

CASE AND COMMENTARY

How Should a Physician Respond to a Patient's Pain When New Opioid Prescribing Laws Limit Shared Decision Making?

Alexander J. Hjelmaas, MD and Christian J. Vercler, MD, MA

Abstract

This commentary responds to a case and examines pragmatic concerns about operating a busy outpatient practice in compliance with new laws that regulate opioid prescribing. Specifically, the article considers how regulating opioid prescribing can influence the therapeutic alliance in patient-physician relationships and how innovations in decision science can facilitate shared decision making given time constraints.

Case

LJ is a 64-year-old woman with a history of hypertension, osteoporosis, and major depressive disorder who fractured her left tibia and fibula and had an open reduction and internal fixation 12 weeks ago. Since the operation, she has been taking oxycodone for pain, and though she has reduced the number of pills she takes from 2 every 6 hours to 1 every 8 hours, she still feels it's helpful to take 2 pills before bedtime each night to sleep. At her follow-up visit, her radiographs do not definitively show complete healing. Since it is difficult to determine whether there has been adequate healing of the bone, a decision is made to have her continue physical therapy and follow up in one month with more radiographs. She is running low on oxycodone and requests more to get through the next 4 weeks.

Her surgeon, Dr M, is concerned that LJ still requires 2 pills at night and worries that LJ is developing opioid dependence. Dr M is running over an hour behind clinic schedule, and new state opioid prescribing laws now require more paperwork and counseling with a patient before prescribing more oxycodone this long after an operation.

Dr M feels conflicted: LJ might not be fully healed from her injury and could be experiencing ongoing pain from an unhealed fracture, or LJ could be developing opioid dependence. Ordinarily, Dr M would prescribe more oxycodone, but new laws have made normal practice less expedient. It has also been Dr M's typical practice to engage in shared decision making with patients when prescribing narcotic pain medications. Now, however, she is unsure how to balance her obligation to follow new legal requirements with her obligation to take a patient's claim of pain seriously. Dr M considers how to respond.

Commentary

When helping LJ, Dr M should be conscious of potentially conflicting ethical principles. For example, Dr M should consider that providing a refill would likely express respect for LJ's autonomy and do good by offering pain relief and enabling continuation of LJ's physical therapy. Dr M would likely weigh these autonomy and beneficence concerns against nonmaleficence: by not prescribing opioids, Dr M could help LJ avoid suffering opioid dependence and substance use disorder. Additionally, Dr M could consider the principle of justice and whether prescribing more opioids for this particular patient at this particular time could constitute overprescription that exacerbates an [ongoing crisis](#). The situation faced by LJ and Dr M is a common one in outpatient practice in the United States and presents several conflicts for both physician and patient.

More Options

It seems reasonable for Dr M to prescribe more opioid medication for LJ in hopes that it would support this patient's continued healing and physical therapy. Adequate pain control in the short term can lead to long-term, opioid-free pain relief. The indication, after all, was for an acute bone fracture and LJ's pain seems to be secondary to inadequate healing of the fracture.

However, in opioid-naïve patients, recovery from surgical pain frequently leads to long-term opioid use¹ and dependence. Prescription of opioids for nonchronic pain has increased in recent years in the United States,¹ which now faces a crisis of widespread opioid misuse. According to the Centers for Disease Control and Prevention, there were 47 600 deaths related to opioid misuse in 2017, representing an astonishing 67.8% of all drug overdose deaths.² In the same year, more than 191 million opioid prescriptions were filled in the United States.³ These facts, surely known to Dr M, would give her good reasons to recommend alternatives to continued opioid therapy.

Dr M could recommend an opioid taper and non-opioid pain medications, such as acetaminophen or nonsteroidal anti-inflammatory drugs, assuming LJ has no contraindications for such therapies. While an opioid taper could be helpful, particularly given Dr M's concern that LJ is developing dependence, several considerations suggest that continuing opioid therapy could also be appropriate. It will be important for Dr M to gather more information about LJ's opioid use and, ideally, engage LJ in a process of shared decision making to arrive at a treatment plan.

Shared decision making (SDM), a component of patient-centered care, has been defined by Elwyn et al as "an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences."⁴ By upholding the principles of respect for autonomy and beneficence, SDM facilitates more meaningful

and appropriate informed consent.⁵ Several studies have demonstrated SDM's benefits in the context of opioid prescribing. SDM can reduce opioid use⁶ and increase physician satisfaction in prescribing opioids for patients with chronic pain.⁷ Moreover, the finding that patients and clinicians offer conflicting narratives about chronic opioid therapy underscores the special need for SDM among these patients.⁸

Opioid Start Talking Form and Shared Decision Making

In Michigan, recently passed laws^{9,10,11,12,13,14,15,16,17,18} concerning [outpatient opioid prescribing](#) seek to reduce opioid misuse, addiction, and diversion; prevent opioid overdose deaths; and eliminate inappropriate practice. These laws' provisions for opioid management include providing patients who have experienced an overdose with information about substance use disorder and available services. However, for the purposes of our case discussion, we will focus on the relevant portions of the laws that affect Dr M's prescription of opioids for LJ.

Michigan Public Acts passed in 2017 require prescribers to review with patients the dangers of opioid addiction, how to properly dispose of unused opioids, and that distribution or diversion of opioid medication is a felony.⁹ Prescribers must also review with pregnant patients the risk of exposing a fetus to an opioid.⁹ That prescribers reviewed this information must be documented on the Opioid Start Talking consent form and in the patient's health record.⁹ The Opioid Start Talking form includes patient identifiers, type and quantity of a prescribed drug, and patient acknowledgment that risks, benefits, and proper medication management were reviewed by the prescriber. Additionally, if prescribing more than a 3-day supply of an opioid, prescribers must obtain and review a report from the state's prescription drug monitoring program.¹¹ (In Michigan, this program is known as the Michigan Automated Prescription System.)

How might these laws affect a prescriber's ability or willingness to engage in SDM? Despite its time requirement, the Opioid Start Talking form could be used to facilitate SDM during outpatient encounters. Implementing patient-provider agreements to define patients' roles and responsibilities while using opioids has been shown to be helpful in presenting risks and benefits and in making decisions about treatment.¹⁹ These and other patient-centered approaches improve patient outcomes and satisfaction,^{6,7,8} and, ideally, the administrative and logistical burdens imposed by the new laws would not prevent clinicians from engaging in SDM. However, because these burdens exacerbate time constraints within which physicians already work, they could threaten the patient-physician therapeutic alliance, which needs time and care to build and maintain.

Enter Decision Science

Developments in decision science can help clinicians implement SDM within an increasingly [time-constrained clinic schedule](#). Several decision support techniques, for example, have been inspired by behavioral economics.²⁰ *Choice architecture* is one such

technique described by Moore et al as “the art of shaping decisions by designing choices within a framework that will encourage a certain choice.”²¹ Imagine that Dr M prefers a particular treatment plan for LJ and still wants to use SDM to foster a therapeutic alliance within the constraints of her clinic schedule. One technique in particular—*nudging*—can be especially useful in facilitating SDM in such circumstances.

Nudges can be used to frame decisions about the appropriate treatment without eliminating patient choice.²¹ For example, whether Dr M tells LJ that “continuing your current opioid prescription has a chance of leading to opioid dependence in 15% of cases” or “continuing your current opioid prescription will not lead to dependence in 85% of cases” can influence how LJ frames the decision and chooses to proceed. Dr M’s choice of which phrase to use during shared decision making with LJ would enable LJ to retain decision-making authority and Dr M to bring to bear her clinical expertise and experience.

Although nudges might seem to undermine patient autonomy, Aggarwal et al note that paternalism and autonomy are extremes “not compatible in a ... moral health care environment” and that “some compromise of these values is unavoidable.”²² Fridman et al found that both physicians and nonclinicians viewed using nudges to overcome patient decision-making biases more positively than not using a nudge.²³ Nevertheless, the ethicality of nudges is context dependent, and prescribers should use language to influence the formation of patients’ perspectives and decisions only to promote patients’ best interests.

Framing and Therapeutic Alliance

If Dr M prescribes more opioids for LJ, the approach she takes will influence the nature of her relationship with LJ. Clinicians are not typically required to complete forms when prescribing, and some patients might be offended that their physician requires their signature on a form explaining that dealing opioids is illegal. The Opioid Start Talking form must be thoughtfully introduced and framed to prevent the form from becoming a symbol of distrust or suspicion. However, it should be noted that Tobin et al question the language used in an analogous form, the patient-provider agreement (ie, “pain contracts” for patients receiving chronic opioid therapy), which seems to stigmatize the patient and thereby risk undermining patient-clinician trust.²⁴ Although the Opioid Start Talking form could facilitate shared decision making in some cases, it could threaten the therapeutic alliance in others. Framing the Opioid Start Talking form in terms of shared decision making about opioid management for pain care could help avoid distrust.

References

1. Sun EC, Darnall BD, Baker LC, Mackey S. Incidence of and risk factors for chronic opioid use among opioid-naïve patients in the postoperative period. *JAMA Intern Med.* 2016;176(9):1286-1293.

2. Scholl L, Seth P, Kariisa M, Wilson N, Baldwin G. Drug and opioid-involved overdose deaths—United States, 2013–2017. *MMWR Morb Mortal Wkly Rep.* 2019;67(5152):1419–1427.
3. Centers for Disease Control and Prevention. *2018 Annual Surveillance Report of Drug-Related Risks and Outcomes—United States.* <https://www.cdc.gov/drugoverdose/pdf/pubs/2018-cdc-drug-surveillance-report.pdf>. Published August 31, 2018. Accessed April 2, 2019.
4. Elwyn G, Frosch D, Thomson R, et al. Shared decision making: a model for clinical practice. *J Gen Intern Med.* 2012;27(10):1361–1367.
5. King JS, Moulton BW. Rethinking informed consent. *Am J Law Med.* 2006;32(4):429–501.
6. Prabhu M, McQuaid-Hanson E, Hopp S, et al. A shared decision-making intervention to guide opioid prescribing after cesarean delivery. *Obstet Gynecol.* 2017;130(1):42–46.
7. Sullivan MD, Leigh J, Gaster B. Brief report: training internists in shared decision making about chronic opioid treatment for noncancer pain. *J Gen Intern Med.* 2006;21(4):360–362.
8. Esquibel AY, Borkan J. Doctors and patients in pain: conflict and collaboration in opioid prescription in primary care. *Pain.* 2014;155(12):2575–2582.
9. 2017 Mich Pub Act 246.
10. 2017 Mich Pub Act 247.
11. 2017 Mich Pub Act 248.
12. 2017 Mich Pub Act 249.
13. 2017 Mich Pub Act 250.
14. 2017 Mich Pub Act 251.
15. 2017 Mich Pub Act 252.
16. 2017 Mich Pub Act 253.
17. 2017 Mich Pub Act 254.
18. 2017 Mich Pub Act 255.
19. Pergolizzi JV, Curro FA, Col N, et al. A multicentre evaluation of an opioid patient-provider agreement. *Postgrad Med J.* 2017;93(1104):613–617.
20. Courtney MR, Spivey C, Daniel KM. Helping patients make better decisions: how to apply behavioral economics in clinical practice. *Patient Prefer Adherence.* 2014;8:1503–1512.
21. Moore SE, Ulbrich HH, Hepburn K, et al. Behavioral economics: a new lens for understanding genomic decision making. *J Nurs Scholarsh.* 2018;50(3):241–248.
22. Aggarwal A, Davies J, Sullivan R. “Nudge” in the clinical consultation—an acceptable form of medical paternalism? *BMC Med Ethics.* 2014;15:31.
23. Fridman I, Hart JL, Yadav KN, Higgins ET. Perspectives on using decision-making nudges in physician-patient communications. *PLoS One.* 2018;13(9):e0202874.

24. Tobin DG, Keough Forte K, Johnson McGee S. Breaking the pain contract: a better controlled-substance agreement for patients on chronic opioid therapy. *Cleve Clin J Med*. 2016;83(11):827-835.

Alexander J. Hjelmaas, MD is an anesthesiology resident at Northwestern University McGaw Medical Center in Chicago, Illinois.

Christian J. Vercler, MD, MA is an associate professor of surgery and the co-chief of the Clinical Ethics Service of the Center for Bioethics and Social Sciences in Medicine at the University of Michigan in Ann Arbor.

Editor's Note

The case to which this commentary is a response was developed by the editorial staff.

Citation

AMA J Ethics. 2019;21(10):E838-843.

DOI

10.1001/amajethics.2019.838.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

**Copyright 2019 American Medical Association. All rights reserved.
ISSN 2376-6980**