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Understanding Clinicians' Decisions to Assume Prescriptions for Inherited Patients on Long-term Opioid Therapy: A Qualitative Study

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Abstract

Objective. Given the changing political and social climate around opioids, we examined how clinicians in the outpatient setting made decisions about managing opioid prescriptions for new patients already on long-term opioid therapy. **Methods.** We conducted in-depth interviews with 32 clinicians in Southern California who prescribed opioid medications in the outpatient setting for chronic pain. The study design, interview guides, and coding for this qualitative study were guided by constructivist grounded theory methodology. **Results.** We identified three approaches to assuming a new patient's opioid prescriptions. *Staunch Opposers,* mostly clinicians with specialized training in pain medicine, were averse to continuing opioid prescriptions for new patients and often screened outpatients seeking opioids. *Cautious and Conflicted Prescribers* were wary about prescribing opioids but were willing to refill prescriptions if they perceived the patient as trustworthy and the medication fell within their comfort zone. Clinicians in the first two groups felt resentful about other clinicians "dumping" patients on opioids on them. *Rapport Builders,* mostly primary care physicians, were the most willing to assume opioid prescriptions and were strategic in their approach to transitioning patients to safer doses. **Conclusions.** Clinicians with the most training in pain management were the least willing to assume responsibility for opioid prescriptions for patients already on long-term opioid therapy. In contrast, primary care clinicians were the most willing to assume this responsibility. However, primary care clinicians face barriers to providing high-quality care for patients with complex pain conditions, such as short visit times and less specialized training.

Key Words: Opioids; Primary Care; Provider Behavior; Guidelines; Prescribing

Introduction

In the last several decades, perceptions of opioid medications for the treatment of chronic pain have changed dramatically, and prescribing behavior has changed accordingly [1,2]. The medical and cultural zeitgeist has swung from one side to the other and back again: from perceiving opioids as highly addictive and prone to misuse to seeing opioids as helpful for chronic pain [3,4], and then back to perceiving these medications as addictive and dangerous [2]. Caught in the middle have been individuals with chronic pain, many of whom were

prescribed opioids in an era when opioids were perceived as appropriate for long-term use and freely prescribed. While many individuals remain on prescription opioids, clinicians are now more reluctant to prescribe these medications [5]. Individuals who may be physiologically and psychologically dependent on opioid medications and may be seeking prescribers have been referred to in the medical literature as "inherited patients" or "legacy patients" [6,7].

Despite volumes of literature on the opioid epidemic, little has been written about how clinicians decide whether to take on the opioid prescriptions of "inherited patients." This decision-making process has important societal implications: if individuals cannot find a clinician to continue prescribing their opioid medications, they may experience severe withdrawal symptoms [8] or turn to illegal drugs to avoid withdrawal [6]. Indeed, there is early evidence that clinicians are increasingly unwilling to prescribe opioids [5]. In response to reports that providers may no longer be prescribing opioids or may be suddenly discharging patients on chronic opioid therapy, the California Department of Public Health released a notice urging clinicians not to drop their patients who may be opioid dependent or struggling with symptoms associated with substance use disorder [9]. Others have also urged that recent guidelines on opioid prescribing for chronic pain should not be understood as a reason to abandon patients or discontinue opioids abruptly [10,11]. Understanding this decision-making process better can provide insight into potentially negative perceptions that clinicians may have about patients taking opioids for chronic pain. Identifying why clinicians may or may not decide to manage inherited patients can ultimately reveal gaps in care for patients in chronic pain and help inform interventions that improve patient–clinician relationships.

This paper describes how clinicians make decisions about assuming opioid prescriptions for patients new to their practices and already on long-term opioid therapy. First, we review the literature on the evolution of perceptions of opioid medications and the implications of the shifts in perceptions. Subsequently, we outline the methodology that guided our analysis of qualitative data from interviews with a sample of clinicians in the greater Southern California region. Our results illustrate a continuum of how clinicians approach assuming opioid prescriptions for new patients on existing opioid therapy. We categorized clinicians into three groups depending on their approach to managing these patients and discuss the implications of their decision-making approaches.

Background

The Changing Landscape of Opioid Prescribing

The rise of the opioid epidemic has resulted in a marked shift in recommendations about prescribing opioids. Before the 2000s, opioids were reserved for postoperative pain, palliative care, and cancer-related pain [12]. A confluence of factors, including changing views about how to treat chronic pain [13], the release of strong opioid medications such as OxyContin, and the heavy marketing of opioids to clinicians [14], resulted in a substantial increase in opioid prescriptions [13]. In 2012, at the peak of opioid prescribing, providers wrote 82.5 opioid prescriptions per 100 persons in the United States [15]. Clinicians prescribed opioids for more individuals, for longer lengths of time, and often at higher doses, resulting in more individuals at risk of addiction, drug overdose, and death [16]. Individuals in the United States were prescribed twice as many opioids per capita as the second-ranked nation [17]. The last decade has seen a spike in opioid-related deaths, emergency department visits, and hospitalizations in the United States, many tied to prescription opioids [16,18,19]. This rise in overdoses and deaths led the Centers for Disease Control and Prevention (CDC) to release guidelines regarding opioid prescribing in 2016 [20]. These guidelines, along with guidelines from other medical societies [21–23], now recommend that clinicians optimize nonopioid therapies and use the lowest dosages possible to achieve realistic functional goals. In addition to the new guidelines, dozens of state laws now focus on regulating opioid prescribing, limiting initial doses and the number of days prescribed [24].

The Challenges of Managing "Inherited Patients"

This regulatory climate, coupled with increased media coverage of the opioid epidemic [25], has placed great scrutiny on prescribing behaviors, increasing clinicians' discomfort with prescribing opioid medications [25]. Providers have reported fear of prosecution or regulatory scrutiny for inappropriate prescribing of opioids [6,26,27]. There have been several reports that clinicians have abruptly stopped prescribing opioids for many patients, resulting in patients with chronic pain feeling abandoned and without treatment [8,11,28,29]. Others have also written about how clinicians' aversion to prescribing opioids has led to patients on chronic opioid therapy feeling highly stigmatized and having to travel long distances to obtain their prescriptions [30]. However, clinicians may fear being trapped in a situation in which they do not agree with the treatment regimen. In an article about recommendations on how to manage "inherited patients" on long-term opioid therapy, Gourlay and Heit noted:

> A very real barrier to undertaking the care of a new patient who is on a complex regimen of medications, especially opioids, is the fear that once they accept the patient into their practice, they will have no choice but to continue on with this course of therapy, even if all reasonable assessments would suggest that it is not optimal. [6]

Gourlay and Heit recommend that clinicians start with an initial visit of "mutual fact finding," in which the patient and clinician assess whether the relationship will be a good fit. Although the authors suggest a mutual process, most of their article concerns actions that the clinician should take, including assessing whether the opioid therapy is appropriate, whether the patient has psychiatric comorbidities, and whether the patient has a personal or family history of substance use disorder or an active substance use disorder [6].

Despite these recommendations, it is not well understood how clinicians approach managing "inherited patients" in practice. The literature on managing "inherited patients" is scant. Owston also recommends an initial assessment with a thorough history, review of previous records, and assessment of risks for overdose, diversion, or abuse [31]. Understanding this process can provide insight into what Gourlay and Heit refer to as not only a problem for patients, but also:

> ...a societal problem.... When legitimate pain patients are deprived of the opioid medication they have been taking, this can lead to an immediate crisis situation.... Patients traveling long distances to obtain medication, frequenting multiple emergency departments or walk-in clinics, or engaging in frank criminal behavior may be a direct result of these patients trying to solve this problem. [6]

Although previous studies highlighted the potential consequences of clinicians' reluctance to prescribe opioids, a lack of insight into the reasoning behind this reluctance and how clinicians acted on this reasoning warrants investigation. Therefore, the purpose of this analysis was to understand how clinicians in outpatient settings made decisions about assuming opioid prescriptions for new patients on long-term opioid therapy.

Methods

Setting and Sample

We used several sensitizing (guiding) concepts [32] to develop potential lines of inquiry, and this was reflected in our sampling methods. Thus, we sought to interview clinicians with different levels of experience, practice settings, payment models, and specialties to capture a wide range of experiences. We sampled clinicians who worked in various outpatient settings in the greater Southern California metropolitan area, including private concierge-style practices or those who accepted only limited insurance plans, such as Medicare and Preferred Provider Organization (PPO) plans, Health Maintenance Organization (HMO) groups, a specialized pain center, and an academic medical center. Some clinicians worked in more than one of these practice settings. After gaining approval from the Institutional Review Board at the study site, we used theoretical sampling [33] to identify potential study participants in the following specialties and with different types of experiences based on training and setting: internal medicine, family medicine, neurology, rheumatology, physical medicine and rehabilitation, and pain medicine (outpatient anesthesiology and dentistry with a specialization in pain medicine). Theoretical sampling allowed us to maximize opportunities to discover variations among concepts and to create rich, dense categories [34]. For example, based on early interviews with pain specialists and primary care clinicians, we sought to include more clinicians of each specialty in our sample to explore why clinicians with training in these two areas had substantially different perceptions of opioid medications and patients already on opioid medications. We excluded clinicians in the emergency department and surgical specialties, given that opioid prescribing in these settings is very different and subject to other guidelines.

We e-mailed 167 potentially eligible clinicians within the medical system. Clinicians were offered $250 to participate. A total of 33 clinicians replied to the e-mails. We interviewed 33 clinicians: One worked solely in the inpatient setting as a hospitalist but had prior experience working in the outpatient setting. For this analysis, 32 eligible and available clinicians reported that they currently worked in an outpatient setting, so data from these interviews were included in this analysis. We used theoretical saturation to determine when we had reached sampling sufficiency: in other words, when categories were fully developed with regards to properties and dimensions and demonstrated variation [35].

Interviews

The first and second authors (MSK and AJ) conducted the interviews from July 2016 to February 2018 at clinicians' offices or in a private room at the researchers' offices. We discuss reflexivity and positionality in Appendix I. Interviews were 60–120 minutes in length (median = 60 minutes). Two researchers were present at every interview, with the exception of four interviews, where logistical challenges made it difficult to have both present. Memos and transcripts were shared among the two interviewers to provide context and information about the interviews where only one interviewer attended. While repeat interviews were not part of the initial study design, one clinician was interviewed twice in order to gather more detailed data. This study participant provided a different perspective compared with the previous interviews, and we pursued this line of inquiry further via a second interview. The overarching research question for the study was as follows: How are clinicians making decisions about prescribing opioids during this opioid epidemic? We designed a loosely structured interview guide with topics to address this study question, including the proportion of patients in the provider's patient population with chronic pain and on chronic opioid therapy,

the assessment and treatment plans for various types of acute and chronic pain, factors influencing the decision to prescribe medications for pain, views on the appropriateness of opioid medications for chronic pain, discussions with patients about pain medications, recent prescribing interactions, and use of risk mitigation strategies for opioid prescribing. Sample questions are available in Appendix II. The interview guide changed as we followed lines of inquiry [36]. A professional transcription service transcribed all interviews, and the transcriptions were checked for accuracy. All identifying information was changed to protect confidentiality.

Coding and Analysis

We used constructivist grounded theory to guide the coding and analysis for this study [32,37,38]. The first author (MSK) coded the first 10 interviews using line-by-line coding (i.e., "initial coding") to identify preliminary reoccurring and significant codes (i.e., "focused codes"). The last author (MH) reviewed and checked the initial codes. Coding is viewed as a way to sort, summarize, and analyze each piece of data [32]. The first 10 interviews were completed and coded before any further data collection occurred. This allowed us to identify preliminary lines of inquiry, and we modified our interview guide based on these ideas. Moreover, based on the preliminary codes, we wrote memos that identified potential focused codes, which are more conceptual codes that identified significant ideas or themes within the data. For example, one focused code captured how various clinicians used screening strategies to avoid seeing new patients who were looking for a clinician to take over their opioid prescriptions. We then proceeded to code the rest of the transcripts using the focused codes (thematic codes), adding to the codebook when new focused codes (themes) were identified. Throughout the rest of the process, we wrote memos using the constant comparison method that is core to constructivist grounded theory, identifying areas where there were similarities, variations, or differences in the data [32,36,39]. The other research team members (AJ, JN, TN) reviewed the categories as they were constructed and developed and provided feedback on the analysis and interpretation.

Results

Study Participants

Data from 32 clinicians were analyzed in this analysis, including data from 17 internal medicine physicians, three family medicine physicians, one primary care nurse practitioner, four rheumatologists, two neurologists, three anesthesiologists, two dentists with additional training in pain medicine, and one physical medicine and rehabilitation physician (Table 1). Primary care clinicians worked in different roles: some primary care clinicians worked solely in urgent care clinics, four practiced in both the urgent and primary care settings, and the majority worked in primary care clinics. Specialty care clinicians worked in outpatient clinics. Clinicians in our sample served patients from predominantly middle- and upper-class neighborhoods. Clinicians ranged in level of experience, from having only two to three years out of residency to greater than 40 years of practice experience. When attributing quotes or experiences in the results, we have obscured the gender of the study participants to protect confidentiality.

Table 1. Clinician Participant Characteristics (N = 32)

Mean years in practice, mean (range)	19.1 (2–40)
Sex, No. (%)	
Male	18 (56)
Female	14 (44)
Clinician specialty, No. (%)	
Primary care (e.g., internal medicine, family medicine)	20 (62)
Pain specialist (e.g., anesthesiology, DDS with residency in pain medicine)	6 (19)
Non–pain specialist (e.g., neurology, rheumatology)	6 (19)
Practice type[a]	
Health Maintenance Organization Group	17 (53)
Private practice	8 (25)
Faculty	3 (9)
Pain clinic	5 (16)

[a]Totals may exceed 100% due to individuals in multiple categories.

Willingness to Manage Patients on Chronic Opioid Therapy: A Continuum

We identified a continuum of willingness to take on patients who were on chronic opioid therapy, from clinicians who were strongly opposed to those who were more accepting. Based on this continuum, we identified three categories of clinicians, which we summarize in Table 2 and Figure 1. One group, the *Staunch Opposers*, was highly averse to taking on new patients already on chronic opioid therapy. These clinicians, mostly pain medicine specialists, used a variety of strategies to screen out patients whom they suspected were looking for a new prescriber. *Cautious and Conflicted Prescribers* were generally uneasy about prescribing opioid medications for chronic pain but willing to manage new patients if they were trustworthy or if the dose and medication type fell within their preset "comfort zone." The *Rapport Builders*, mostly primary care physicians, were the most willing to assume a new patient's opioid prescription, even if the prescription was for a high dose. These clinicians were strategic in their approach to transitioning patients to safer doses, working to form a strong clinician–patient bond before introducing the idea of reducing the dose or tapering down medications. We describe these three groups in detail below.

Staunch Opposers

Clinicians identified as Staunch Opposers expressed a high aversion to managing new patients already on

Table 2. Clinician approaches to assuming opioid prescriptions for new patients on opioid therapy

Staunch Opposer	Conflicted and Cautious Clinician	Rapport Builder
• Highly averse to managing new patients on chronic opioid therapy • Implemented strict no-opioid or low-opioid prescribing policies • Used strategies to screen out patients seeking opioid refills • Felt that patients on chronic opioid therapy were "dumped" on them by other clinicians • Perceived patients on chronic opioid therapy as time-consuming, difficult, outside of their clinical interests	• Hesitant and conflicted about assuming prescriptions for patients on chronic opioid therapy • Assessed whether patient was trustworthy before starting prescriptions • Relied on trusted referrals before taking on new patients • Scrutinized legitimacy of patients' chronic pain • Also felt that other clinicians "dumped" patients on chronic opioid therapy on them	• Willing to take on patients already on high doses of opioids, seeing the new relationship as an opportunity to transition patients to a safer dose • Emphasized shared decision-making when managing opioids • Prided themselves on close relationships with patients • Embraced the management of psychosocial issues in relation to chronic pain treatment • Ascribed poor opioid prescribing and management to other clinicians, not patients

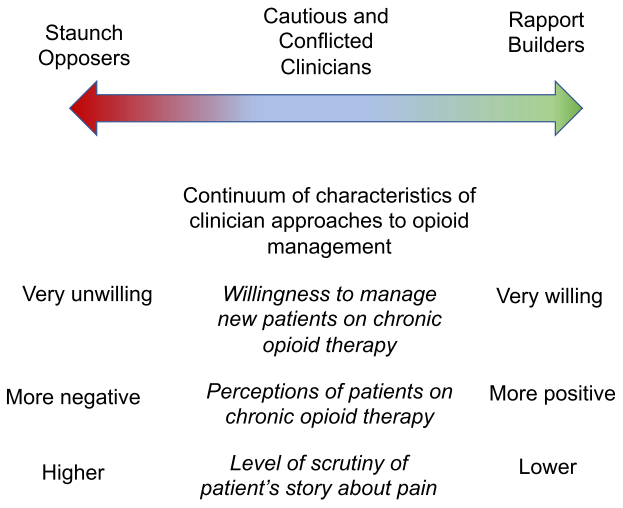

Figure 1. Continuum of clinician approaches to opioid management.

chronic opioid therapy. These clinicians sought to distance themselves from patients on chronic opioid therapy by prescreening patients or making their opposition to opioids apparent in the first visit. For example, one rheumatologist who noted that they didn't "like to provide narcotics" explained how they approached new patients: "I give [patients] a disclaimer right up front that I'm not the right doctor to come to if you just want a prescription for your pain pill." Several clinicians working in a pain center setting, including anesthesiologists and dentists with specialized training in pain medicine, described using a structured screening process involving medical assistants or front desk staff to assess whether patients were looking for a new provider who would continue their opioid medications. Most of these clinicians had implemented strict no-opioid or low-opioid policies and instructed their staff to ask questions about a patient's reasons for the visit. Clinicians described how their medical staff would communicate their no-opioid policies to patients, either specifically noting the policies or noting that the first visit was a consultation and that patients should not expect them to refill a medication. One clinician summarized their approach:

> I mean, if the patient calls [for] an initial consult, at least I know my assistant then will tell the patient that this is not how I practice, and I don't prescribe narcotics, so if they're coming for that purpose, then they'll just be let down from the get-go.

This prescreening strategy allowed clinicians to assert their autonomy not to prescribe before the patient ever walked in the door, which they noted was preferable to having to say "no" in person. Clinicians described pushing back against a patient's demand for a refill, particularly when the request was for a regimen the clinicians did not find acceptable. One anesthesiologist explained:

> [Patients will] come with high-dose narcotics, and they expect, 'Oh, you're just gonna refill my narcotic.' No, I'm not. Whatever they've been doing maybe wasn't right, and I'm not agreeing with that plan. So, yeah. I don't have to.

Anesthesiologists and other pain specialists in the Staunch Opposer group also perceived that patients were "dumped" on them by other clinicians, and participants resented this action. This dumping was reportedly done by surgeons and other primary care clinicians who no longer wanted to prescribe opioids. One pain specialist explained: "Some internists, they just wanna dump the patient. They don't wanna deal with them. . . . If it's a dump, they just want us to take over, and [if] we don't, they get upset." This clinician and other participants said that they often did not agree with the current dose or frequency and that it was very challenging to taper patients down if the patients did not want to do so. By setting no-opioid policies, participants were able to assert their clinical autonomy not only with patients, but also with other clinicians.

Several Staunch Opposers said they perceived managing patients on chronic opioid therapy as time-consuming, difficult, and not within their clinical interests. They therefore preferred to refer those patients to other physicians. One primary care physician explained that they found patients on chronic opioid therapy to be "a pain—excuse the pun—to manage." This participant

described inheriting several patients already on chronic opioid therapy who typically had severe pain conditions and the various reasons they preferred not to manage their prescriptions and conditions:

> Those are very difficult, and those are the ones [that] generally I'll refer to pain management. But because I think to properly manage these patients, it takes more than the usual 15-minute office visit.... [It takes] a dedicated approach that focuses on pain management, and it's a very difficult group of patients, and, frankly, it's not one of my interests.

A neurologist echoed this sentiment, saying that while they previously had managed a few patients on chronic opioid therapy, they had switched their practice to doing more specialized tertiary care. This clinician said the reason they declined new patients on chronic opioid therapy was not "because of all the craziness that's going on about the opioid epidemic" but rather because "it's not what I want my role to be."

Most of the Staunch Opposers perceived opioid medications as largely ineffective for chronic pain, noting that the medications not only failed to address the pain but also often caused other problems, such as side effects or increased pain. One clinician emphasized that they would "never give narcotics to somebody with chronic migraines.... If you look at chronic migraines, it's the biggest no-no, since that's going to cause more relapse." Other clinicians pointed to the adverse effects of opioid medications as reasons for their aversion to prescribing. One primary care clinician explained: "I'm concerned about the adverse effects, and also in the older people, all you've got to do is give them severe constipation, and you can have a problem that's as bad as what you used the narcotic for in the first place."

Staunch Opposers also questioned the legitimacy of patients' needs for the medications or viewed their use as problematic. One primary care clinician noted that "the majority of people who are not drug addicts don't like to take [opioids].... [The people who] every day, they're popping six tablets a day, they're hooked!" This clinician perceived that patients on chronic opioid therapy were often on multiple opioid or benzodiazepine medications, some of which the clinician viewed as inappropriate. They recalled covering for another clinician who had patients whom the clinician described as "Triple V," meaning that they would call on a Friday at 5 PM for their Vicodin (an opioid), Viagra (an erectile dysfunction medication), and Valium (an antianxiety medication). The clinician found the request for the combination of all three medications concerning and questioned whether the patients really needed these medications.

Cautious and Conflicted Prescribers

We characterized a second group of clinicians as Cautious and Conflicted Prescribers. These clinicians approached long-term opioid prescribing guardedly, both in terms of the types of patients they were willing to prescribe to and the approach they took when continuing prescriptions. Cautious and Conflicted Prescribers were willing to manage new patients on chronic opioid therapy if the dose or medication fell within their "comfort zone" and if they deemed the patient to be trustworthy to handle an opioid prescription. Their approach stemmed from a perception that opioids were ineffective for long-term use and harmful, and many explicitly expressed that they would not start a patient on long-term opioid therapy. A family practice physician said, "As far as a chronic pain patient who comes to me not on opiates, I'm never going to be the one to start that."

To appraise the trustworthiness of prospective new patients on chronic opioid therapy, Cautious and Conflicted clinicians scrutinized the legitimacy of the patient's pain and any existing evidence of potential misuse behavior. Whether the patient came from a trusted referral source or was self-referred played an important role in determining if clinicians would continue a prescription. For example, participants would agree to take on patients on chronic opioid therapy from "reliable," "legitimate," and "trusted" peers. One rheumatologist described their decision-making process:

> There was a patient who was 90 years old-ish and was on Norco, four a day, came to me from another physician who retired and had been on that medication for 15–20 years without changing the dose.... [The patient was] compliant in terms of getting the prescription, not requesting more than was asked for, and needs it because [the patient] has spinal stenosis and didn't seem altered in my meeting [with them].... So, although I'm not entirely comfortable giving a 90-year-old pain medication, it was the natural thing to do rather than stop it.

Self-referrals raised concerns, as clinicians were wary about why such patients were seeking a new provider. Cautious and Conflicted participants expressed trepidation that these patients may have misused or abused opioids or may have been discharged by their previous physician. They were also concerned that perhaps the relationship had soured with the previous clinician, which put them on edge. One internist noted:

> So when we see that new opioid patient, you know obviously we're not happy about that because we know that they failed with another primary care doctor already.

To understand what had happened with previous doctors, several participants asked for previous records, and if the patient reacted badly to the request, they refused to refill the prescription.

Cautious and Conflicted participants also assessed the legitimacy of the patient's pain when deciding whether to manage a new patient's opioid regimen, looking for whether patients had diagnoses that appeared severe or

whether they seemed to demonstrate high levels of pain. One rheumatologist described how patients' severe deformities guided the decision to continue opioid prescriptions. They said they typically got to know the patient over several months, and when they felt comfortable, they would take over the opioid prescriptions from the former prescriber:

> I have a small cadre of patients who are on opiates because their [rheumatoid arthritis] or even their degenerative disease is just so bad and so deforming and there are just no other options. And those are the patients [for whom] I will continue [the opioid medications].

Clinicians in the Cautious and Conflicted group expressed concern for the welfare of their patients on chronic opioid therapy, even when they were conflicted about whether the prescription was the ideal regimen for the patient. One internist explained why they continued to refill the medication for a new patient: "I'm his doctor now.... You can't leave 'em hanging out to dry." Primary care clinicians in particular expressed how important it was to develop a relationship with new patients to establish continuity of care for all their concerns. One family practice clinician stated:

> I mean, it's tricky because there are times when even though I feel like it may not be the optimal thing, I'll keep prescribing the medication because I do have this rapport with the patient, particularly if I'm seeing them about other issues. Because I don't want 'em to then [go] off the map for their other issues that I'm treating. You feel like you have a relationship with the patient, so there is sort of just this kinda sympathy thing.

However, the same clinician described conflicted feelings about prescribing long-term opioids:

> I'm trying to really limit it to that.... A lot of the patients who I deal with [on] chronic opioid therapy—it's patients whom I've inherited, from when I first started out in practice.... As a primary care doctor, I just don't want chronic opioid therapy to be part of my practice, to be honest.

Like those in the Staunch Opposers group, clinicians in the Cautious and Conflicted group also described feeling as though patients were "dumped" on them by other physicians. Numerous clinicians noted that they had inherited patients from surgeons who had started the opioid prescription but no longer wanted to continue prescribing—or, as one rheumatologist described it: "hit-and-run prescribing." Moreover, primary care clinicians described being asked by pain specialists to continue prescribing the patient's opioid medications once the patient was stabilized on a regular dose. Participants expressed their belief that many pain specialists were unwilling to continue opioid prescriptions for new patients because they had no incentive to do so. There was a perception among participants in the Cautious and Conflicted group that anesthesiologists preferred to perform procedures such as injections and nerve blocks, which are more highly reimbursed than doing office visits for opioid refills. Similarly, many participants, including anesthesiologists, felt that surgeons were not incentivized to provide follow-up pain management care for their patients given the low reimbursement rate for office visits. As a result, participants in this group spoke of the lack of trained and willing clinicians to manage patients on chronic opioid therapy as a "big hole in the system." One primary care physician described how patients on chronic opioid medications bounced around the health care system:

> It's very rare that you find a surgeon that will continue to follow up and manage your pain. They'll end up referring them to a pain specialist if that's the case.... But a lot of pain specialists don't do prescriptions, and then that's a frustrating area also.... Yeah, so then it's on us to handle the pain meds.

Rapport Builders

Our third group, characterized as the Rapport Builders, prided themselves on developing close relationships, working collaboratively with patients to decrease doses of opioids that they found unsafe, and feeling comfortable with managing psychosocial issues. Like the Cautious and Conflicted Prescribers, these clinicians expressed concern that their patients would be worse off if they did not continue the prescription. However, in contrast to the other groups, Rapport Builders were more willing to take on patients already on high doses of opioids, seeing the new relationship as an opportunity to transition patients to a safer dose. They worried that if they didn't become the new prescriber, the patient would end up with a clinician who would just refill the prescription without considering the patient's safety.

Heightened apprehension about where patients would end up played an important role in how clinicians in this group made decisions about managing new patients on chronic opioid therapy. One family practice clinician explained that they were willing to manage a new patient on opioids even if it wasn't a dose that made them "comfortable in any way, shape, or form." While the dose wasn't within their comfort zone, they worried the patient would end up in a worse situation:

> If you're not willing to refill that medication and then you're going turn that person on the street and say, 'I'm not going to be your primary care doctor,' well, then that's an opportunity you lost to transition someone to an appropriate pain control regimen. And if that person's motivated, they will find a doctor who's just gonna write the opioids for them and not care and just say, 'Come back every 30 days. I'll give you your script. We won't

talk, but I'll just continue refilling this for you.' There are folks out there that do that.

Other Rapport Builder participants has similar perceptions and perceived that some clinicians either just refilled the opioids without ensuring the patient's safety or refused to fill the prescription, effectively abandoning the patient. They used these anecdotes as a contrast to their own approach, which they described as collaborative and patient-centered. Unlike the Staunch Opposers, the Rapport Builders did not see chronic opioid use as a personal failure of the patient. Rather, Rapport Builders attributed the inappropriate opioid prescribing to their predecessors. One family practice clinician described how they believed patients often ended up on chronic opioid therapy:

I think what happens is if you fail a back surgery, the back surgeon either prescribes you a fentanyl patch or he sends you to his buddy down the street who's a rehab doctor, maybe a pain medicine doc, and you get on some of these things.

Participants in the Rapport Builders group acknowledged that others might see some patients as "drug seeking" or a "pain in the ass"; in contrast, they suggested that some patients may have been incorrectly diagnosed and therefore incorrectly treated with high doses of opioids. Finding the right diagnosis and helping the patient transition to more effective, nonopioid medications was perceived by Rapport Builders as highly rewarding. For example, one internist began seeing a new patient who was taking several strong opioids. They eventually identified a new diagnosis for the patient, who subsequently stopped taking opioid medications:

I found her rheumatoid arthritis, you know, got her the rheumatologist, got her treated, and, you know, so she's now back in the world off of all narcotics.

What also distinguished the Rapport Builders, aside from their willingness to take on patients' opioid prescriptions, was their overall approach to patient care. Several clinicians used language such as "I'm not the boss" as a descriptor of emphasizing patient autonomy and a shared decision-making process when discussing chronic pain treatment. These clinicians also described the importance of creating mutually trusting relationships with patients. One family practice physician described the importance of showing patients that they were open to building a relationship and demonstrated this by refilling a patient's opioid prescription:

I won't refuse a refill on someone who's been taking them for years and years and years. It's kind of like a bad way of starting a trusting relationship with someone that you just met by saying, 'Oh hey, I'm the boss here, and I think things should go this way, and you're going to listen to everything that I say.'

As part of this approach, Rapport Builders described not reducing high-dose opioid regimens until the relationship was established or, in some cases, until the patient was ready for a change. One family practice clinician described getting to know one patient over a year before the patient was ready to change to a less potent pain medication. The clinician explained their approach as working with patients with the goal of eventually reducing their medications:

It's like, there's psychological research on readiness for change, right? A year ago, they were not ready, or open or willing to look at something in a different way or to change, and then, at some future time, they were.

In addition, in contrast to other clinicians who often preferred to refer out patients with substantial psychosocial issues, Rapport Builders described embracing psychosocial approaches to pain management. One primary care clinician described working with one patient regarding managing a stressful work situation while they were working on tapering down from a high-dose opioid prescription. The clinician, who used a biopsychosocial approach to chronic pain treatment, slowed the taper, added several adjuvants, including gabapentin, and waited until the patient felt their work situation was more manageable. This clinician had patients regularly write in a journal about various stressors in life and worked with them to address how the stressors were affecting their physical symptoms, including pain severity. Another clinician spoke about how they felt it was part of their role to listen to patients' emotional and psychological concerns and to help them address these problems:

It's hard because those folks come in with a big emotional overlay, and the other thing that I find is that if you spend a few minutes actually talking to people and you find out what their lives are like at home. I mean it's pretty nuts the way a lot of people are forced to live. The lack of supports, lack of services.

This clinician and others also noted that it was important to help patients feel as though clinicians believed in the source of their pain, as it helped foster mutual trust and opened the door to more honest and open dialogue.

In sum, we found that participants in the Rapport Builder group weren't necessarily in favor of keeping patients on high doses of opioids, but they were the most willing of the groups to continue prescriptions for new patients on chronic opioid therapy. Rapport Builders also ascribed responsibility for the high-dose regimens to other physicians instead of the patients. The Rapport Builders, who were mostly primary care clinicians, worked to establish relationships with patients before trying to reduce the doses, using an approach aimed at empowering patients to manage their care, and described

supporting patients through nonmedical situations that affected their ability to manage chronic pain.

Conclusions

In this qualitative analysis of data from 32 clinicians working in outpatient settings, we used grounded theory methodology to identify a continuum of how participants made decisions about assuming opioid prescriptions for new patients already on chronic opioid therapy. On the continuum were three groups, including the Staunch Opposers, who were highly averse to managing new patients on opioids, the Cautious and Conflicted Prescribers, who were willing to continue prescriptions if they perceived that the patient was trustworthy and on low and stable opioid therapy, and the Rapport Builders, who were open to assuming the prescriptions for new patients already on opioid therapy even if patients were on high doses. We found that most clinicians in our sample, including those in the Staunch Opposers and Cautious and Conflicted groups, were unwilling to assume a new patient's existing opioid prescription and that some clinicians screened out patients seeking refills. We also found that many clinicians had negative perceptions of patients on opioid regimens, often viewing patients as drug-seeking or difficult. The Rapport Builders, on the other hand, emphasized building relationships and working collaboratively with patients to reduce doses.

That many clinicians may be unwilling to manage patients on existing opioid regimens suggests that there is an important gap in the health system with regard to managing opioid prescriptions, especially for patients who require more complex tapering regimens and intensive chronic pain management. We found that primary care and non–pain specialty clinician participants in the Staunched Opposers and Cautious and Conflicted groups described feeling frustrated that specialists with training in pain medicine did not want to take over opioid prescribing for complex patients or for patients on high doses. On the other hand, pain specialists (typically Staunch Opposers) felt that certain clinicians, including primary care clinicians and surgeons, prescribed too many opioid medications and then "dumped" the patients onto pain specialists. These findings suggest that our health system lacks clarity on the management of pain and pain-related prescriptions, particularly in cases where acute pain evolves into chronic pain or where there are acute exacerbations of chronic pain. There are few mechanisms or tools available for providers working with patients in these types of situations, and care coordination is often lacking. Other qualitative studies have found that clinicians treating pain feel frustrated with the lack of consistent information flow [40], collaboration [41], and differences in training [41] between different care settings. Patients also report frustration with lack of coordination between care settings for pain management (e.g., surgery and primary care), and researchers have found an association between poor care coordination for pain and worse clinical outcomes [42].

We found that the patient-centered chronic pain management approach used by the Rapport Builders touched upon how chronic pain was influenced by and had an influence on socioeconomic and psychological conditions. These clinicians espoused a biopsychosocial model of pain management, which posits that social and psychological factors are critical to how pain is perceived and how it can be treated [43–46]. There is a substantial body of literature demonstrating how psychological and social interventions can reduce pain-related disability, improve coping resources, and reduce emotional distress [46]. Training clinicians to offer or refer patients to interventions such as biofeedback, relaxation training, guided imagery, and other biopsychosocial approaches may assist patients in managing chronic pain and being more open to reducing opioid doses over time. Additionally, clinicians might partner with social workers to support patients with issues surrounding pain self-management and social determinants of health that affect the experience of chronic pain [47,48]. Ensuring that these services and interventions are accessible and reimbursed is critical to improving how chronic pain is treated and managed.

With the large number of patients now on chronic opioid therapy, ensuring ongoing access to medical care (whether to continue or taper opioids) will be important to reduce the number of patients at high risk for adverse events. Some patients may have even greater difficulty finding a clinician willing to take on their opioid prescriptions, such as those who do not have a referring provider because of conflicts with a previous doctor or a move to a new area [11,30]. If clinicians are unwilling to prescribe opioids to these patients, they may go into withdrawal or turn to street drugs. For those developing opioid use disorder—a chronic, progressive disease—lack of high-quality treatment may lead to overdose or death [49]. Low reimbursement rates for managing chronic opioid therapy and opioid dependence may impede proper care, and specialists may opt to focus on performing more remunerative procedures instead of managing prescriptions [50]. Thus, insurance payers and health systems should consider developing incentives to encourage clinicians to take on new patients on chronic opioids so that their pain is better managed and they are maintained on safer doses of opioids or tapered off opioids, as indicated. One potentially effective incentive would be higher reimbursement rates for Evaluation and Management services dedicated to managing chronic pain and/or opioid dependence.

Additionally, our analysis touches on the stigma of patients with chronic pain, who are on opioids, or who have substance use disorders. Many participants in our sample were reluctant or, worse, unwilling to see individuals on long-term opioid therapy. Clinicians may have internalized stigma about treating patients on chronic

opioid therapy. This is in line with a prolific literature on clinicians' ambivalence related to treating chronic pain [51–54]. As Trait and colleagues (2009) noted in a review about provider judgments of patients in pain, clinicians tend to have more negative attitudes about patients with chronic pain [53]. Patients with chronic pain report feeling that clinicians see them as drug-seeking or malingering [55]. Other studies have also found that clinicians attribute problems with pain care and opioid prescribing to patients, even as they recognize that there are existing systemic issues in how chronic pain is managed [55]. Additionally, in many chronic pain situations, no clear diagnosis exists for the patients' pain, leading to higher levels of suspicion about the legitimacy of the pain and the appropriateness of pain medications—or even administering treatment for substance use disorder [51,56–58]. Patients with chronic pain or opioid use disorders also have an increased likelihood of depression, anxiety, and other mental health conditions, which may further complicate appropriate care. To avoid the many issues associated with prescribing opioids, many clinicians in our study developed strategies, including setting clear boundaries around the doses of opiates or opioid medications they would prescribe—or whether they would prescribe opioids at all. However, these strategies may leave many patients already on opioid therapy without access to care.

Clinicians often feel low self-efficacy and little professional satisfaction in treating chronic pain and find that opioid tapering is emotionally charged and exhausting [51,54–56,59]. Moreover, there is little evidence available to guide clinicians on the reduction or discontinuation of long-term opioids, making this process more difficult [60]. Better training regarding opioid prescribing and tapering may help clinicians feel greater confidence in treating patients already on chronic opioid therapy. There is early evidence that Motivational Interviewing, a brief intervention aimed at understanding how individuals make sense of their chronic illness, could be used to increase prescription opioid adherence [61], which could further promote trust-building between patients and clinicians. Using these types of interventions could increase clinician satisfaction with prescribing and tapering opioids. Policies that support training and management of safe and appropriate opioid management and tapering could increase the number of clinicians willing to manage patients already on opioid medications.

The decision to add new patients to one's practice and assume existing prescriptions touches on the issue of clinical autonomy, or the right of medical professionals to control their clinical performance [62]. Prescribing, in particular, is an activity that differentiates physicians from many other clinical professionals and is thus a core component of clinical freedom [62]. Moreover, prescribing opioids poses risks to clinicians as well as patients. Recently, there have been several news stories about physicians being found to be not only negligent but also criminally liable for prescribing opioids [63]. As some have noted, the act of prescribing (or not prescribing) can thrust clinicians into conflict with those who threaten their autonomy. The act of refusing to prescribe opioids may be an assertion of clinical autonomy on the part of certain clinicians within our study. Perceptions of patient expectations about prescriptions are also thought to play an important role in clinician behavior. Bitten and Okomunne (1997) found that physicians' perceptions of their patients' expectations to prescribe were the strongest predictor of their final decision to do so [64]. Several clinicians in our sample spoke of having new patients who expected their opioid prescription to be refilled, and clinicians' screening practices may be an attempt to push back against this patient demand. Interventions designed to assist clinicians with setting appropriate boundaries while managing patients on chronic opioid therapy may help clinicians retain feelings of autonomy while increasing access for patients.

Our analysis has some limitations. The clinicians who participated in our study serve patients of middle-to-high socioeconomic status in an urban area, so the results may be more applicable to clinicians in similar settings. We focused on interviewing clinicians in nonemergency, nonsurgical settings because surgeons and emergency clinicians have different guidelines for prescribing, and we thus felt that their prescribing behavior was outside the scope of our study. Still, as a result, our analysis does not include surgeons' and emergency physicians' perspectives on seeing patients on chronic opioid therapy. Another limitation is that while our sample size includes a diverse group of providers from different specialties and settings, it is too small to make strong distinctions between provider types. Finally, we did not have other sources of data (e.g., quantitative data about number of patients on opioids or on high doses of opioids) to triangulate our findings.

In conclusion, provider concerns and judgments may be contributing to significant systemic issues that affect access for patients on chronic opioid therapy. Our findings provide a basis for designing future research with a much larger sample to corroborate and extend our results. If confirmed, our results foreground a specific need for addressing providers' fears and concerns related to the care of patients on opioids.

Improving pain management training for clinicians in different specialties that focuses on identifying and reducing the stigma surrounding this patient population is needed to address the increasingly complex situation of caring for patients with chronic pain. In addition, given that chronic pain and behavioral health disorders are often comorbid, clinicians with training in both fields are needed to address this population. As many chronic pain and behavioral health conditions are treated in the primary care setting, this may entail the need for

additional incentives and training for primary care providers to improve the quality of care for patients with chronic pain.

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