NARRATIVE MEDICINE

Nerve Pain

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Lisa was a real thorn in my side as a patient in the Philadelphia jail 10 years ago. She was a twentysomething-year-old, mostly healthy female who somehow entered my chronic medical care clinic within a day of entering the jail. Urgent appointments in the chronic care clinic were typically reserved for someone with insulin-dependent diabetes or severe asthma. Lisa was placed on my schedule for "nerve pain."

Although all detainees met with a nurse within four hours of entering the jail to identify urgent problems and continue existing medications, physician evaluations for chronic illnesses were routinely scheduled to occur three weeks after a person entered the jail. This timeframe provided a crucial advantage. The jail system routinely processed more than 30,000 people a year,[1] but at least half were released within two weeks. Seeing every incarcerated person with a health problem before then was unfeasible.

Sometimes, persistence trumped procedure at the jail in the face of vociferous patients, no matter how minor the complaint. Bearing prominent and protruding brown eyes against a gaunt face — I initially wondered if she had a thyroid problem — Lisa confidently strode into the exam room. She offered to make the appointment easy for me.

She said, "You just need to prescribe me Pamelor, and then after I try that for four weeks, I will come back, and you can give me my Neurontin."

I was the one who prolonged the interaction by asking where she had pain, for how long, and how the problem was initially diagnosed. She helpfully pointed out that I had many patients to see and could get on to more meaningful work by following her lead and prescribing a low dose of nortriptyline.

A noticeable cacophony of gripes from many older patients outside the exam room door waiting to see me validated Lisa's observation. I was swamped and obliged, hoping she would follow the probabilities and leave within two weeks. The odds did not play out that way.

Lisa returned to my clinic after four weeks with a chief complaint of "nerve pain." Her eyes were less prominent, and her face was fuller. She was wearing makeup crafted from soft drink mix and powdered sugar. The ever-present low rumble from older patients with medical concerns waiting outside the exam room door continued to make me feel rushed.

Lisa again took charge of the interaction, pointing to a filing cabinet in the corner of the exam room. "Just fill out the paper in that drawer saying Pamelor did not work so you can give me my Neurontin, " she directed.

Indeed, the filing cabinet did contain a form for non-formulary requests. Formularies are standard in correctional health, just like in community health settings. However, some inexpensive medications are non-formulary because they are problematic in other ways. A prescription for gabapentin for "nerve pain" — especially from the new jail doctor — would likely elicit hundreds of requests from other patients with the same complaint.

This time, I pushed back. I pointed out that I had prescriptive authority despite her propensity to call it *her* Neurontin. I remarked that she did not appear very ill, and the many people grumbling — now more loudly and impatiently — outside the exam room door had needs that outweighed this unsubstantiated complaint of "nerve pain."

This did not deter Lisa; she persisted until I eventually completed a non-formulary request for gabapentin. Over subsequent weeks, my efforts to stick to a relatively low dose were futile. I eventually increased her gabapentin prescription to 800 mg three times per day, which fulfilled another one of Lisa's prophecies: "That is the only dose that will work for me."

Yet, that did not eliminate her presence in my chronic care clinic. Lisa was an ever-present force on my schedule in the months that followed.

She complained about the fish served for dinner every Friday and requested a note from me stating that

she needed an alternative. She also wanted a note saying that a bottom bunk was medically necessary and that she needed two mattresses. Only having one mattress was terrible for her back, she said, and might exacerbate her nerve pain. Without that note, she might need tramadol.

The implicit threat of a campaign for tramadol (also non-formulary for reasons other than the cost) was not benign. Time was a crucial resource, and Lisa tended to linger in the exam room longer than necessary after achieving her day's objective. I usually spent that time laboriously describing the difference between medical and humanitarian problems and reminding her that my job was only to address one of those categories.

Yet, such exchanges were not always bitter. After one somewhat playful debate about whether combining two thin, hard mattresses would provide comfort equal to a well-crafted soft one, Lisa peered suspiciously at me while I wrote in her chart.

"What are you writing about me?" she asked.

"I am simply preparing for the eventual deposition," I responded in exasperation and only half-jokingly. Lawsuits were widespread in the Philadelphia jail.[1]

"I wouldn't sue you," she reassured me. "You are a nice doctor." Compliments did not come easily at the jail. On that day, I needed one. The jail was a difficult place for both of us.

At security orientation for the job, correctional officers warned me about the unscrupulous nature of inmates and the importance of always keeping them at arm's length. The training was brought to life with striking examples of weapons crafted by prisoners from seemingly harmless everyday items like soap, toothbrushes, and toilet paper.

However, cautionary tales involving prisoners who manipulated staff to undermine rules in the institution — sometimes called "getting got"[2] — fixed more deeply in my mind. In extreme cases, staff unwittingly facilitated an escape or introduction of dangerous contraband into the inmate population. These relationships gone awry seemed to have a partial foundation in empathy and human connection toward the incarcerated individual.

I guarded against this phenomenon carefully. Patients who attempted to direct their medical care — a natural inclination protected by the pillar of autonomy — provoked suspicion. Praise from patients may not have been genuine; rather, it could have been a Machiavellian effort to subvert a system designed to reform them. Detachment had its value in avoiding this can of worms altogether.

Such disconnection was not my natural inclination and required work. That day, perhaps more tired and beleaguered than usual, I received Lisa's compliment with gratitude. With a less guarded demeanor, I saw beyond her uniform of jailhouse makeup and blue jumpsuit, and I became curious about Lisa's life outside the jail. I wondered if she had children and an occupation. I imagined her as an overprotective parent, a fearsome litigator, or a highly effective salesperson.

Lisa's primary care provider outside the jail undoubtedly knew these aspects of her life. I avoided discovering them for fear of a perceived slippery slope without considering a more precipitous descent that accompanied purposeful disconnection. Over time, I discovered that an ideal middle ground lay someplace in between — a precarious peak requiring constant balance to avoid sliding too far into an abyss on either side.

Yet, I did not learn much more about Lisa because, as is always the case, her time at the Philadelphia jail was limited. Patients were eventually transferred to a state correctional institute for a longer sentence or went home.

Lisa went home, but not for long. I learned that she died of an opioid overdose the day after she was released.

Among her countless petitions, one thing Lisa never requested was buprenorphine for opioid use disorder. Such a request would have been reasonable and lifesaving if met[3] because Lisa was regularly injecting heroin before entering the jail. Yet, many prior instances of incarceration taught her that this request was outside the realm of negotiation.

Lisa's assumption 10 years ago was correct. I routinely denied such requests despite regularly prescribing buprenorphine in the community up to that point. Denying access to that medication was the status quo among all health care providers working at the jail, and conformity was comfortable. Within a milieu that cultivated patient mistrust, it was not difficult for me to rationalize that prisoners who requested buprenorphine were trying to maintain addiction instead of freeing themselves from it.

Lisa, and hundreds like her, managed opioid cravings by requesting sedatives like gabapentin and other minor comforts from me instead. The prevalent complaint of "nerve pain" throughout the jail was not just

a premise for receiving these tokens; it was a stand-in for more profound discomfort caused by many intractable, unsolvable problems.

Psychoactive medications offered temporary anesthesia, as did genuine human interaction with the jail doctor — however contentious at times.

Nowadays, I do not work in a jail but in a family medicine office, and every patient I meet who displays a clinical need for buprenorphine promptly receives a prescription. Equally important, I warmly accept patients' compliments when offered; I may even place a hand on their shoulder if that is helpful during trying times. When I prescribe medication to treat addiction and cultivate a therapeutic alliance, I think about Lisa and others left behind.

Fatal overdoses trigger a cascade of interminable pain that ripples through family and friends. A dissection of the event will reveal many systemic problems, frequently involving overpopulated jails, prisons, and community probation and parole.[4] Health care providers working in these overburdened systems may experience a different but equally valid ache.

We may have been conditioned to view patients as adversaries. We may have been compelled to withhold or withdraw lifesaving medication that can prevent fatal overdose. We may be plagued by deep regret for perpetrating, failing to prevent, or bearing witness to circumstances that violate our moral code.[5]

Academics label this phenomenon moral injury. I describe it as nerve pain.

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