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Physician as Enabler

By Vik Ready

I met Ms. Brown over two years ago in my clinic for a new consultation. As a plastic surgeon, a large part of my practice involves breast reconstruction following cancer surgery. I recall her being a pleasant, healthy, middle-aged woman who had gone through a double mastectomy for breast cancer years ago. She had a complication, however, and she had to forego any kind of reconstruction at the time. Now, cancer free for years, she was meeting with me with the hope of feeling "whole again."

The surgery and a complication

The surgery would be a complicated one. Due to Ms. Brown's not having healthy skin over one side of her chest wall, we could not use tissue expanders: silicone-shelled balloons with metallic ports that could be filled with saline over time to stretch the skin overlying them. Once the skin had been expanded enough, a second surgery was necessary to replace the tissue expanders with permanent breast implants. One of the main benefits of using tissue expanders for breast reconstruction is the lack of having to operate anywhere else on the body—no need to borrow tissue from somewhere else.

Unfortunately for Ms. Brown, tissue expanders would only be an option on one side. I recommended that, on the side with the damaged skin, we use tissue from her abdomen. The operation, known as a TRAM flap, involves a surgeon taking one of the six-pack muscles with the overlying skin and fat, and transferring the tissue towards the chest to create a breast. The surgery is time consuming, more painful for the patient, and requires placing a prosthetic mesh over the area where the muscle had been in order to prevent a hernia from developing.

I spent a great deal of time with Ms. Brown, including a second consultation, to go over the fine details of the operation. We scheduled her surgery, and I hoped for a smooth operation and, with luck, a smooth recovery.

The surgery went well, and Ms. Brown's immediate postoperative course was without any complications. Three weeks afterwards, however, she developed an opening along the abdominal incision. The wound had separated, and the mesh I had placed was exposed. My hope was to try and get her through this complication without having to remove the mesh. The one bit of good news was that the tissue used to recreate one of her breasts was alive and healing nicely. Ms. Brown took the news in stride, but she did ask for a refill of her pain medications: Percocet, Valium, and Oxycontin. She was three weeks out from her operation, and, while it did seem like a lot to me, I rationalized her needing the medications because of the complication. I filled out the three prescription sheets, and said I would see her next week.

Lessons learned from residency

I cannot overemphasize the impact my experiences during residency training have colored the way I practice medicine. At that time, the state of California required physicians to complete a paper prescription form called a "triplicate" if they wanted to prescribe a certain

class of narcotics. The triplicate form, as it sounds, consisted of a form with two other carbon copies, so that the prescription written on the first page would be transcribed on the two others. One was for the patient, one for the physician, and the final one was for the pharmacy. The triplicate was designed to prevent the fraudulent dissemination of these medications.

One of the main tasks for interns and residents at a teaching hospital was to make sure the paperwork of a patient being discharged was done in a timely fashion. On one rotation, a patient was ready for discharge, and, as I leafed through her discharge medication list, I saw a medication (Percocet) that would require at triplicate. I walked over to the clinic, and asked the chief resident for guidance. He informed me that the only surgeon who had triplicate prescriptions was operating, and that I could ask him to fill one out. I went over to the operating room with the triplicate prescription, and donned a surgical cap and mask.

"Excuse me, sir, I need a triplicate filled out to discharge a patient," I mumbled.

He raised his eyes from operating and lowered them again. "So, no one else has triplicates and they sent you over to ask me," he asked.

"Yes," I answered.

"So, do they think that not being able to prescribe the stronger medications will somehow make someone's pain go away" he queried.

I stared at him and did not know how to respond.

"You don't need to answer. Ok, give me a second." He took off his surgical gown and gloves, walked over to me, and filled out the triplicate. I thanked him graciously and ran off to do the discharge. That same surgeon would go on to become a very good friend and mentor.

What that interaction taught me was the absurdity of not being able to prescribe appropriate pain medications. The other surgeons who did not carry the triplicate form probably found the process overly burdensome, and, quite frankly, so did I, but I viewed it as necessary to take care of patients. Once I left residency, (and paper triplicates ceased to be used) I followed my own mantra of giving patients what they needed for pain without any reservation. I often started with higher doses with the rationalization that it would save patients the burden of having to suffer while I was guessing how much pain relief they would need.

A second operation and a third

When patients have complications, you don't run away, you run towards them.

I remember hearing a physician telling me that, and it is advice that I have tried to incorporate into my own practice, including in Ms. Brown's case. We had a weekly appointment scheduled for every Friday afternoon to see how her wound was healing.

After a few weeks of treating her wound, she came in for one her regularly scheduled appointments stating that she had developed a fever and some swelling over her abdomen. I examined her and found a large mass near her the site of her mesh and the overlying skin was red and warm to the touch—an abscess. We would have to take her to the operating room that evening and drain the infection and remove the mesh. I broke the news to her telling her that if we did not operate soon, the infection could make her very ill. She nodded her head, and asked me to make sure to refill her pain medications. Valium. Percocet. Oxycontin. I filled all three out and called the operating room to schedule her for that evening.

After I removed the infected mesh, Ms. Brown developed a hernia, a weakness in her abdominal wall that caused a bulge. A very rare complication after a TRAM flap, and one that

was difficult to correct. Her wound was still open, and I promised her that I would try and repair the hernia once her wound had healed. I remember her, at one appointment, nodding wanly, and saying that she trusted me. As she was walking out, she asked for her pain medication prescriptions. I was becoming alarmed at the amount of medications she was taking (and I was prescribing). I asked her if she thought she could start cutting back on them. She looked away and said: "I've already started taking meds from other people." I dropped the subject, filled out the three prescriptions, and told her that we would focus on the next operation.

Her statement haunted me. I took it as a tacit acknowledgement of an addiction to the medications. Fueled by guilt, I made sure that the next operation had to work. I ordered a CT scan to assess the size of the hernia, enlisted another surgery colleague to assist me during the procedure, and made sure to keep the patient on antibiotics before, during, and after the operation. I would treat Ms. Brown's hernia and then get her treated for her addiction. Despite any formal religious affiliation, one phrase took up residence in my mind—the road to Hell is paved with good intentions.

Ms. Brown's third surgery went well. My surgery colleague placed in a new mesh and we both thought she had a good chance of recovering without incident. Not one week had passed when I saw her in clinic and she mentioned that her wound had reopened. For the first time in the months that I had been taking care of her, Ms. Brown showed a flash of anger and frustration. I did not know what else to do for her and told her as much. I recommended that she should seek out another opinion. She agreed and left the clinic. I've never seen her again.

A complication compounded

Physicians should have regrets. While many complications and bad outcomes are out of a doctor's hands, and relentless self-flagellation is not productive, ruminating on cases can allow one to find areas where mistakes can be acknowledged and, hopefully, avoided. There is not one technical aspect I would have changed in Ms. Brown's operations. What I should have done, however, is addressed her growing dependence on prescription pain medications. A mixture of guilt and pride lead me to continue giving her the medications with the hope that the end of her surgical problems would eventually lead to the end of her addiction. I now understand that I was wrong. While pain should be treated, prescription pain medications are not without risk.

How have I changed my practice? I set clear guidelines with my patients about managing their pain. I inform their primary care physicians that I will be prescribing a patient's pain medications so that only one person is in charge. Most importantly, I will tell a patient when I believe they have developed a dependence on prescription medications and get them the help that they need. A report from JAMA Psychiatry states that more than 75 percent of current heroin users started with the abuse of prescription drugs.[1] I do not know what became of Ms. Brown, but I am hoping she found the help that she needs—and which I should have helped her receive.

References:

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