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The Patient You Least Want To See

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Signing my first orders as a medical intern was distinctly disconcerting. Wait, I can just sign this order and it will happen? Are we sure this is safe? Safe or not, new physician trainees suddenly wield the power to administer medications that can be life-saving or life-ending. Pharmacists corrected my orders for excessive doses of insulin or potassium, while senior physicians guided my selection of vasopressor infusions and antibiotics. When it came to intravenous (IV) opioids however, those pharmacists never hesitated to approve my orders, and I found little structured guidance from supervising physicians. With no questions asked, I included “as needed” acetaminophen (Tylenol), oxycodone, and IV morphine in my standard order set for every patient I admitted. I congratulated myself on a time-saving trick to anticipate patient and nursing needs that would spare me an extra page to respond to. Instead, I unexpectedly found patients skipping the acetaminophen and getting their “as needed for severe pain” IV opioids around the clock for days. This often culminated in a last minute desperate discharge plan, with many demoralizing negotiations over “just one more push of IV Dilaudid and Benadryl.” I came to appreciate a more insidious problem, and even worse, worried that I was contributing to it.

I soon found that the patients I least wanted to see were those fixated on negotiating for additional opioids in the hospital. These were the cases where I was caught between challenging patients and inconsistent supervising physicians, between the power to prescribe potent medications and learning to compassionately manage pain, and between social mores steeped in prioritizing pain treatment to one recognizing the dangers of prescription opioid drug misuse.¹ With the pervasiveness of the prescription opioid problem,² the inconsistent practices amongst even seasoned physicians, and policy calls for increased prescriber education and monitoring,³ we may all be “trainees” when it comes to these complex cases.

I was called to admit a middle-aged woman with a history of heart disease and long-term prescription opioid and benzodiazepine use. She presented for one of her many visits to the emergency department for chest pain. Before I could propose a management plan, she preemptively noted, “ECGs and lab tests never work to detect my chest pain. Don’t bother with nitroglycerin either, that just gives me a headache. If you could get me 2mg of Dilaudid and 1mg of Ativan however, that would help a lot.” From the emergency room staff (who knew the patient well from her regular visits) to my attending physician, all suspected the admission had more to do with substance dependence than acute coronary syndrome. Given

her prior cardiac history however, we admitted her nonetheless. Twenty-four hours later with no acute change in symptoms or objective findings (including a cardiac stress test) we discharged her home. “Before I go, can you write me a refill for my Norco, Ativan, and Soma?” she asked, “I ran out early and will just end up back in the emergency room if I don’t get more.” I later consulted with my peers on what to document for her principle discharge diagnosis. I found that most of them would not commit to anything beyond non-specific “chest pain.” One resident physician summed up a collective sentiment that, “Drug seeking is almost certainly what’s happening here, but I wouldn’t stick that onto the patient’s chart since I can’t be *absolutely* sure. If we mislabel her, she’ll just be stigmatized and someone could miss a real medical problem in the future.” I noted that this perspective does not consider prescription drug misuse a “real” medical problem, and the expected response from the medical system is stigmatization, rather than appropriately directed resources and treatment. This patient continued to return to the ED periodically for complaints of chest pain with requests for IV medications, and was admitted by one my co-residents a year later. After having lingered in the ED for several hours, this resident reviewed her ECG and realized that she actually *was* having a myocardial infarction. The resident team initiated appropriate medical therapy, but still sought to set limits to avoid misuse of additional IV opioids. By the next morning however, the attending physician preferred to avoid conflict with the patient and directed the team to “just give the patient whatever she wants.”

Role modeling from supervising attending physicians can directly impact a trainee’s future career prospects and practices. I found this especially challenging in cases of drug misuse with a lack of consistency in practice patterns across (and sometimes within) different physicians, resulting in team splitting and undermined decisions. Some residents, including myself, have been overtly censured with poor attending evaluations when patients complained that we paused to discuss the risk and benefits of requested IV medications. Perhaps some find it simpler, as I did as an intern, to respond to such patients by generally avoiding them, ordering whatever they ask for, and simply keeping our head down until either we or the patient leaves the hospital. One attending’s explicit advice for such cases: “If you just stop ordering the opioids, these patients will eventually find their way out of the hospital.” While this was a convenient abstract philosophy, it did not offer much concrete help to the nursing staff, primary intern, and least of all the actual patient, in facing a difficult problem at the bedside.

With limited guidance from senior physicians in facing patients with drug misuse problems, my sense of isolation culminated in one of my last admissions as an intern. A young woman with scoliosis and chronic back pain developed prescription opioid dependency, which then turned into IV drug addiction (dissolving pills in water) and an infected heart valve. After urgent valve replacement surgery, she was transferred to my care on the medical service. I first met her as her perioperative morphine pump was abruptly discontinued by the transferring team without a follow-up plan. After I found her panicked and trembling in acute dysphoria, I advised her that I would consult with my supervising resident and attending to figure out a sensible management plan. “Wait! You can’t just leave me like this,” she exclaimed, “You have to give me something right now. Now. NOW!” I covered my eyes as I wrote the order for IV morphine before I fled the room, half terrified and half

ashamed. Once my team gathered, my attending dismissed the patient's concerns by telling her that "it was these drugs that got you into trouble in the first place, so you won't be getting anymore." Meanwhile, my senior resident informed me that, "You can do whatever you want with this patient. I have no intention of seeing her again." Psychiatry, infectious disease, and surgical consults similarly provided no further substantive input into management. Keeping my head down for just a couple days was not a viable strategy, as the liability of discharging a known drug addict with a semi-permanent IV line resulted in her remaining in the hospital for a month of antibiotics. Without an escape, I instead decided to dive in as her primary physician in the hospital. I reassured her that she could reach me to help her through any issues, even as most of the treatment team seemed to have abandoned her. After the attending on service rotated out a couple days later and repeated pages from nursing staff about the patient complaining of persistent pain, I realized I should be thinking less about "pain management" and more about opioid withdrawal. I started to recognize withdrawal symptoms just as real and that warrant as much attention as acute pain, except that the appropriate response was not more IV opioids. In the absence of formal guidance, I resorted to internet searches to self-learn how to implement an ad hoc methadone taper to finally negotiate a way to calm her symptoms over the duration of her extended hospitalization.

When I work with medical trainees myself, I hope that we can together learn a thoughtful and consistent approach to opioid prescribing in both acute inpatient and chronic outpatient settings. This is just as I expect us to learn a systematic approach to prescribing insulin to diabetic patients, recognizing that as a fundamental skill for a pervasive medical problem. When addiction affects more Americans (40 million) than heart disease (27 million), diabetes (26 million), or cancer (19 million),⁴ I hope we will be empowered to recognize a disease process as common and as treatable as other chronic medical conditions. While many clinical topics compete for education priority, prescription drug misuse and addiction is one that an inadequately trained medical community will routinely contribute to, if not overtly cause. Facing this is challenging, but I recall one of my medical school attending's teachings: The patient you least want to see is probably the one who needs you the most.

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