Just Another Drug Seeker

David R. Lindsay, MD

(A Fam Med 2017;49(3):230-1.)

As a young physician fresh out of fellowship training, I knew I had to prove myself before being fully accepted by the established physicians in my new community. I may have been in the community but I was not yet of the community. My outpatient clinic was filled with the patients nobody else wanted. When I was asked to help care for an inpatient, there was usually a catch. I wasn’t surprised when I was asked to help take care of a teenage patient suffering sickle cell crisis. He was the kind of patient often described as “well known to the system.” His physicians were dubious regarding the “legitimacy” of his pain complaints. They considered him a “drug seeker.” He was just the kind of patient for the new pain doctor: a “problem patient,” a gauntlet to drop in front of the young hotshot. I welcomed the challenge.

Before I even met him, I thought I had a pretty good idea of how to help him. I’d taken care of dozens of similar patients during my residency and fellowship. When I met him, I immediately identified with him. In the overwhelmingly Caucasian community, he, like me, was in the community but not of it or so I believed.

When I saw the ineffective treatment prescribed for his pain, I could hardly contain my joy: intramuscular (IM) meperidine. A treatment from the age of dinosaurs. It was the perfect opportunity to show off my superior knowledge of pain management.

I was well taught that IM injections were needlessly painful and that meperidine has potentially dangerous metabolites. To make matters worse, once the patient began to hurt and asked for his injection, he would have to wait in pain until his nurse was available. I pronounced his treatment archaic and wrote the order for hydromorphone patient controlled analgesia (PCA). No more painful IM injections. No more dangerous metabolites. No more waiting in pain for a nurse to administer an injection. It was a technically perfect plan.

It didn’t work.

Several hours after I started the PCA, the patient was still asking for his meperidine shot. The nurses seemed more than happy to report to me that my brilliant plan (perhaps I should have been a bit less vocal about telling everyone within earshot exactly why it was so brilliant?) was not working. They tried to convince me that he was “just a drug seeker.” Perhaps they were right, and he was playing me for a fool. Had my identifying with the patient as a fellow outsider clouded my judgment? For that matter, was he even an outsider? Those nurses and those doctors had been taking care of that patient in that hospital for years. I was the new guy. My treatment plan was no more effective than theirs, and he still wanted his meperidine. But why?

My regimen simply had to be providing more analgesia than the old regimen. I could have dismissed the patient as a “drug seeker.” I could have given him what he asked for despite knowing it hadn’t been effective. Either way, I would end up looking like the naive new doctor. In an attempt to save face, I decided to perform an experiment. I told the patient I would reinstitute his shot and continue the PCA, giving him the best of both. Then, I wrote an order not for IM meperidine, but for IM saline. I truly believe the nurses agreed to execute my plan just so they could tell the story to the evening shift.

When I next spoke to the patient, he was feeling much better. PCA in combination with IM saline (placebo) was a vast improvement over either PCA or IM meperidine alone. This served only to reinforce the prevailing belief that this patient was just a drug seeker and in no way improved my reputation.

While I didn’t like the idea that the patient was a drug seeker, I didn’t yet have a better explanation. The PCA hydromorphone appeared to be necessary; it should

From the Durham VA Medical Center, Duke University.
have been sufficient. It was easy for me to understand why the PCA was necessary: it was providing an opioid analgesic far more powerful than the IM meperidine. What I didn't understand was why the PCA was not sufficient. What was the placebo adding?

Over the course of several days, speaking to the patient became listening to which in turn became hearing. I learned that he had recently declined offer of a bone marrow transplant. I could certainly understand his choice: it was a very high-risk procedure. But he had declined not out of fear of the risks but rather fear of the benefit. He was concerned that it would cure him.

I began to see the patient as a young man whose identity and disease were inseparable. He was the sick child in his family who became the sick adolescent at school who became the sick young man. With illness a constant companion, he had learned that his role in society was that of a patient. The as-needed saline injection I prescribed came with a nurse attached to it. In retrospect, I had not prescribed a placebo; I had prescribed a visit from a nurse. While the PCA hydromorphone did a fine job controlling his physical pain, it did nothing for his needs as a human being. When he asked for a shot, he was not asking for a drug: he was asking for human contact.

The current national emphasis on opioid safety has generated enormous new pressure to “get patients off opioids.” In such a climate, I am sorely tempted to adopt a hard line and simply stop prescribing opioids to patients who display drug-seeking behavior. Perhaps such an approach would solve my problem. I don’t see how it could solve the patients’ problems.

A young man in sickle cell crisis taught me that drug-seeking behavior is not a diagnosis: it is a symptom. He taught me to look beyond the behavior to find the diagnosis. Perhaps the diagnosis is undertreated pain. Perhaps the diagnosis is a substance use disorder. Perhaps it is depression or anxiety or an unmet need for human contact or some combination of the above. That patient taught me that while opioids may treat physical pain, they do not help emotional pain or social pain. He taught me that by seeking the true cause of pain, I can see the problem patient as a patient with problems. Not bad for “just another drug seeker.”

CORRESPONDENCE: Address correspondence to Dr Lindsay, Durham VA Medical Center, Duke University School of Medicine, 508 Fulton Street 112C, Durham, NC 27712. 919-286-6938. Fax: 919-286-6853. david.lindsay@duke.edu.