

You just can't trust the histories

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It isn't like the Free World. Getting the truth out of patients is like going round and round with the questions, peeling a rotten onion. Especially with things like sinus and heart meds. They would just about kill me for pseudoephedrine. I can't tell you how many patients are coming for it. It's currency. So is diphenhydramine. These are the last possible drugs that the average inmate has a chance of abusing. Contraband. For sale. Bupropion is evidently the big seller, \$3/tab.

But they come in complaining about the sinus problems, and they often have these long-running prescriptions for dexbrompheniramine twice a day, every day, for months on end. As if those sinus problems just never will go away. And the affect is so glib. "I'm here to get my prescription refilled." Or they come demanding it. And recently the rules have changed: Pseudoephedrine must be controlled. Pseudoephedrine is an OTC, pitifully low-octane stimulant, but they take what they can get. So now this drug of abuse can only be given for short terms, 10 days max. And then they'll come back. Over and over. They present with a typical rehearsed story. "Can't sleep at night." "All stopped up." And so on. "Close your mouth," I say, "and take a deep breath." They do it. "Well, you seem to be breathing pretty easily now." And they don't have anything I can see. If I don't see the pale, boggy nasal mucosa, or the swollen red turbinates, or at least some injected conjunctiva, I won't do it. I can't. I don't like getting conned.

But sometimes it's stickier. Here's the best case: A guy got referred to me because he came in to nurse sick-call with elevated BP that morning. It was way high then. And so he's at me now, immediately put on the machine for routine vitals. Machine starts screaming: He's 225/125 in the right arm. Okay, hold on, let's try the other arm. Machine starts screaming again, same deal. Holy cow!

I look in his chart. He's getting hydrochlorothiazide-triamterene, metoprolol, enalapril, verapamil, and doxazosin, every day. Maxed out on all of those. "Are you taking your meds?" "Are you crazy? Of course I'm taking my meds. I don't want to die!"

After graduating from the Long Island University PA program in 2005, the author moved to Texas and began working in a maximum security state prison as a locum tenens. He also works in an urgent care clinic in Austin, Tex. He has indicated no relationships to disclose relating to the content of this article.

He's on the edge of his seat. Baby-soft, scared eyes imploring me with fear and "Can I die from this?"

I don't answer. It doesn't make sense.

He's been chatting up the nurse, "Thank God you're here. That other nurse isn't like you. She doesn't know what she's doing." He's cracking jokes. "You'll wait for me when I get out, right?" She told me later that he had asked her to marry him. She was flattered enough to be on his fighting side. And at the moment, his BP really was 225/125, and it's late Friday afternoon, and everyone else is gone. It's just me to sort this one out.

Well, I try to get a little history from him, and I find out that he's been to the big prison hospital for high blood pressure and they put him on clonidine. He says that one really worked. The other ones don't. The nurse then informs me that the prison system is cutting out all the clonidine. She thinks they're crazy for taking it away. Clonidine is a CNS drug with abusive potential. Withdrawing it too quickly can cause a spike in BP. Evidently, that's what's happening here. It's in the nurse protocol to give 0.1 mg of clonidine in the clinic. Okay, give it. He gobbles it up. This problem has got to go away.

I can write for the clonidine that he was on before, which was working, and I do so. Considering his current status, I give him more than he was on before. He says, "Do I really need that much?"

"I wouldn't give it to you if I didn't think so," I said.

But he's won, see. He's tricked me. He goes back to his cell, scared for his life. I'm scared for his life. The nurse has saved another life. He walks out of the clinic, head down, shuffling his feet. On Monday, his BP is at remarkably low levels.

When the doctor finds out about this, he d/c's the clonidine immediately and tells me it's all a big scam. But 225/125 on a Friday afternoon? What would you do?

The doctor orders him out of High Security, where I work, to come to the prison infirmary. That's a different building. The prisoners I see, like this one, are a security threat. They are not allowed to be with the general population. This one in particular is a known gang leader. Theoretically, he's the guy who can call out hits or kills within the prison system. He's segregated from the other 3,600 inmates because he's too dangerous to mix with them. So getting him to the infirmary building is kind of a big deal. At first he refuses to go. When

his clonidine is shut off, he doesn't want to play along. He won't take any meds. He won't do anything right.

But he has no choice about housing. The doctor orders that he come to the infirmary for housing, not for medical treatment. An inmate has no choice about housing. He is told that he can go peacefully and his personal property will come with him, or he will be gassed and taken unconscious to his new housing, and his belongings will follow eventually. He comes peacefully.

In the infirmary, he submits to the medical therapy. It is directly observed therapy (DOT), which means that someone puts a pill in his mouth and gives him a drink of water, and then he must open his mouth and a tongue blade is inserted to see he is not cheeking the pill. If it has been swallowed, he is given another pill, and the routine is gone through again. So he's given the original therapy of all those heart meds and, miraculously, his BP is down to 100/62 in 48 hours. He even refused a dose the night before the 100/62. This is the way it goes.

I sometimes have to look at my notes, and hear the inconsistencies in the history.

The antisocial personality has no concern for reckless behavior. They are extraordinarily good manipulators, no remorse or guilt for doing the wrong thing. Antisocial is psychopathic or sociopathic and sane, as opposed to psychotic, which is insane. Interestingly, the psychiatric nomenclature has stopped using words like psychopath, being born with it, and sociopath, developing it along the way. Antisocial personality disorder with psychopathy is the diagnosis now that tends to fit extremely dangerous people.

With the antisocial, every interaction is an opportunity to win, to take something, to be in control. With the DOT, this inmate lost control. He could have refused all therapy. That is within his rights. But the doctor told me that this inmate did a similar thing 2 years ago. It wasn't in his chart. I could not have known about it when I saw him. I was a new PA working High Security, and this inmate was willing to risk the high BP, willing to risk his life, for control. For a little clonidine. He beat the nurse. He beat me.

"Only treat what you can see." I heard it 10 times my first day of work. Okay, they don't get the pseudoephedrine without pale, boggy nasal mucosa. And listen, most of my work is about skin infections, and I wish they were all

issued a tube of clotrimazole with their white prison jumpsuits. They're all going to need it. Then there's a lot of muscle strain and chronic arthritic pain. We sort through the NSAIDs. Sorry, that's the best I can do.

It's just about the histories. I've written so many times that the history sounds unreliable.

But what happened to that patient who conned me for the clonidine? He got moved back to High Security, and I saw him again in Chronic Clinic. His BP was 220/120. He was refusing his meds. I had the cup of pills in my hand, offering it to him. He named various side effects of each of the pills. I told him I would work with him about the side effects. He was going along for a while, but in the end, he wouldn't do it. He'd rather die first. He didn't say that, but I implored him to take the medicine and he wouldn't. 220/120. Okay. He doesn't really care. He'll have a stroke before he backs down.

It's the antisocial personality disorder that can't be treated. And that's why they are in this particular maximum security state prison. This is not Camp Cupcake. I work behind 20 locked gates, with three ID checks along the way.

The prisoners I treat are in High Security for unspeakable violent crimes in the Free World, yes, and beyond that, intolerable behavior in prison. When these guys come to me, they are all in handcuffs and escorted by a guard. The guard is with us at all times. Sometimes two guards. The handcuffs behind the back can make abdominal exams tough, but it's not dangerous. I guess they could bite me. Blood pressures do run high, and I might get fooled again. But I have to rely on objective signs, and despite the frequently wildly exaggerated histories, conservative therapy must be the answer.

I sometimes have to look at my notes when I'm talking to someone who sounds false, and hear the inconsistencies in the history. Then I look at the problem. Reptilian eyes can mesmerize the best of us, and baby-soft, help-me-please begging is hard to refuse. Histories can be so fantastic and absurd that you just don't know what to do. But objective signs can't be faked.

Most antisocial personality types do not end up being serial killers. They are out in the Free World taking advantage of people and doing what they please. If they grew up in a nice family, they might become white-collar criminals or shady entrepreneurs or politicians. If they grew up in a disturbed family, they are more likely to do violent crimes. But they are out there.

Prison medicine is exasperating, because you just can't trust the histories unless you can see objective signs of the problem. But most of them won't curse you or threaten your life if you don't give pseudoephedrine. Most of them won't.... □