drugs

One of the issues I struggle with the most is trying to decide when it is appropriate to use narcotics for chronic pain. On the one hand, it feels good to be able to help patients improve their pain, but on the other hand, there is a part of me that has become a little cynical and wonders what my patients are really doing with the oxycodone (or whatever drug of choice it is) that I am giving them. Early on during my first year of residency, I was approached by a number of patients requesting pain medications and was disenchanted by a few cases that ended with me feeling like I had been taken advantage of.

This case was a situation that started out like many of the others, but ended in a unexpected way. My patient is a middle aged gentleman (I'll call him Mr. Joe) who has struggled with many of the basics of life. He was never able to hold a job, was on disability, and found himself living either out of his van or on a friend's couch for the majority of the time. He has had chronic low back pain for many years and at points in his life found himself on the street injecting morphine subcutaneously. He came to me after being admitted for cellulitis and an abscess that had resulted after one of his injection sites became infected. So here I am, a second year resident, trying to decide how I can improve this patient's pain without violating my own sense of what is appropriate medicine. Complicating the situation was that not only had Mr. Joe been injecting morphine on the street, but he had a history of using cocaine and other drugs. What am I to do?

My gut instinct was to deny this patient narcotics as he clearly was a high risk patient for abuse given his history of injecting morphine and using other drugs. At the same time, if I said no, I knew he would just end up back on the street with another terrible abscess infection. What is more harmful, treating his pain with long acting narcotics and trying to meet him halfway, or leaving him to his own devices knowing full well that he will end up in the hospital on IV antibiotics in a short period of time. Did I mention that my patient also suffered from depression? This was something that he had been dealing with for many years but had gone without treatment. He was uninsured and the wait list at Dane County Mental Health was a mile long. I took a deep breath, and with the help of the staffer decided to try the "harm reduction" approach.

It actually worked quite well for a little while. Mr. Joe's pain was better controlled, he wasn't injecting morphine, he was functioning better and actually doing some work on the side as a mechanic. We were working on treating his depression and seemed to have a respectful patient-physician relationship. I always had this fear though that something would happen and he would "mess up," break the narcotic contract in some way by asking for early refills, taking more than he was supposed to, have a positive urine drug screen. Sure enough, things slowly started to fall apart. First he started needing stronger doses, then marijuana showed up in his urine, and when amphetamines appeared I decided I couldn't continue prescribing narcotics for him. That had crossed a line, not only was it unsafe, but it violated the agreement we had initially made.

Part of the reason I don't like starting patients on narcotics is because I worry about having to stop them at some point. In a way it feels like setting my patients up for failure. It does work out okay occasionally, but when it ends with the patient violating the contract in some way, it can be quite painful for everyone involved.

This case was no exception, initially. Mr. Joe tried a number of things to try to get me to restart the narcotics, including saying it wasn't his urine he brought in and also threatening to harm himself. I had a few sleepless nights thinking about all of this. However, this time, we ended up getting Patient

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Relations involved and they were able to arrange for him to be admitted to a mental health facility for some intensive treatment. This is what he really needed.

Stopping narcotics for a patient is always an uncomfortable encounter, but I have to trust myself that it oftentimes is the best thing for the patient. Not only that, but it is sometimes what is needed in order for me to maintain my sense of boundaries. In this case, I was able to see how it actually led to something positive for the patient- he was finally able to establish care with the mental health community. Not a fairy tale by any means, but probably, in the end, the best thing for him.