

# Doctors and patients in pain: Conflict and collaboration in opioid prescription in primary care



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## ABSTRACT

Use of chronic opioid therapy (COT) for chronic noncancer pain has dramatically increased in the United States. Patients seek compassionate care and relief while physicians struggle to manage patients' pain effectively without doing harm. This study explores the narratives of chronic noncancer pain patients receiving chronic opioid therapy and those of their physicians to better understand the effects of COT on the doctor–patient relationship. A mixed method study was conducted that included in-depth interviews and qualitative analysis of 21 paired patients with chronic pain and their physicians in the following groups: patients, physicians, and patient–physician pairs. Findings revealed that patients' narratives focus on suffering from chronic pain, with emphasis on the role of opioid therapy for pain relief, and physicians' narratives describe the challenges of treating patients with chronic pain on COT. Results elucidate the perceptions of ideal vs difficult patients and show that divergent patterns surrounding the consequences, utility, and goals of COT can negatively affect the doctor–patient relationship. The use of paired interviews through a narrative lens in this exploratory study offers a novel and informative approach for clinical practice and research. The findings have significant implications for improving doctor–patient communication and health outcomes by encouraging shared decision making and goal-directed health care encounters for physicians and patients with chronic pain on COT.

*Perspective:* This study found patterns of understanding pain, opioid pain medications, and the doctor–patient relationship for patients with chronic pain and their physicians using a narrative lens. Thematic findings in this exploratory study, which include a portrayal of collaborative vs conflictual relationships, suggest areas of future intervention and investigation.

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## 1. Introduction

In the United States, chronic pain is the cause of significant suffering and economic loss for more than 50 million Americans, costing the nation up to \$635 billion each year in medical treatment and lost productivity [10,15,18,20]. It has been increasingly recognized as both a top public health and national priority [10]. Chronic pain, as defined by the International Association for the Study of Pain, is “pain which persists past the normal time of healing,” which is generally 3 months or longer [33]. Chronic noncancer pain (CNCP) is chronic pain unrelated to cancer that may or may not be

associated with a pathologic process and is estimated to affect 22% of primary care patients, most commonly involving the lower back, limbs and joint, head and neck, and nerves [21,31,34,35].

Treatment options for chronic pain include both nonpharmacologic and pharmacologic modalities, ranging from physical therapy to opioid analgesics. Opioid pain medications, which may be effective in relieving pain and suffering through their analgesic effect, are commonly used [28]. It is estimated that 90% to 95% of chronic opioid therapy (COT), defined by “near or near daily use of opioids for at least 90 days, often indefinitely,” is prescribed for CNCP conditions [9,31]. Long-term use of opioids puts patients at risk for serious adverse effects that include tolerance, dependency, iatrogenic addiction, cognitive dysfunction, and abuse [2,19]. Progress in providing pain relief through opioids has been accompanied by marked increases in medical use and abuse of potent opioid analgesics resulting in serious injuries and overdose-related deaths

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in the United States. Opioid analgesics accounted for 9.9% in 2002 of all drug abuse, up from 5.8% in 1997 [16]. Physicians struggle to treat pain effectively while thwarting opioid drug abuse and patient harm from potential adverse effects.

The importance of interactive processes that underlie the doctor–patient relationship in illnesses such as CNCP cannot be overestimated. Effective patient–physician communication has been shown to correlate with better health outcomes, such as lower blood pressure and better pain control [4,30]. Patients' and physicians' explanatory models of illness and their lived experiences can inform us about the doctor–patient interaction within this population [7]. Although pain is a subjective experience, there have been few studies examining CNCP patients' experiences or those of their physicians [5,6]. One valuable technique to access patient and provider experiences is through the use of narrative. Morris states that narratives “get the stories into the open where we can examine their values, sift their conflict, and explore their power to work on us” [25]. Medical narratives provide a window for understanding complex suffering and challenges faced by both patients and physicians, and they give voice to the invisible and often silenced experience of pain [8].

This research builds on the understanding of pain through a narrative lens to explore ways in which opioids medication influence the doctor–patient relationship. We examine the experiences of adults receiving opioid therapy for relief of CNCP and that of their physicians.

## 2. Methods

### 2.1. Sites and subjects

This exploratory study was conducted at the Family Care Center (FCC) at Memorial Hospital of Rhode Island (MHRI), a model teaching practice of the Department of Family Medicine at the Alpert Medical School of Brown University. It serves 12,500 patients from the Blackstone Valley region of Rhode Island and southeastern Massachusetts, the majority of whom are medically underserved. Patients receive medical care from either fully licensed family physicians (attending physicians) or by postgraduate family medicine trainees (residents) with an attending physician as the preceptor.

A purposeful sample was recruited from active patient rolls in a 3-stage process [27]. Primary care physicians (PCPs) and nursing staff at the FCC were contacted and asked to review their patient lists of those diagnosed with CNCP who met the inclusion and exclusion criteria. Inclusion criteria for patients included CNCP (any type of nonmalignant chronic pain for >3 months in the last year), opioid prescription medication for chronic pain >3 months, age >18 years, fluency in spoken English, and willingness to participate in an in-depth interview. A pain contract is mandatory for FCC patients to be prescribed long-term opioid prescriptions. Exclusion criteria were limited to a history of psychotic illness, cancer-related pain, or severe comorbidities that might interfere with the interview process. Potential patient participants who met the criteria were then contacted, and if they agreed to participate, an interview was conducted either in the FCC or at another acceptable location. Participants' PCPs were then subsequently interviewed within 1.5 months of the patient interview to avoid timeline confounders.

The protocol for this study was approved by the MHRI institutional review board. All study participants gave their written informed consent before sharing medical or personal information with an investigator. Confidentiality was maintained throughout the study. Information from interviews was not shared between patient and physician participants, and nothing was entered into the medical record.

### 2.2. Data collection

Subjects' medical narratives were collected using the qualitative research technique of in-depth interviews in a one-on-one format by the researcher (AYE) [22,23]. The in-depth interviews utilized a semistructured moderator's guide of open-ended questions with investigator-developed prompts. This guide was designed to allow participants (both patients and PCPs) to tell patients' pain stories, provide perspectives on opioid usage, and portray the effect of chronic pain and opioid use on the doctor–patient relationship. At the point of saturation, when no new concepts emerged with successive interviews, participant recruitment was stopped. Audio recordings were made of each interview. Additional interviewer notes and observations were also immediately recorded. Interviews of each patient and his/her physician were identified as a dyad; once completed, each dyad was transcribed verbatim and prepared for analysis. Patient questionnaires included the SF-12, Graded Chronic Pain Scale 2.0, and the Prescribed Opioid Difficulties Scale [14,28,32,37]. Questionnaires were scored and tabulated according to their respective scales and subcategories.

### 2.3. Analysis

Thirty-eight patients were invited to participate and at initial contact agreed to participate. Twenty-three interviews were successfully conducted along with electronic record chart review of 2 years or from first documented visit. The remaining patients were lost to follow-up ( $n = 13$ ) or refused after further consideration ( $n = 2$ ). In-depth interviews were transcribed verbatim and analyzed using a multistep iterative approach designed to elucidate inherent patterns and meanings. All interview transcripts were read and transcribed by the research team, with secondary quality assessment of 30% of interviews. The research team categorized observations and emerging themes in these narratives through the immersion/crystallization process used in qualitative research to generate a thematic codebook [11]. Relevant quotes were extracted, discussed, and interpreted by members of the research team until consensus was reached. Alternative interpretations were sought and recorded when applicable.

All patient and physician narratives were individually analyzed using the codebook, and then patient narratives were compared to physician narratives in the aggregate for points of convergence, divergence, and omissions (Table 1). The research team then applied the list of thematic codes to interview dyads, each composed of a doctor–patient pair. For each theme, data were compared between patients and physicians within the dyads using an iterative process for interpretation [1,5].

The patterns that emerged in the aggregate sample of physicians and patients, and then between the doctor–patient dyads, became our organizing principles. Quantitative analysis was conducted using the SF-12 Physical Composite Score (range 0–50) and the SF-12 Mental Composite Score (range 0–50); the Graded Chronic Pain Scale 2.0 and its subscales for Characteristic Pain Intensity (range 0–10) and Disability Score (range 0–40); and the

**Table 1**  
Thematic codebook.

Understanding the experience of pain
Use of pain medications
Doctor–patient relationship
Communication
Perception of physician
Making meaning in life
Nonorganic factors affecting pain experience

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