Patient Perspectives of Acute Pain Management in the Era of the Opioid Epidemic

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Study objective: To inform the development of interventions that could improve patient engagement around the risks and benefits of alternative approaches to pain management in the emergency department (ED), we seek to capture the perspectives and experiences of patients treated for pain in this setting.

Methods: Three trained interviewers conducted semistructured open-ended telephone interviews with patients discharged from a single urban academic ED after presenting with acute pain related to fracture, renal colic, or musculoskeletal back injury. We recruited subjects until achieving thematic saturation according to periodic review of the interview transcripts. Interviews were audio recorded, professionally transcribed, and uploaded into QSR NVivo (version 10.0) for coding and analysis using modified grounded theory. An interdisciplinary team double coded the data and convened to review emerging themes, ensure interrater reliability, and establish consensus on discrepancies.

Results: We had 23 completed subject interviews, the majority of which were women. Interrater reliability for coding exceeded 90%. The major themes elicited centered on domains of patient awareness of the potential for opioid dependence and patient-provider communication relating to pain management. From the patient perspective, emergency physicians typically do not present alternative pain management options or discuss the risks of opioid dependence. Patients with negative experiences related to pain management describe deficiencies in patient-provider communication leading to misunderstanding of clinical diagnoses, fragmentation of care among their health care providers, and a desire to be involved in the decisionmaking process around their pain management. Patients with positive experiences commented on regular communication with their care team, rapid pain management, and the empathetic nature of their care providers. Patients communicate fears about the risks of opioid addiction, beliefs that following a prescribed opioid regimen is protective of developing opioid dependence, and an understanding of the broader tensions that providers face relating to the prescription of opioid therapy.

Conclusion: Patients identified a deficit of communication around opioid risk and pain management options in the ED. [Ann Emerg Med. 2015;66:246–252.]

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INTRODUCTION

During the last 15 years, governing bodies such as the Joint Commission emphasized recognition of pain in patients, labeling pain assessment as a fifth vital sign.[1,2] The prevalence of pain as the presenting complaint in emergency departments (EDs) ranges between 38% and 78%.[3-5] Up to 70% of patients with acute pain fail to receive any analgesics in the ED.[6-9] Previously noted barriers to adequate pain management included provider failure to acknowledge pain, failure to document pain, inadequate training on analgesia, and sociodemographic biases.[10]

Criticism of emergency physicians for insufficiently treating pain now is crossing with concerns about an opioid epidemic, the latter accounting for the greatest number of current injury-related deaths in the United States.[11-13] Emergency physicians are confronted with the challenge of how to alleviate pain in a manner appropriate and adequate, which requires balancing the analgesic needs of patients with the potential risks associated with opioid therapy, including diversion, misuse, and dependence.[14] During the course of the last decade, the federal government through the National Drug Control Strategy pushed for a multipronged approach to address the opioid

Editor's Capsule Summary

What is already known on this topic

Providers in the emergency department (ED) often give opioids to patients with pain. Little is known about patients' knowledge and perceptions about analgesia after a visit to the ED.

What question this study addressed

What are the patient perspectives on their care after an ED visit for acute pain?

What this study adds to our knowledge

Open-ended interviews with 23 patients with selected acute pain complaints at 1 urban ED revealed themes of opioid addiction fear, perceived lack of provider concern, and opportunity for better communication about analgesia options.

How this is relevant to clinical practice

If sustained by research in other settings and conditions, these observations will inform analgesic protocols and care plans in an ED, targeting the opportunities noted.

epidemic, deploying initiatives that focus on drug monitoring, proper opioid disposal, physician education, and law enforcement.[15] Few of these initiatives examined or implemented interventions that engage patients around understanding of the risks and benefits associated with opioid and other alternative treatments.[16] In the context of competing public health priorities presented by the 2 larger issues of patient oligoanalgesia and opioid misuse, the patient voice has been omitted.

We sought to inform potential patient-centered interventions that can both provide adequate pain management and decrease the potential for opioid misuse. We chose a qualitative approach to uncover patient perspectives and attitudes related to pain management in an ED setting.

MATERIALS AND METHODS

Study Design and Setting

We conducted semistructured open-ended interviews with patients who presented to a single, urban, academic ED (annual census 64,000) with complaints of acute pain relating to renal colic, musculoskeletal back pain, or extremity fracture.[17] Our institutional review board approved the study protocol and written consent for audiotaped interviews. We used the Consolidated Criteria for Reporting Qualitative Research to guide data collection, analysis, and reporting.[18]

Selection of Participants

Patient recruitment occurred between July 25, 2014, and October 3, 2014. We approached a convenience sample of all patients presenting during data collection periods with complaints of one of the following: acute renal colic, acute musculoskeletal back pain, or an extremity fracture. We used trained assistants to screen patients for eligibility by study personnel using the electronic medical record. Data collection periods were limited to weekdays in the mornings and afternoons for staffing reasons. We excluded patients who were pregnant or currently receiving opioids for a chronic medical condition. Because we were particularly interested in opioid treatment, we also excluded patients younger than 18 years or older than 65 years because of age-based recommendations about outpatient use of opioids.[19] After consenting, enrolled subjects completed a basic verbal survey relating to their pain status and demographics. We sought to complete a follow-up semistructured telephone interview for all subjects finishing the initial survey, compensating them with a $30 gift card. To take a patient-centered approach to the study, allow meaningful recovery time, and limit recall bias, we conducted the telephone interviews 1 to 2 weeks after the ED visit. We enrolled until reaching thematic saturation, defined as the point when additional interviews stopped providing novel experiences and opinions.

Data Collection and Processing

We used a semistructured guide developed by the study team and pilot tested to conduct the interviews (Appendix E1, available online at http://www.annemergmed.com). Three qualitatively trained investigators (R.J.S., B.P., and S.K.) conducted the interviews, which we audiotaped, professionally transcribed, and entered into NVivo (version 10.0; QSR, Doncaster, Australia) for qualitative data management and analysis. We used Stata (version 13.0; StataCorp, College Station, TX) for quantitative analyses.

Primary Data Analysis

We approached the analysis with modified grounded theory. This approach included the use of an a priori set of codes that addressed our research questions, as well as a set of codes that emerged from the data de novo through iterative line-by-line reading of the interviews. The entire team of investigators reviewed early interviews and developed consensus on the list of codes that corresponded to emerging themes. Each code was then clearly defined and applied to all transcripts by 2 study investigators