

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

### My Dealings with CD

I first met CD in clinic. The month was September, two months into my first year of residency. To paraphrase the nurse's introductory note in EPIC: *C is a new patient here to establish care. She has pain in her lower back and both hips with numbness in her left foot. She also reports she has not taken any medication for one month for her hypertension, asthma, and diabetes. BP was repeated and remains 160/110. C states she feels okay.*

Eight months and 15 clinic visits, 18 phone calls, 8 ED drop-ins, 5 hospitalizations, and two procedures - including a fem-pop bypass - later, CD's diabetes, hypertension, and asthma are still out of control and she is on 12 medications and a hodge-podge of narcotics without a narcotic contract. She has four prescribing doctors: me, her vascular surgeon, her Wisconsin Care PA, and the random ED physician. Surprisingly, she still has her left foot. But I am getting ahead of myself; back to that first day in clinic.

CD is 54 years old and African American. She arrived in Madison from Indiana three weeks prior and was staying at her son's home. She told me she was getting help from the Salvation Army who referred her to our clinic. She was waiting on disability determination. She enjoys singing in the church choir. Minus a sentence or two, that was the entire scope of my "get to know you" note. On physical exam: in addition to the high blood pressure, she had 2+ pitting edema and decreased sensation on the lateral edge of her left foot.

CD left that day with three drug prescriptions, a load of lab work and a follow-up appointment. But before she saw me again, she saw a colleague who was on urgent care duty because her left foot numbness turned into left leg pain. Soon that pain was what drove CD to drop in to the ED on a regular basis (sometimes twice in a week), and to be hospitalized when she refused to go home. And between all of us - the clinicians, the inpatient service team, the ED physicians - we tweaked and worked on and refined and re-dosed and discontinued and restarted her medications so many times that even the most adept patient would have trouble keeping track of which medications to take, come a.m. and come p.m..

I remember the day CD visited me in clinic, about five months into our relationship, and from one of her purses (she brought two purses to clinic that day, one just for the medications), came a multitude of bottles; I was amazed and horrified and confused. As best as I could I kept track of her new medications and dosings via the hospital discharge summaries and vascular clinic visit notes, but the pharmacopoeia that flowed from CD's purse was another thing all together. There was gout (Gout? Does she have gout?) medication I didn't know about. Medication for depression from two hospitalizations ago I didn't know about. And an added diabetes drug that I didn't know about. I was worse than a charlatan doctor; I was an out-of-the-loop doctor.

And, in short order, I became a suspicious doctor. As you can imagine, when I asked CD about when and how she took most of her drugs, she got all confused. I say most of her drugs, because she was absolutely sure how and when she took her pain medications and wanted to be sure and have refills on all of them.

Requests for pain medication refills became a near weekly drama between CD and the clinic pharmacist. The pharmacist would count the amount CD should have left from the last refill and declare that she should still have pills left over if she was taking them as prescribed. To which CD would become indignant and demand a refill. Or demand to speak to me. At first my intention was to be an advocate for CD; I wanted to be her friend-doctor. I would listen to her, give empathic lines, and refill

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her pain medications to get her to the next appointment. But after a while, I turned into her police-doctor, adding stipulations to her refill requests such as urine drug screens and that she pickup the refills of her diabetes and blood pressure medications first and then she would get the pain medications. I started to see CD as my adversary - I dreaded opening my EPIC inbox for fear of seeing a phone call from her - and less and less like a person in need and a patient. She became someone I had to deal with and not someone I took care of. And when vascular surgery took a role in her care I was frankly relieved that someone else had to deal with her.

And this is where I am today with CD: relieved that others are taking responsibility for her - including Care Wisconsin (the great coordinator of difficult healthcare needs?). But even more so, I am mortified at my feelings because they are neither just nor compassionate. I am not sure what the outcome will be for CD – she is still my patient and I will see her this coming month – but I know that if I take the time to get to know her and her goals, maybe even do a home visit with the Care Wisconsin nurse – that that is a start to a better relationship.