Original Research Article
Contrasting Tensions Between Patients and PCPs in Chronic Pain Management: A Qualitative Study

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Disclosure and Conflicts of Interest:
This manuscript has not been previously published and is not under consideration in the same or substantially similar form in any other peer-reviewed media. We presented an earlier version of the manuscript at the Society of General Internal Medicine conference in May, 2012, in Orlando, Florida. All authors listed have contributed sufficiently to the project to be included as authors, and all those who are qualified to be authors are listed in the author byline. To the best of our knowledge, no conflict of interest, financial or other, exists.

The project reported here was supported by the Department of Veterans Affairs, Veterans Health Administration, Health Services Research and Development (PI: Krebs-CDA #07–215; PI: Matthias-CDA 10–034), and the Health Services Research and Development Associated Health Fellowship Program. The views expressed in this article are those of the authors and do not necessarily represent the views of the Department of Veterans Affairs or the United States Government.

Abstract
Objective. With greater scrutiny on primary care providers’ (PCPs) approaches to chronic pain management, more research is needed to clarify how concerns and uncertainties about opioid therapy affect the ways both patients with chronic pain and PCPs experience primary care interactions. The goal of this qualitative study was to develop a better understanding of the respective experiences, perceptions, and challenges that patients with chronic pain and PCPs face communicating with each other about pain management.

Design. Purposive and snowball sampling techniques were used to identify 14 PCPs. Patients who received ≥6 opioid prescriptions during the prior year were selected at random from the panels of participating physicians. Face-to-face in-depth interviews were conducted individually with patients and PCPs.

Setting. VISN 11 Roudebush VA Medical Center (RVAMC) in Indianapolis, Indiana.

Subjects. Fourteen PCPs and 26 patients with chronic pain participated.

Methods. An inductive thematic analysis was conducted separately with patient and PCP interview data, after which the emergent themes for both groups were compared and contrasted.

Results. Three notable tensions between patients and PCPs were discovered: 1) the role of discussing pain versus other primary care concerns, 2)
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Acknowledgment of pain and the search for objective evidence, and 3) recognition of patient individuality and consideration of relationship history.

Conclusions. Competing demands of primary care practice, differing beliefs about pain, and uncertainties about the appropriate place of opioid therapy in chronic pain management likely contributed to the identified tensions. Several clinical communication strategies to help PCPs mitigate and manage pain-related tensions are discussed.

Key Words. Primary Care; Pain Management; Opioids; Standards of Care

Introduction

Chronic pain poses numerous communicative and relational challenges to the patient and primary care provider (PCP) relationship, including power struggles [1,2] and a lack of mutual trust [3]. For PCPs, stressors are often related to opioid prescribing, which is perceived as adding significant complexity to patient care [4], including concerns about inadvertently facilitating or contributing to diversion or addiction [5,6]. Not surprisingly, PCPs’ reports of treating pain have been characterized by low satisfaction levels [7] and high levels of frustration [5,8]. Patients with chronic pain have reported that their experience of pain management involves strenuous work to establish one’s credibility [3] and evokes feelings of stigmatization, distrust, and isolation [9], as well as stress, depression, and anxiety [2,10,11].

Critical challenges in pain management likely contribute layers of difficulty to this already tension-filled relational dynamic. The Institute of Medicine has called for a cultural transformation regarding chronic pain, stating that it is "underreported, underdiagnosed, and undertreated in nearly all health care settings," while pointing to persistent deficiencies in access to evidence-based and coordinated models of pain care [12]. Meanwhile, the dramatic recent rise in opioid abuse and overdose deaths, identified as a public health epidemic by the Centers for Disease Control, has intensified concern about the appropriateness of opioid therapy for chronic pain management in primary care. The need for PCPs need to take more time understanding patient history and context before prescribing opioids has become a focus of both American Pain Society (APS) pain management guidelines [13] and the popular media [14].

Because much of the qualitative work done in the area of pain management and the patient-provider relationship has previously focused on either the patient or the provider perspective, the goal of this qualitative study was to develop a better understanding of the respective experiences, perceptions, and challenges both patients with chronic pain and PCPs face communicating with each other about pain management in the primary care setting.

Methods

PCPs and their patients with chronic pain at the VISN 11 Roudebush VA Medical Center (RVAMC) in Indianapolis, Indiana, were recruited for one-time in-depth interviews. PCPs were identified who delivered primary care to patients in one of five RVAMC primary care clinics, and snowball sampling techniques were used by asking participating PCPs to recommend other PCPs who thought differently about the topic, in order to capture as much diversity as possible. Participating PCPs authorized contact with their patients, which provided a convenient sample from which to recruit for the patient interview wing of the study. In order to ensure a diverse range of perspectives, recruitment of patients were spread out as evenly as possible between all participating PCPs. Using purposive sampling, eligible patients had received at least six opioid prescriptions in the previous 12 months from the outpatient pharmacy. All interviews were conducted in a private room after obtaining informed consent (see Appendix A and B for patient and provider interview guides). Patients received $20 as compensation for participating; PCPs were not compensated. Both university Institutional Review Board and VAMC Human Subjects approval were obtained prior to recruitment.

Analytical Method

An inductive thematic analysis [15] was conducted separately with patient and PCP interview transcript data, while data collection was still ongoing. Recruitment of both PCPs and patients continued until theoretical saturation, when no more novel themes or information emerged [16]. All four authors coded each set of interviews using an iterative process of independent transcript review and consensus discussion. Using a subset of all transcripts, initial labels and codes that were identified within and across the patient interview transcripts were finalized and then applied to all remaining patient transcripts. The process was the same for PCP transcripts, and the qualitative software QSR Nvivo 9 (QSR International (Americas) Inc., Burlington, MA, USA) was used in order to store and sort the coded data. Through consensus, codes were collapsed into a list of categories and subcategories for each group of interview data. Emergent themes (i.e., those not originating from summarized answers to specific interview questions) were then uncovered by identifying the most compelling higher order concepts represented across categories (e.g., patients wanting the benefit of the doubt; PCPs trusting in radiologic evidence/physical exam findings). The emergent themes for both groups were then compared and contrasted, resulting in the identification of three pairs of core tensions existing between the two groups.

Results

Fourteen PCPs and 26 patients with chronic pain participated. Patients were 49 to 79 years old (M = 62), 92.3% men and 7.7% women, 76.9% White and 15.4% Black, and 7.6% other. On average, two patients were recruited per provider to ensure a wide variety of patient views were...
represented, and at least one patient was enrolled for 12 out of 14 PCPs; the most patients for a single PCP was three. PCPs were 32 to 57 years old (M = 47), 50.0% women and 50% men, 42.9% White, 42.9% Asian, and 14.3% Black.

A noteworthy interplay of tensions emerged between PCPs’ and patients’ perspectives about pain management in three areas: 1) the role of discussing pain versus other primary care concerns, 2) acknowledgment of pain and the search for objective evidence, and 3) recognition of patient individuality and consideration of relationship history (Table 1).

Table 1  Core pairs of tensions between patients and PCPs*

| Role of discussing pain versus other primary care concerns | PT: | “99 percent of the conversations we ever have, because it’s only every six months or once a year, is my physical, my weight, blood pressures, what number of pain I’m in . . . but there is no conversation about pain.” (PT 11) |
| pacientes: | “I mean, I could not take care of this patient’s medical needs. I was always talking to him about his pain.” (Physician 4) |

| Acknowledgment of the reality of pain and the search for objective evidence | PT: | “I use a fictitious, make-believe feeling to make me feel better. I always tell everybody I am fantastic. It’s a wonderful day. I’ve got to build that up in my mind, in my body and I do that. And when I do that with him, he takes it there’s no pain; he doesn’t have pain. I can’t do that with [current doctor]. So I just learned that.” (PT 3) |
| pacientes: | “They’re supposed to have all this pain and they’re supposed to have this, you know severe pain and so forth, but when you see them it just doesn’t quite look that way, and I know chronic pain doesn’t always manifest itself but um, you know.” (Physician 7) |

| Recognition of patient individuality and the consideration of relationship history | PT: | “They [providers] need to see the patient, not the statistics.” (PT 16) |
| pacientes: | “The problem always comes when I don’t know the person. Then you don’t know what they were before . . . and, you know diversion is pretty common.” (Physician 5) |

* Dyads of contrasting quotes in Table do not represent patients linked with their respective PCPs.

PCP, primary care provider; PT, patient.

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Role of Discussing Pain Versus Other Primary Care Concerns

Patients

Because pain overshadowed so many other aspects of their lives, patients often believed that conversations about their struggles with pain should be a priority during clinic visits. At the same time, many discussed feeling as though their PCPs were not interested in talking about their pain. One patient explained, “They come in here and they wanna talk about my cholesterol and my blood pressure or my mammogram and a colonoscopy and everything, which, to me, I just do that really kind of to appease them “cause I’m not interested in it . . . I mean to me what affects every single day, every single waking moment and half the time my nights, is this constant pain.” (PT 16)

Some patients viewed PCPs who initiated conversations about other health concerns without first addressing pain issues as lacking sympathy or empathy. For example, one patient said, “He [the physician] could have more of a sympathetic ear toward how I feel instead of the route [of addressing] what he feels is more important” (PT 1). Another patient became impatient after several unsuccessful attempts to bring up her pain during visits, and recalled finally succeeding by being very assertive: Normally I go in and see him, [and] it’s this, this, this, goodbye. No. I forced him to become alert to it [pain]. I would not let him go that day. I said, “[Doctor] I gotta talk to you about my pain.” I said, “I’m not gonna leave today until we talk about this.” (PT 5)

PCPs

PCPs, in contrast, sometimes perceived discussions about pain as detracting from their fundamental roles and responsibilities, such as having adequate time to address important primary care concerns with the patient during the clinic visit. For this reason, a patient’s tendency to prioritize pain was sometimes disconcerting to PCPs. As one PCP explained, “Oftentimes even [when] you know if they have diabetes or high blood pressure, their chief concern is their chronic pain” (Physician 1).

When patients wanted to spend time talking about their pain, some PCPs interpreted it as a lack of concern about more substantial and urgent health conditions. For instance, another PCP said,

They don’t seem to worry about issues that might be real . . . like his cholesterol is high, [but] he’s not worried. You know? There are some other issues that he needs to attend to, and he’s not worried. His father died when he was 52. He’s not worried. He was 53. He’s not worried. (Physician 5)

Other PCPs expressed frustration about the often ambiguous nature of the pain symptoms, and how the
resulting conversations could be time consuming and unproductive. One PCP questioned whether primary care providers should even play a role in pain management, asserting, “It’s too much for the primary care provider to handle everything else, to handle their blood pressure, their diabetes, their high cholesterol, plus have the time to address all the pain management issues” (Physician 6).

Acknowledgment of the Reality of Pain and the Search for Objective Evidence

Patients

Patients discussed their desire for PCPs to acknowledge that their pain was real, even when there was no physical or behavioral evidence. As one patient said,

They did this and that and they couldn’t find anything. Doesn’t mean I don’t have pain. You know, you can’t just say you don’t have anything because you can’t see it . . . why would I wanna waste my gas to come all the way here and everything, you know, to lie about pain. (PT 13)

Before a torn ligament was eventually diagnosed in her knee, another patient recalled having to be persistent in her attempts to convince providers that her knee pain was real. She recounted,

You know, I’ve been around long enough. And sometimes they’d say well move your knee. Well it moves okay. Well this one day the doctor did that, and this young man got up to leave, and I said, “no you’re not leaving. Sit down.” And I’ll give him credit, he sat down. (PT 5)

Another patient explained, “Well, I’d, I really say here as well as any place else, they don’t take it [pain complaints] serious enough . . . they should treat everyone as if they’re telling you the truth “til they find out different, you know” (PT 18). Other patients described how they learned to adjust their verbal and nonverbal behaviors (e.g., not displaying a cheerful demeanor) when interacting with PCPs in order to increase the believability of their pain symptoms.

PCPs

For many physicians, the search for objective evidence of patients’ pain was indeed a crucial component of their evaluation. As reflected by one physician’s decision-making criteria, objective evidence was particularly important when determining if and when to prescribe opioid therapy:

. . . if they complain of pain and if they have some sort of objective data that supports, that claim of pain . . . bony changes on their x-rays, or, you know just, if they’ve had some sort of procedure that leaves them with chronic pain. (Physician 3)

Many physicians struggled with the dilemma of how to respond to patients’ complaints of pain given its subjectivity, especially in the absence of physical or radiographic findings. One physician explained why she would like more training on when to use what kind of pain treatments:

Pain is so subjective. You can have a patient that doesn’t have a lot show up on X-ray and nothing really shows up on MRI, but they’re interpreting their pain as, you know, 10 out of 10. You don’t wanna go too far and you don’t want to have the patient suffer and not give him enough [pain medication]. (Physician 14)

Similar to what some patients voiced, without objective evidence, some providers looked for behavioral and nonverbal cues exhibited by the patient that would indicate the presence or absence of pain. One physician would often pay close attention to how patients walked: “Some of them you know, from the get-go are, you know, ‘my pain is not controlled, my pain is not controlled’, and, but when you see them walking or, you know, they don’t look that much in pain” (Physician 12). A different physician took note of how patients would sit: “Sometimes I could have a patient sitting there and saying that they are hurting, 10 out of 10, and they are sitting like you and I” (Physician 4).

Although many PCPs doubted the legitimacy of pain in the absence of objective evidence, it is important to note that several others acknowledged the subjective nature of pain and the importance of taking patients at their word. As Physician 3 explained, “Pain is so subjective and so that’s where the difficulty lies . . . I find it hard to say how someone’s pain can be judged by someone else.” Another physician gave the following advice: “You have to show a patient you’re empathetic to him. There is a pain. Pain is real” (Physician 10).

Recognition of Patient Individuality and Consideration of Relationship History

Patients

When it came to making decisions about pain treatment, patients talked about the importance of being treated as individuals by their physicians, which they contrasted with being treated with one-size-fits-all prescriptions, being stereotyped, or receiving rushed and depersonalized attention. Patients wanted to be recognized as unique individuals who really mattered, with distinct physiologies and treatment needs. As one patient put it, “You should treat all your patients as individuals and treat them individually instead of you know lumpin’ them into one category . . . you can’t treat that patient as he’s like a homeless person that don’t know anything” (PT 1).

Another patient explained, “I think that they need to actually start taking more interest in what’s patient by patient instead of just a cross blanket situation and saying well, you’re only allowed this, you’re only allowed that . . .” (PT 10). Other participants felt as though they were just another number to the physician. One patient said, “What I’m telling you about my body isn’t relevant to you ‘cause you see so many people” (PT 7). Several patients complained that provider turnover affected their ability to
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receive individualized care; conversations about pain and treatment options often had to be started over again from scratch. When one patient was asked whether his PCP was ever concerned about how he used his pain medications, he said, “I don’t have the same doctor long enough to know” (PT 17). Another patient lamented, “Some of the statements they make and some of the things that they say or ask you, you can tell that they haven’t even read anything on your file. They haven’t skimmed over it” (PT 12).

PCPs

PCPs also expressed their desire to approach pain management with each patient individually and without any preconceived notions. However, for many physicians, this required time to develop a relationship with patients. For example, one physician indicated that when conflict occurred, it was usually early in the relationship and not a recurring pattern: “I think that usually over the course of a few visits you can come to a shared approach where you’re both in agreement and comfortable with that approach” (Physician 1). When providers had no experience with an individual, discussing opioid therapy was challenging because it was not clear whether the patient was taking the medication correctly, benefitting from the medication, or if he or she was an appropriate candidate for opioids in the first place. A key concern was ensuring patient safety. As one physician explained,

I think you try not to get prejudiced against your patients, “cause again, when I came here a lot of people were new to me so I don’t have the history of knowing this person’s personality or that sort of thing. And so you kind of tend to think they must be using it [opioids] for other things. They must be using it for other symptoms besides just pain. But you can’t really know for sure until you get to know your patient, really.” (Physician 14)

PCPs also described the difficulties that come along with inheriting new patients, especially those who have requested a new physician due to prior disagreements over pain management. Many PCPs conveyed that it takes time to develop trust in patients, but trust lays the foundation for successful pain management—especially when opioid therapy is involved. PCPs needed to trust that patients would not sell their opioids on the street or take higher doses than prescribed in order to get high. As one physician explained, “You get to just know people. You just know, the people that are just BS’ing you and the people that are really very sincere. You know?” (Physician 3).

Discussion

By comparing patients’ and PCPs’ perspectives on chronic pain and opioid management in primary care, we uncovered three notable tensions. First, patients expressed frustration because they wanted more of a focus on their pain during clinic visits, whereas many PCPs voiced dismay over patients not prioritizing discussions about other pressing primary care concerns. Second, patients reported distress when their PCPs did not acknowledge that their pain was real and important, whereas many PCPs were skeptical about patients’ truthfulness and motivations in the absence of pathophysiologic evidence for the pain. Finally, both patients and PCPs preferred individualized pain care approaches, but PCPs felt especially constrained in making decisions about opioid therapy by a lack of relationship history with new or inherited patients.

The tensions we identified may stem from the sometimes contrasting and contradictory needs and desires inherent in patients’ and PCPs’ roles. We found that the tensions between patients and PCPs sometimes seemed to represent a polarity, with the pursuit of one negating or weakening the other. For instance, if a patient succeeded in discussing pain to the exclusion of other primary care concerns, PCPs were frustrated by their inability to fulfill aspects of their professional role. Conversely, when PCPs prioritized the discussion of other chronic disease or preventive health goals, patients perceived their PCPs as uncaring or lacking empathy. PCPs face well-documented time pressures and other competing demands of primary care [17–20], which are relevant to pain management; although conflicts related to competing demands in primary care are not unique to pain, they may be more consequential in chronic pain care because of the subjective nature of pain and its pervasive effects on patient function and quality of life.

Diverging beliefs about the nature and causes of pain seemed to be another important contributor to tensions. When pain symptoms lacked a clear pathophysiologic basis, some patients questioned the quality of their physicians’ care, while some physicians questioned the legitimacy of their patients’ symptoms and looked to behavioral cues for signs of pain. Although a number of patient–physician pairs successfully navigated this ambiguous territory, accepting the subjectivity of pain and allowing patients to feel validated, many PCPs struggled to make decisions based on evidence but also adequately control a patient’s pain.

In light of prior research demonstrating the association between unexplained physical symptoms among patients and clinical encounters physicians perceive as frustrating [21,22], it may also be important to consider how a physician’s fundamental role as “problem solver” can be challenged when caring for patients who express ambiguous pain symptoms that cannot be explained by physical findings. PCPs’ natural tendency to focus on problems perceived as solvable might not meet patients’ more basic needs for a listening ear and empathic responses. This is particularly important given previous findings that physician listening has important therapeutic value for patients [23].

Past studies have documented physicians’ tendency to interrupt and redirect patients early in the clinical encounter, preventing full expression of the patient agenda [24,25]. In our study, patients’ stories suggested this dynamic was contributing to dissatisfaction with pain
management; patients who sought an empathetic interaction were dissatisfied when they perceived their physicians as trying to shift the focus away from pain. Although findings from other qualitative studies of patients with pain have likewise uncovered dissatisfactions with physicians’ listening and interest [9,26], our study is unique in that we assessed both patient and provider views in the context of long-term opioid therapy for chronic pain.

It is important to note that many of the patients who wanted more priority placed on discussing pain, as well as those who expressed desire for their pain to be recognized as real, were not seeking to discuss opioids; many were in fact avoiding opioids and looking for a sympathetic ear, while others wanted answers to questions about the origins and implications of their pain symptoms. Indeed, prior research has demonstrated that especially for patients with substance abuse disorders, concerns about addiction and side effects can be barriers to the use of opioid therapy [27]. If PCPs conclude that those patients who want to discuss pain necessarily want to discuss opioids, there may be a tendency for conversations about pain to be approached more hesitantly or even delayed until the patient–provider relationship is perceived as more well defined. Particularly with new patients, this course of action might lead to missed opportunities to express validation and empathy, and in some instances, negative impact on the development of the patient–provider relationship. Especially when there are no physical manifestations of pain, such an approach might also preclude opportunities to investigate and uncover important psycho-social and contextual factors in patients’ lives that may be producing or contributing to how they experience pain in their bodies.

Conclusion

There are no easy solutions for the problems that we have identified, and especially because patients and PCPs were both largely correct about their perceptions regarding one another; patients did indeed want to focus first and foremost on pain, and PCPs often preferred to focus on other pressing primary care concerns; PCPs did indeed sometimes doubt the reality of their patients’ pain, as patients feared was the case. However, some communication strategies may provide opportunities to mitigate tensions and strengthen the primary care relationship.

For example, when time pressures preclude an in-depth discussion of pain, a brief expression of empathy, coupled with explicit communication of the problem may be helpful (e.g., “I know you are suffering and I want to hear more about your pain, but we only have a few minutes left today.”). Nonviolent communication (NVC) processes and strategies developed by Marshall Rosenberg [28] can also be applied in this context; in order to establish an empathic connection, there is no need to feel the same feelings and pain symptoms as patients (and that is what makes empathy distinct from sympathy), but it does involve going beyond mental understanding of what they are saying by emptying our minds and hearing them with our whole being.

An important component of decision making is encouraging patients to share their goals and preferences [29], and this may be particularly relevant when difficult conversations arise regarding pain treatment options and medications. Even when patients prefer that their physicians make final treatment decisions, research has demonstrated that they still desire to be given choices and asked their opinions [30]. Moreover, when denying a patient’s request for opioid therapy, it might prove beneficial to explicitly share one’s reasoning when it pertains to concerns about their well-being and safety. Although not in the context of evaluating chronic pain patient outcomes, randomized controlled trials of diverse communication interventions have indeed demonstrated positive effects on patient and provider communication outcomes [31], as well as on PCP self-reported competence, satisfaction, and patient centeredness [32,33].

In this article, we have clarified how tensions around prioritization of pain, legitimacy of pain, and desire for individualized care affects how patients with chronic pain and their PCPs perceive and experience clinical interactions about pain. In doing so, we move closer to a holistic understanding of patient and provider perspectives on the pain management problem and potential solutions for relational improvements. In the popular imagination, tension is stereotypically viewed as negative. We believe that recognizing and addressing tensions in the relationship between physicians and patients, especially those experiencing pain, can actually be a gateway to increased intimacy and mutual understanding.

There are several limitations to this study. Although we elicited in-depth information on participants’ thinking and reasoning, the sample comprised a small number of patients and providers in a single VA health care system, which limits generalizability. Furthermore, the sample was lacking in diversity, with patient participants predominantly male, White, and 49 years of age or older. For instance, missing are the experiences and expectations of the increasing numbers of women veterans who struggle with chronic pain. Future research in this area would benefit from a larger and more diverse sample across multiple health care systems, including both patients who are on opioid therapy for their chronic pain and those who are not. It would be instructive to explore if and how ongoing or past use of opioid therapy might influence patients’ and providers’ perceptions, experiences, and expectations for chronic pain-related communication.

Acknowledgments

We thank our colleagues, Richard M. Frankel, who provided invaluable support and guidance throughout the development phase of the study as well as a critical reading of the manuscript, Steffanie Campbell, who helped with data collection and analysis, and Christy Sargent, who provided support and technical assistance.
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Appendix A: Patient Interview Questions

1. Could you tell me briefly about your pain condition?
   - How long have you had the pain?
   - Who is the main health care provider who helps you with the pain?
   - Is there anyone else you see for pain?
2. Tell me about the most recent memorable conversation you had with a doctor or other health care provider about pain medications.
   - How typical was that conversation?
   - [If atypical] Tell me about a more common conversation for you.
3. How do you think your doctor decides which pain medications to prescribe for you?
   - [Clarification (if needed): Are there certain questions (s)he asks or tests (s)he orders?]
   - [If you offer your opinions] How much say do you think you should have into decisions about pain medications?
4. Tell me about a conversation you had about pain medications—how well they were working or whether to make a change.
   - Was there a time when you preferred one medication to another or when a medication wasn’t working well? How did you tell your doctor? How did that conversation go?
5. Have you and your doctors ever disagreed about whether to change or stop pain medications?
   - Give me an example of a situation.
   - How typical was that conversation? [If atypical] Tell me about a more common interaction for you.
   - [If disagreed] How did you talk about the disagreement? What solution did you find?
6. Have you ever had concerns about how you are taking your pain medications?
   - Clarification (if needed): Like taking more or less than you should? Or not being sure how to take them?
   - [If yes] Did you talk with your doctor about that?
   - Has your doctor ever been concerned about how you take your pain medicine?
7. Have you ever been concerned about how someone else uses pain medications? Or known anyone who has had problems with them?
   - Clarification (if needed): Like side effects from them? Or trouble with abusing them?
   - Tell me what happened.
8. How comfortable are you talking to doctors about pain medications?
   - Do you think you are more or less trusting of doctors than most people?
   - How do you know if you can trust a doctor?
   - [If you think your doctors know if they can trust you to handle your pain medications safely]
9. If you could change one thing about how doctors treat pain, what would it be?
10. Is there anything you’d like to add about your experiences with pain medications? Anything else that came to mind during this interview?

Appendix B: Provider Interview Questions

11. Tell me about the most recent memorable conversation you had with a patient about opioid pain medications.
   - How typical was that conversation?
   - [If atypical] Tell me about a more common interaction for you.
12. How do you decide whom to prescribe opioids for?
   - Clarification (if needed): Are certain patients better candidates than others? Any that are not good candidates for opioids?
13. How much input do you think patients should have into pain medication decisions?
   - How often do patients offer their opinions?
   - How do you involve them in decisions?
   - [If they say that]
14. How would you define a good response or success with opioid therapy?
   - [Clarification (if needed): What kind of results would convince you to continue a certain drug or dose vs increasing it or switching to something else?]
15. How often is incorrect or inappropriate use of opioids a problem among your patients?
16. In your experience, what’s the best way to assess whether patients use their opioids correctly?
   - How do you know if you can trust your patient?
   - What else? Any subtle observations that are useful?
• Are you more or less trusting than most primary care providers?
• How do you think your patients know if they can trust you?

17. Do you and your patients ever disagree about whether to change or stop opioids?
• Give me an example of a situation when you disagreed.
• How typical was that conversation?

• [If atypical] Tell me about a more common interaction for you.
• How are disagreements typically resolved?

18. If you could change one thing about how opioid prescribing is done here, what would it be?

19. Is there anything you’d like to add about your experiences with prescribing opioids? Anything that came to mind during this interview?