

Communicating about Opioids for Chronic Pain: What Really Happens in Clinic Visits?

Marianne S. Matthias, Ph.D.

**Research Scientist, VA HSR&D Center for Health
Information and Communication, Roudebush VAMC,
Indianapolis, IN**

**Research Scientist, Regenstrief Institute, Indianapolis,
IN**

Pain is a significant health problem

- **Over 100 million Americans suffer from pain**
- **Analgesics are second most prescribed class of drugs = 12% of all prescriptions in ambulatory office visits**
- **Over \$600 billion/yr in health care costs and lost worker productivity**

Communication is difficult in chronic pain management

- Research has described a “burdened physician-patient relationship.”
 - Power struggles
 - Threats to trust

Bieber C, Muller KG, Blumenstiel K et al. Long-term effects of a shared decision-making intervention on physician-patient interaction and outcome in fibromyalgia: a qualitative and quantitative 1 year follow-up of a randomized controlled trial. *Patient Education and Counseling*. 2006;63:357-366

Kenny DT. Constructions of chronic pain in doctor-patient relationships: bridging the communication chasm. *Patient Education and Counseling*. 2004;52:297-305

Effects on Patients

- **Poor communication has led to adverse health effects:**

Patients w/ back pain who disagreed with physicians about cause, diagnostic plan, and treatment plan for back pain

- **Decreased satisfaction**
- **Lower SF-36 scores for mental health, social function, and vitality (than pts who agreed with physicians)**

Effects on Patients

- Burdened and depressed when physicians did not believe their pain complaints
- Interactions “strenuous,” “complicated,” “heavy”

Werner A, Malterud K. It is hard work behaving as a credible patient: encounters between women with chronic pain and their doctors. *Social Science & Medicine*. 2003;57:1409-1419.

Effects on Providers

- Caring for patients with chronic pain: a “thankless task” in which they are “confronted with failure every day.”
- 73% of VA providers: “major source of frustration”

Dobscha SK, Corson K, Flores JA, Tansill EC, Gerrity MS. Veterans Affairs primary care clinicians' attitudes toward chronic pain and correlates of opioid prescribing rates. *Pain Medicine*. 2008;9:564-571

Effects on Providers

- “Frustrating”
- “Overwhelming”
- “Ungratifying”
- “Feeling Guilty”
- “Unsuccessful as a doctor”

Matthias MS, Parpart AL, Nyland KA, Huffman MA, Stubbs DL, Sargent C, Bair MJ. The patient-provider relationship in chronic pain care: providers' perspectives. Pain Medicine 2010;1688-97.

Why is communication difficult?

- Subjective nature of pain
- Clinical uncertainty in pain management
- Negative provider attitudes and lack of training
- Controversial treatments (e.g., opioids)

Opioids: Major Source of Communication Problems

- Feeling pressured to treat with opioids
 - Guilt
 - Fear of being “fired”
 - Patient demands for opioids: “It was like you go to the McDonald’s drive-through and you order what you want, and they should give it to you.”

Opioids for Chronic Pain

- Dramatic increase in prescriptions in recent decades (Caudill-Slosberg et al., 2004; Compton et al., 2006; Zerzan et al., 2006)
- Similar increases in misuse (Warner et al., 2011)
- Opioids for chronic non-cancer pain are controversial
 - Benefits are unclear (no long-term studies, see Manchikanti, 2011)
 - Some observational studies raise questions about long-term benefits (e.g., Dillie et al., 2008; Sjogren et al., 2010)

Communication is Especially Important in Opioid Management

- Much opioid management is based on communication
 - Decision-making about opioid treatment (opioid initiation, changes in dose, tapering)
 - Discussion of risks and benefits of opioids
 - Opioid monitoring strategies

Communicating about Opioids

- In sum, communicating about chronic pain in primary care can be challenging, especially if opioids are involved.
- Patients and providers have expressed this in interview studies.
- Very little research examining the actual communication in clinic visits that takes place between patients and providers about chronic pain.

Pilot Study

- To better understand communication behaviors in clinic visits
- Setting: 5 primary care clinics at RVAMC
- Participants: PCPs and their patients. Patients had 1) diagnosis of chronic pain (ICD-9 codes) that persisted ≥ 6 mos , 2) at least moderately severe pain (≥ 4) recorded at their last primary care visit, and 3) had an appointment with PCP during study period

Methods

- Audio recording of regularly scheduled primary care visits
- Patients were told the study was about communication, but not about pain, so that pain discussions would emerge naturally.
- Patients were interviewed after PCP visit about their PCP, their pain experiences, and pain treatments.

Data Analysis

- Two data sources:
 - Audio and Transcripts of PCP visit
 - Audio and Transcripts of qualitative interview with patient
- Immersion/crystallization approach
 - Iterative process
 - Organized data into meaningful units
 - Inductively developed categories (codes)
 - 4-member analytic team

Results

- 5 PCPs participated
 - All physicians
 - 3 female
 - Years of practice 6-23 years
- 40 patients participated
 - Pain not discussed in 10 appointments, so these were dropped from analysis
 - 4 women
 - 7 African American
 - Ages 27-70 (mean=57)
 - Duration of pt/PCP relationship: 0 (first visit)-16 years (mean=4 years)
 - 17 low back pain; 13 arthritis

Results

1) How do doctors and patients communicate about opioids?

Matthias, M.S., Krebs, E.E., Collins, L.A., Bergman, A.A., Coffing, J., & Bair, M.J. (2013). “I’m not abusing or anything”: Patient-physician communication about opioid treatment in chronic pain. *Patient Education and Counseling, 93*, 197-202.

2) What influences these communication patterns and patients’ interpretations of physicians’ opioid prescribing decisions?

Matthias, M.S., Krebs, E.E., Bergman, A.A., Coffing, J., & Bair, M.J. (2014). Communicating about opioids for chronic pain: A qualitative study of patient attributions and the influence of the patient-physician relationship. *European Journal of Pain*. DOI:10.1002/j.1532-2149.2013.00426.x.

1) Communicating about Opioids

- Some discussions about opioids were brief: renewal of an opioid, no further discussion
- Other discussions revealed 3 patterns of responses to uncertainties about opioids:
 - Reassurance
 - Avoiding Opioids
 - Gathering Additional Information

Pattern 1: Reassurance

- When either patient or PCP raised an issue related to opioid misuse or addiction, the other often responded with reassurance.
- These issues were most frequently raised by PCPs.
- One participant, in his interview, recounted a discussion of reassurance with his PCP:

Reassurance

“He told me that it [the prescribed opioid] was addictive, and he would only give me so many pills at a time. And I told him that he don’t have to worry about it, ‘cause I’m not gonna take any more than I have to.”

Reassurance

- Candid clinic discussions about concerns over opioids:

Physician: I'm hoping we could help you to cut back on this other stuff, this crap that we're having to give you because they're not controlling...that methadone's not good. Period. It's not as dangerous as some drugs, it's just the side effects and dealing with, you know...

Patient: Possibly addiction and whatnot

Physician: Yes, exactly

Reassurance

This patient goes on to reassure his doctor:

“I think I’m doing pretty good...I don’t have to double up [on the methadone dose] every night. I’m not abusing or anything.”

Pattern 2: Avoiding Opioids

- Sometimes patients and/or their physicians preferred to face the uncertainties presented by opioid treatment by avoiding the medications altogether.
- For patients, fear of addiction led to the desire to avoid opioids:
 - (Interview) “They said, we’ll give you those pills...and I said, those are addictive. I don’t want that.”
 - (Interview) “I’m trying to stay off narcotics. I don’t want to get addicted.”

Avoiding Opioids

- Patient/physician concordance

Physician: (to patient in clinic visit) “The more you can stay off these medicines—one patient after another are on narcotics, and once they’re on, can’t get ‘em off.”

Patient did not reply, but said in interview: “I’m really happy not taking narcotics.”

Avoiding Opioids

- The following physician expressed the desire to discontinue opioids and explore alternative treatments—did not bring up addiction concerns.
- The patient agreed, but emphasized in his interview that his concern was risk of addiction.

Avoiding Opioids

Physician: I'm going to give you no hydrocodone refills, because my goal is after your injection you're not going to be having much pain.

Patient: Yeah. I don't think I'm going to need anything.

Physician: I think you're potentially going to have chronic back issues. If we can help you with a couple of things. One, weight loss, two strengthening your back with physical therapy, I think it's going to help you in the long run.

Avoiding Opioids

In his interview, the patient agreed with his doctor's approach, saying,

“I don't take [hydrocodone] unless I have to, because I don't wanna get hooked on anything.”

Pattern 3: Gathering Additional Information

- Sometimes patients and physicians reacted to uncertainty about opioids by having extended conversations to gather more info.
- Sometimes more info included requests for urine drug screens.
- Often included candid discussions about opioid misuse that explored issues of trust, particularly when patients had history of substance use disorder.

Additional Info

- This physician had a candid discussion with a patient with history of cocaine use about the possibility of opioid misuse.
- First addressed with request for urine drug screen, then with further discussion about patient's history

Physician: Have you been using cocaine recently?

Patient: No.

Physician: When was the last use?

Patient: Uh, I don't remember.

Physician: Approximate.

Patient: Maybe a year, year and a half

Physician: Nothing since then?

Patient: No

Physician: Can I do a urine drug screen today?

Patient: Uh...I got a ride. I can come back today...I just gotta go out there and tell them-

Physician: Will it be clean?

Patient: Can I come tomorrow?

Physician: Will it be clean tomorrow?

Patient: Yeah.

Physician: Okay. My general approach to patients that have had a positive urine drug screen, which I think yours was in '09, I require them to go through substance abuse treatment.

Patient: Well, I'm not going to do that, because I don't think it's necessary. I've been going to substance abuse treatments all my life.

Physician: Uh huh.

Patient: And you test me, I think you tested me last time for drugs.

Physician: Well, it seems like you've been doing pretty well...Why don't we check it tomorrow? If it's positive, obviously we'll put a stop to it, but I'm okay renewing your hydrocodone [today].

- In the end, although the doctor was straightforward about his uncertainty about opioid misuse, he was willing to give his patient the benefit of the doubt.
- Even praised him for “doing pretty well” with his substance use.
- Despite this disagreement, they later shared laughter over the patient’s weight.

- In his interview, the patient acknowledged that he and his doctor have had disagreements, but put it in perspective:

“I feel I’ve got more rapport with him over time. We’ve had our differences and now we have a better relationship. But you know, everything is rocky sometimes when you’re dealing with people.”

Summary

- Three ways of communicatively handling uncertainty about opioids in clinic visits: 1) reassurance, 2) avoidance, 3) gathering more info.
- Physicians and patients frequently shared concerns about opioids.
- Concerns about opioids most frequently revolved around fears of addiction or abuse (esp for pts)—most common with patients who had history of substance use disorder.
- More agreement than disagreement was observed.

2) How does the patient-physician relationship influence opioid communication?

- Sometimes patients responded very differently to virtually identical physician behaviors and decisions regarding opioids (e.g., requests for urine drug screening; limiting, decreasing, denying, or discontinuing opioids).
- What accounts for these differences in patient reactions?

To understand this, it's helpful to look at

- Patient accounts of conflicts with prior physicians (from interviews)
 - These emerged in interviews and were discussions of physicians they were no longer seeing.
 - Conflicts revolved around 2 concerns:
 - Perceptions that a previous physician did not care about or believe their pain
 - Disagreements over opioids, including patient's belief that the physician was "withholding" opioids or believed the patient was "drug seeking"

Concern, Trust, and Productive Patient-Physician Relationships

- The majority of patients in this study believed their doctors listened to them and demonstrated genuine concern for them:
 - “I feel he’s concerned about my health.”
 - “Not only does she listen, but she shows her concern. She knew I used to drink...When she asked me today how my drinking was, she told me she was proud of the fact that I had stayed two years sober.”

- These patients also trusted their doctors' treatment decisions about pain, even when the physicians were cautious about prescribing opioids.
- One patient, who said his hydrocodone was ineffective, told us he wouldn't ask his doctor for additional opioid medication, explaining that he trusts his doctor: "I have 26 open prescriptions, 5 psych medications. So she balances what will not affect the other medications."

Attributing Decrease in Opioids to Concern

- In another patient's clinic visit, he asked for an opioid refill, which his doctor granted immediately.
- Interview reveals that, in a previous appointment, his doctor had reduced his hydrocodone earlier because of concerns about liver toxicity. The patient noted that, even though he has more pain now, he believes the doctor acted in his best interests. When asked how satisfied he was with his doctor's management of his pain, he said:

I'm satisfied because he looks out for me, because he was giving strong medication, but he was more concerned about my liver. I could see that he was really concerned, so he cut [the hydrocodone] back. And...as long as it helps me out—there's some pain you're going to have to endure. But when he said he was concerned about my liver, I am as well. So after a while I adjust my mind down to what I'm getting now. He was concerned about me, and he brought up how it causes liver problems and so forth.”

Another patient credited his doctor with helping him to stop smoking marijuana. Recently he had gone to the ER and received additional hydrocodone. His doctor discovered this and decreased the patient's hydrocodone dosage as a result. The patient was generally positive, saying in his interview:

“I was a little upset at first, but I kind of understood what he did, because I’ve been coming into the emergency room for other issues, and the other doctors were giving me stuff and they weren’t notifying him. I don’t feel it as punishment, but he just wanted to make sure I wasn’t getting overindulged in, you know, what I was using. So I was glad he did what he did. Gotta keep me in check sometimes.”

Positive sentiment reflected in clinic visit

Physician: How are you?

Patient: I'm doin' well. Well, I say that. I'm getting by. Getting by.

Physician: Yeah, well, you know, it's obvious the muscle relaxers are helpful.

Patient: Mmm hmm. When you knocked it down to 20 on the pain killers, it didn't quite get me through, not even one day. You know, I'm trying to hold off and use them only when needed, but there's some days when you just, you almost need more than...I found myself taking more of the muscle relaxers because I didn't have the pain killers. But other than that, I'm not feeling too bad.

This patient explained in his interview how he and his doctor were careful with his hydrocodone:

“He takes me off of [hydrocodone] for a while, or limits me to fewer amounts, so I don’t get too addicted. I don’t take them as prescribed. I only take them when I need them...so there’s days when I won’t take any. I’ll wait until I absolutely can’t take [the pain] anymore, and then I’ll take it...And he understands that...They’re keeping me healthy. I know there’s a lot of people out there that abuse.”

Summary and Implications

- Patients interpreted similar physician decisions about limiting or denying opioids very differently.
 - Mistrust or punishment versus their doctor's genuine concern for their health
- Patients who believed their doctors were concerned for them adapted to lower opioid doses.
 - Adjusting expectations for pain levels/pain relief
 - Learning how to modify activities to minimize pain

Summary and Implications

- This study suggests that the nature and history of the patient-physician relationship influences how patients interpret their physicians' decisions about opioid prescribing.
- In many cases patients who were positive about their physicians' decisions to limit or deny opioids had a long history with the physicians.
- Some had even confronted substance use disorders with the help of their doctors.

Summary and Implications

- These findings underscore the critical role of the patient-physician relationship in pain management, particularly when opioids are involved.
- Patients were more accepting of limitations on opioids when they believed their doctors really cared about them.

Practice Implications

- Supports the idea of fostering a therapeutic alliance, in which patients and physicians have shared goals, mutual liking and trust—may make conflict less likely.
- A strong therapeutic alliance can lead to more positive responses from patients when limiting opioids by shifting the focus from the patient and whether he or she is trustworthy or “drug seeking” to the benefits and harms of opioids themselves (Nicolaidis, 2011, Pain Medicine).
- This framing emphasizes concern for the patient, which patients in our study highly valued.

Final Observations

- Paucity of pain discussions
- Many discussions were very brief (“Need a renewal?” “Yes.”)
- Contrasts with recent study (Henry and Eggly, 2012, JGIM) in which 1/3 of clinic time was spent discussing pain.
 - However, those were not necessarily repeat appointments

Final Observations

- It is possible that patient and physician perceptions about the difficulty of pain conversations led to avoiding them when possible.
- Many physicians might have avoided asking about the patient's pain unless the patient mentioned it.
- Visits were often dominated by discussions of conditions such as diabetes or hypertension, which physicians are likely to prioritize because poor management of these conditions can lead to serious complications—this may have crowded out pain discussions.

Final Observations

- Conflict was infrequent in our sample
 - Could be selection bias: contentious patients (or physicians with contentious patients) might have declined to participate in study
 - Although we were hoping to learn more about conflict, we found that there is a lot to learn from conversations about pain and opioids that go well, which can serve as a foundation for a well-targeted communication intervention.

Limitations

- Single VAMC, select sample
 - Intent not to generalize but to gain a richer, more detailed understanding about how patients and physicians actually communicate about pain
- We captured only a single PCP appointment in the context of an ongoing relationship
 - We missed other conversations that occurred in other appointments (Interviews provided insight into some of these conversations)

Future Research

- Longitudinal research is needed to better understand pain communication patterns over time.
- Future research should seek to understand what factors influence presence and extent of pain discussions (e.g., pain intensity, psychiatric comorbidities, the patient-provider relationship, others?).

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