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## Police Officer, Deal-Maker, or Healthcare Provider? Moving to a Patient-Centered Framework for Chronic Opioid Management

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### Abstract

How we frame our thoughts about chronic opioid therapy greatly influences our ability to practice patient-centered care. Even providers who strive to be non-judgmental may approach clinical decision-making about opioids by considering if the pain is real or they can trust the patient. Not only does this framework potentially lead to poor or unshared decision-making, it likely adds to provider and patient discomfort by placing the provider in the position of a police officer or judge. Similarly, providers often find themselves making deals with patients using a positional bargaining approach. Even if a compromise is reached, this framework can potentially inadvertently weaken the therapeutic relationship by encouraging the idea that the patient and provider have opposing goals. Reframing the issue can allow the provider to be in a more therapeutic role. As recommended in the APS/AAPM guidelines, providers should decide whether the benefits of opioid therapy are likely to outweigh the harms for a specific patient (or sometimes, for society) at a specific time. This paper discusses how providers can use a benefit-to-harm framework to make and communicate decisions about the initiation, continuation, and discontinuation of opioids for managing chronic non-malignant pain. Such an approach focuses decisions and discussions on judging the treatment, not the patient. It allows the provider and the patient to ally together and make shared decisions regarding a common goal. Moving to a risk-benefit framework may allow providers to provide more patient-centered care, while also increasing provider and patient comfort with adequately monitoring for harm.

### Keywords

chronic non-malignant pain; opioid management; patient communication; patient-centered care

### Introduction

Many physicians strive to provide patient-centered, evidence-based care. Good intentions, however, often make way for frustration, tension, mistrust, and miscommunication in the

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setting of opioid prescribing for chronic non-malignant pain.<sup>1</sup> Patients may feel like they are being treated judgmentally or with suspicion.<sup>2-4</sup> Providers may feel trapped between threats from medical boards for the under-treatment of pain and from the Drug Enforcement Agency (DEA) for the irresponsible use of controlled substances.<sup>5,6</sup> Physicians may feel like they are put in the uncomfortable role of a police officer or judge, having to catch addicts and diverters who are out to fool them or having to judge whether a patient is telling the truth. Alternatively, they may find themselves bargaining with patients over how much opioid to prescribe, as if they were settling on a price for goods in a bazaar.

The American Pain Society (APS) and the American Academy of Pain Medicine (AAPM) have published excellent guidelines for the use of opioids in the setting of chronic non-malignant pain.<sup>7</sup> This paper discusses a framework that providers can use to translate the APS/AAPM guidelines into practical patient-centered care practices.

## Principles of patient-centered care

Patient-centeredness – one of the six dimensions of quality outlined in 2001 by the Institute of Medicine<sup>8</sup> – is increasingly regarded as a crucial component of healthcare delivery. Patient-centered care originated as a patient-communication approach characterized by the appreciation of each patient as a unique human being<sup>9</sup> with emphasis on involving patients in decision-making<sup>10</sup> and the associated communication skills of listening carefully, showing respect, and explaining things clearly.<sup>11</sup> Though there is no single agreed-upon definition, Mead and Bower describe 5 conceptual dimensions common throughout the literature on patient-centered care: 1) a biopsychosocial perspective (ie, understanding patients' illnesses within a broader biopsychosocial framework); 2) the "patient-as-person" (ie, understanding the individual's experience of illness); 3) sharing power and responsibility (including making shared decisions); 4) the therapeutic alliance (ie, emphasizing the importance of the provider-patient relationship, joint agreement over goals of treatment, and the patient's perception of the provider as caring and sympathetic); and 5) the "doctor-as-person" (ie, attention to the influence of the personal qualities of the doctor, as well as a self-awareness of emotional responses).<sup>12</sup> Patient-centered care has been reported to increase patient satisfaction,<sup>13-15</sup> as well as improve health outcomes in patients with conditions such as diabetes, hypertension, or HIV.<sup>16-19</sup>

Some aspects of patient-centered care intuitively apply to chronic pain management. For example, many have argued for the importance of using a biopsychosocial perspective when addressing chronic pain and attending to the individual's experience of chronic pain.<sup>20-23</sup> However, other aspects of patient-centered care may be more challenging in the context of chronic pain management. How should providers share power and responsibility with patients around the prescribing of controlled substances, where there is a potential for possible misuse, addiction, or diversion by the patient? How does a provider maintain a strong therapeutic alliance when he or she does not agree with a patient's demands for opioids? How should a provider handle his or her anger when a patient has lied or been dishonest about opioid use? Despite the inherent challenges, practicing patient-centered care is possible in the setting of chronic non-malignant pain, and may help alleviate both patient and provider discomfort. Two randomized trials found that training providers in a shared

decision-making model improves physician satisfaction in caring for patients with chronic pain<sup>24,25</sup>

## Frameworks for thinking about opioid use for chronic non-malignant pain

How we frame our thoughts and decisions greatly influences our ability to practice patient-centered care. Even providers who strive to be non-judgmental may approach clinical decision-making about opioids by considering if they can trust the patient, whether the pain is real, whether the patient is drug-seeking, or whether the patient deserves reprimand.<sup>26</sup> Not only does this framework potentially lead to un-shared or poor decision-making, it likely adds to provider discomfort by placing the provider in the position of a police officer or judge. Furthermore, it makes it very difficult to communicate decisions to limit opioid therapy without causing significant strain on the physician-patient relationship. After all, if the decision was based on judging the patient or the pain, then the provider has to explain a decision to limit opioid therapy by communicating (in as nice a way as possible) why the provider does not believe or trust the patient or his/her experience of pain.

Another common framework is that of bargaining. When discussing opioids, providers often find themselves interacting with patients using a framework that would be best described as “positional bargaining”<sup>27</sup> in the negotiation field. Positional bargaining assumes an adversarial relationship where the patient and provider have opposite goals, usually with the patient striving for as high an opioid dose as possible and the provider trying to limit opioids or using opioids as a bargaining chip for compliance with other desired behaviors. Even if a compromise is reached, this framework can potentially inadvertently weaken the therapeutic relationship by solidifying the idea that the patient and provider have opposing goals. Moreover, it can potentially encourage both parties to make more extreme demands (eg. asking for a higher dose or offering a lower dose of opioids), knowing that they will need to concede some of those demands in order to reach a compromise.

Reframing the issue can help providers get back to a more productive and comfortable therapeutic role. The question is not whether the patient is good or bad or whether the pain is real.<sup>28</sup> Nor is the goal to bargain for as low a dose of opioids as the patient will accept. *The question is whether the benefits of opioid therapy are likely to outweigh the harms for this specific patient (or sometimes, for society) at this specific time.* The APS/AAPM guidelines recommend performing a benefit to harm evaluation before initiation and on an ongoing basis during chronic opioids therapy.<sup>7</sup>

Table 1 shows a comparison of three common frameworks for thinking about opioids in the management of chronic pain. The benefit to harm framework is commonplace in medicine when making other decisions. For example, the potential risk of aspirin would be greater for a patient with a history of gastrointestinal (GI) bleeding than for one without. The potential benefit of aspirin depends on the patients’ cardiovascular risk factors and history of coronary artery disease. One’s threshold for how much benefit is expected to warrant prescribing aspirin would be higher for a patient with a history of GI bleeding than for one without. We would not bargain with a patient to use as little aspirin as possible, though we often do this with opioids. Similarly, asking whether a patient can be trusted to take opioids without

getting addicted is akin to asking whether a patient can be trusted to take aspirin without experiencing a GI bleed. Yes, a patient who has developed an addiction may potentially act in ways that diminish trust – for example, by being dishonest about his or her use of opioids – whereas a patient with a GI bleed may not. However, addiction should be recognized as a well-documented, adverse effect of opioids, not an inherent quality of the patient or a personal slight to the provider. In this manner, the main issue is not the physician’s trust in the patient, but a shared assessment of the potential benefits, the magnitude of risk, and an appropriate monitoring strategy for level of risk.

The benefit-to-harm framework can be used regardless of one’s individual views on the utility of opioids in managing chronic non-malignant pain. Providers may have different assessments of the level of benefit or risk in a particular case, and may make different judgments about how much risk is tolerable or how much benefit is needed to outweigh the risks. However, reframing the issue as a balance of the benefits and harms of treatments allows the provider to judge the treatment not the patient. It also changes the dynamic so that the provider and patient can ally for a common goal - maximizing benefit while minimizing harm. Working together toward a common goal is an important aspect of the therapeutic alliance dimension of patient centered care.<sup>12</sup>

As recommended in the APS/AAPM guidelines, clinicians and patients should regard treatment with opioids as a therapeutic trial.<sup>7</sup> It is very important that the trial is a test of *the therapy*, not a test of the patient. I find it helpful to discuss opioid therapy as a very imperfect treatment which we need to test to see if in fact it will provide enough benefits to be worth all its potential harms. The patient and provider should jointly discuss how to measure if the therapy is working and how to monitor for signs that it may be harming the patient. This shared decision-making is another critical dimension of patient-centered care.<sup>10,12</sup>

### Assessing and discussing benefits

It is important to clearly link decisions regarding the continuation of opioids not only to the absence of harm, but also to the demonstration of benefit. There is general consensus that chronic pain management should focus on functional goals, not pain scores.<sup>7,29</sup> However, standard assessments of function developed for use in research settings<sup>30</sup> may not necessarily measure the types of functional goals that are most important in a clinical setting. I find it most useful to measure benefit by helping the patient set his/her own personal goals – preferably ones that are “SMART”, i.e. specific, measureable, action-oriented, realistic, and time-bound. For example, a patient may decide to measure the benefit of increasing the dose of an opioid by seeing if it will allow her to do housework for 20 minutes a day and get out and see her grandchildren once a week. This type of goal-setting has been a core component of self-management for many other chronic illnesses.<sup>31</sup> Linking decisions to the demonstration of benefits reduces the need for the patient to prove that his or her pain is terrible in order to be assured that opioid therapy will be continued. (See Table 1.) It also helps the patient be more realistic about the expected benefits of therapy. Moreover, using personalized goals helps the provider better understand the patient as a

person, including how pain is affecting the individual's experience and what is most important to the patient.

## Assessing, monitoring and discussing risks

Opioid therapy entails multiple risks, including risks of sedation, confusion, constipation, gonadal dysfunction, hyperalgesia, opioid misuse, and addiction.<sup>7</sup> Numerous tools exist to assist clinicians in assessing risks related to opioid misuse or addiction.<sup>32–35</sup> However, studies have found that only a minority of providers discuss issues of substance abuse with patients on chronic opioids.<sup>36,37</sup> Providers may feel uncomfortable discussing addiction, as they may worry that it will interfere with the physician-patient relationship. Conversely, patients may be concerned about being seen as addicts.<sup>2</sup> When using a law enforcement mindset, both provider and patient concerns may be warranted since, in fact, the unspoken goal of the assessment is to catch addicts. The risk-benefit framework allows providers to talk about addiction as a risk of *the medication*, in the same way that they might discuss risk of constipation or sedation. I find that it is helpful to state outright that no one wants to be harmed by a medication and to ally with the patient on a common goal of protecting the patient from harm. I often assign responsibility for catching early signs of addiction to the patient. For example I ask them to notice if they are craving the medication or are having difficulty controlling their use of opioids. This empowers the patient and puts me in the position of supporting their desire to stay safe from harm. The Prescribed Opioids Difficulty Tool, a patient-centered scale for assessing possible harms of opioids, may serve as a particularly useful tool in facilitating discussions about harm from the patient's perspective.<sup>34,38</sup>

When using opioids, clinicians should always monitor for risks, using a consistent and systematic approach.<sup>7</sup> Such an approach may potentially include use of patient care agreements (also referred to as “contracts”), pill counts, or urine drug screening. In a law enforcement framework, patients and providers may feel discomfort using such tools since they may indicate that the provider does not trust the patient. However, in a risk-benefit model, such tools are not an indication of mistrust, but a strategy for protecting the patient from harms of the medication. I often use an analogy of monitoring liver function tests when prescribing statins, and explain, that in the case of opioids, we unfortunately have no simple blood test that can help us monitor for adverse effects of the medication, so we need to use a more complex and imperfect strategy.

In this context, patient care agreements become an important communication tool, not an uncomfortable clinic policy. I list what types of behaviors are known to be associated with increased risk of opioid misuse or addiction. I then explain clinic policies in the context of my responsibility to monitor for harm. For example, we have policies that patients can only use one pharmacy, that patients cannot obtain opioids from other providers, and that we will not grant requests for early refills. I acknowledge that there may be many justifiable reasons, unrelated to addiction, why a patient would, for example, go to more than one pharmacy or provider. However, I ask patients to refrain from such behaviors as they will interfere with my already limited ability to monitor for harm. When using a risk-benefit framework, such discussions may *strengthen* providers' relationships with patients, not weaken them, as they

can allow providers to express their concern for the patient's well-being and to sympathize with the patient's fears. Increasing the patient's perception of the provider as caring and sympathetic is another important aspect of the therapeutic relationship and patient-centered care.<sup>12</sup>

As recommended in the APS guidelines, providers should match the intensity of monitoring to the level of risk.<sup>7</sup> Numerous tools exist (e.g. the Opioid Risk Tool<sup>35</sup>) to assist providers in assessing level of risk.<sup>35</sup> A patient at high risk for opioid addiction – for example, a patient with a prior history of substance abuse - may require much closer monitoring with more frequent pill counts or urine drug screening than a patient at low risk for addiction. Qualitative studies have noted mutual mistrust between patients with substance abuse disorders and their medical providers.<sup>39</sup> Providers may feel hesitant to talk openly to patients with a history substance abuse about this history as they fear that patients will feel that they are being discriminated against. However, studies have shown that, amongst patients with chronic pain, those with a history of substance abuse have a higher awareness of the addiction potential of opioids than those without a history of substance abuse.<sup>40</sup> In my own experience, I have found that patients with a history of substance abuse appreciate discussion about addiction, if framed properly. I always start with showing admiration for that hard work and strength it takes to overcome addiction. I then acknowledge the patient's desire to “never go there again” and openly discuss why he or she is at greater risk for harm than patients without a history of substance abuse. I then partner with the patient to monitor for risk, framing it as what each of us can do to help with our shared goal of minimizing risk.

### **When there is not enough benefit to outweigh possible harm**

Providers may sometimes feel trapped into continuing opioid therapy that they do not feel is indicated or may worry that if they start using opioids, they will have to continue using them forever, even if they are not helping the patient. As the APS/AAPM guidelines say, “the decision to proceed with chronic opioid therapy should be intentional and based on careful consideration of outcomes during the trial.”<sup>7</sup> The provider should regularly assess and document the benefits and harms of opioid therapy. To continue prescribing, there should be clear benefits and the benefits should outweigh the observed or potential harms. Often, opioids do not produce the benefits the patient or the provider was expecting. In that case, I would recommend re-assessing the many factors that could be contributing to pain and re-attempting to treat the underlying disease and co-morbidities. One may also consider increasing the dose as a test. If there is still no positive effect, however, then the benefit cannot outweigh the possible harms and opioids should be slowly tapered down and discontinued.

In this situation, it is easy for patients to feel that the clinician doesn't believe their pain is real or severe. It is very important to stress to a patient how much you believe and empathize with the severity and/or impact of his or her pain and to express your own frustration with the lack of a good medication to treat the problem. Similarly, it is critical to focus on the patient's strengths and encourage counseling or other therapies for coping with pain. The provider should show a commitment to continue caring about the patient and the pain. I



often see providers lessen the frequency of visits as they feel that the need for close follow-up is diminished when they are not prescribing opioids. However, in many cases, treating pain without opioids may require as many if not more visits. As in the case of treating medically unexplained symptoms,<sup>41</sup> regular scheduled follow up needs to be a critical component of the management plan.

Tapering opioids due to lack of benefit results in a number of different scenarios. Some patients may become upset and threaten to seek care elsewhere. This response, however, increases concern that the risks of opioid treatment outweigh the benefit. Many patients may agree to a taper, especially if the provider shares control with them around the actual logistical details. (For example, the patient may decide if it is best to decrease the dose at each administration or the frequency of administration.) Of those patients, some may find that in fact they were not gaining any perceptible benefit from opioids and opt to discontinue them. Others may realize that their opioid therapy had a significant impact on their functioning and recalibrate their expectations of therapy. For example, a patient explained to me that, after a taper, she realized that the main effect of her medication was not to take away the pain – as she had previously hoped – but to allow her to do activities such as washing dishes or walking her dog. Of course, when comparing what a patient can do with or without opioids, one may misinterpret signs of withdrawal for evidence of effectiveness. However, appropriate patient education, a slow tapering schedule, and careful attention to signs of withdrawal can help one distinguish between the two.

### **When there is concern for misuse, addiction, or diversion**

The literature highlights numerous aberrant behaviors that could potentially be indicative of opioid misuse, addiction, or diversion.<sup>32</sup> Examples can range from behaviors such as repeated requests for early refills or reports of lost prescriptions, to use of more than one pharmacy or use of family members' prescriptions to actual prescription forgery or theft. Deciding on the appropriate response to such behaviors can be challenging. When operating in a law enforcement framework, providers may try to match the punishment to the level of infraction. (See Table 1.) For example, providers may respond to low level aberrant behaviors by issuing a warning, high level aberrant behaviors by discontinuing opioids, and mid level behaviors by decreasing the dose of opioids. Alternatively, when operating in a bargaining framework, providers may respond to aberrant behavior by explaining why it is a breach of contract. They may then renegotiate a new deal, depending on how well the patient argues his or her case. The final decision (eg. continuing or discontinuing opioids; changing a dose, etc.) may potentially be appropriate, but these approaches run both the risk of poor management decision (eg. decreasing the dose of opioid in a patient whose behaviors were related to pseudo-addiction; or responding to signs of addiction by dismissing the patient from the practice instead of referring him/her to addiction services) and of undermining the physician-patient relationship. The risk-benefit framework encourages providers to consider the differential diagnosis for the observed behavior and then work with the patient on a strategy that best corresponds to what is on the differential.

It is possible that aberrant behaviors could be caused by a miscommunication of the provider's expectations, inadequate pain control (or pseudo-addiction), opioid misuse,

opioid addiction, or diversion. If the possibility of miscommunication is high on the differential, then it would be appropriate to clarify clinic policies and continue prescribing. Similarly, if inadequate pain control or pseudo-addiction is high on the differential, an appropriate response to aberrant behavior could possibly be to *increase* not decrease opioid therapy. However, miscommunication or pseudo-addiction would be low on the differential if the behaviors continued.

There are times when opioid addiction is high on the differential diagnosis. In this case, it is appropriate to refer to addiction treatment and discontinue opioid therapy. Both patients and providers may feel the need for proof of addiction or misuse in order to justify such a decision. However, the decision simply needs to be that the risk is high enough to outweigh the benefit. We do not require proof in other clinical decisions. Doing so in this situation only puts providers in an uncomfortable law enforcement mode and possibly leads to the inappropriate continuation of opioids when the potential risks outweigh the benefit. It is important to reinforce a commitment to treat pain and to continue the physician-patient relationship, but to explain the inability to responsibly prescribe opioids until the addiction (or possibility of addiction) is addressed.

Providers may get requests for a final prescription of opioids to bridge to another prescriber or program. In a negotiation framework, such requests may become a bargaining chip for the provider or a way for a provider to feel less guilty about his or her decision to stop prescribing opioids. However, in a risk-benefit framework, the decision has to be based on what the intent is of the bridging prescription. Depending on the situation, it may be appropriate to continue prescribing opioids (either at the same dose or with a taper) for a brief period of time to control pain while a patient is waiting to enter addiction treatment. In this case, one is treating pain while actively attempting to address the addiction. Precipitating withdrawal from opioids being used for pain control may potentially lessen the chances that a patient adequately addresses the addiction. However, if a patient is not considering addiction treatment, it would likely not appropriate to bridge to a new primary care or chronic pain provider since, in that situation, one would continue opioid prescribing in the face of an unaddressed addiction, which would ultimately lead to increased risk. A provider may choose to taper or abruptly discontinue opioids, depending on his or her assessment of the degree of risk that having access to any additional opioid prescriptions may carry.

Personally, I find discussing the possibility of diversion to be more difficult than discussing addiction. Still, there are situations where diversion is very high on the differential diagnosis. In these cases, I find the conversation is most effective if I discuss my concern as being both for diversion and addiction/misuse, especially as it may be hard, as a provider, to distinguish between the two. I always leave open the possibility that I am wrong, but explain that my responsibility to society makes me unable to prescribe when there is any chance of diversion or misuse. I still always offer resources both for addiction treatment or detoxification services and let the patient decide if these would be of use.



## Conclusions

The APS/AAPM guidelines offer providers a comprehensive summary of current recommendations for the use of opioids to treat chronic non-malignant pain. The guidelines recommend that providers make decisions about opioids by balancing the benefits and harms of therapy. However, providers may need to actively make a conscious effort to stop using common paradigms such as the law enforcement and bargaining frameworks. Moving from these frameworks to one that compares benefits to harms may help providers conceptualize chronic pain management in a way that is more consistent with patient-centered care and communication.

Already, there is a strong acceptance of the need for approaching chronic pain medicine with a bio-psychosocial perspective.<sup>20–23</sup> Using a benefit-to-harm framework supports other key dimensions of patient-centered care, including the patient-as-person, the therapeutic alliance, and shared decision-making. Ultimately, it may also support the fifth dimension of patient-centered care – that is, the doctor-as-person. A majority of primary care providers strongly agree that patients with chronic pain are a major source of frustration.<sup>1</sup> A large part of that frustration may be related to the very uncomfortable roles that we accidentally find ourselves in when we use law enforcement or bargaining frameworks. The benefit-to-harm framework allows us to go back to our much more satisfying and comfortable roles as healthcare providers. Furthermore, it not only helps patients to see us as caring and sympathetic, but it allows us to think of ourselves as caring and sympathetic, even when handling difficult issues such as the need to discontinue opioids. Perhaps that is why training in a shared-decision-making model improved not only knowledge and attitudes, but also provider satisfaction.<sup>24,25</sup> It is still sometimes difficult, especially during an emotionally charged interaction, not to revert to judging the patient or bargaining. However, it is at those exact moments that one most needs to make every effort to think and communicate using a clear benefit-to-harm framework.

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**Table 1**

Comparison of common frameworks for the use of opioids in the management of chronic non-malignant pain

	<b>Law Enforcement Framework</b>	<b>Bargaining Framework</b>	<b>Benefit-to-Harm Framework</b>
Clinical questions	Is the pain real? Is the patient telling the truth? Is there proof that the patient has or has not done something wrong?	How low a dose of opioids will the patient accept? Is the patient keeping up his/her end of the bargain?	Do the benefits of opioids outweigh the risks for this patient at this time?
Goal of initial assessment of addiction / misuse potential	Catch “addicts” early.	Decide whether or not to enter into negotiation or how strict to be during negotiation.	Assess risk (to be balanced with benefit) and determine appropriate level of monitoring for degree of risk
Goal of patient care agreements	Set up way to catch “addicts”; protect clinic from DEA.	Set up “contract” that parties must uphold. (Or complete annoying paperwork to fulfill clinic policies).	Ally with patient to protect against harms of treatment; explain how clinic will monitor for risk and what behaviors will raise concern for misuse.
Goal of urine drug screens or pill counts	Prove guilt or innocence.	Assess if patient is keeping up with his/her end of the bargain.	Monitor for addiction as one of the ways that medication can be harming patient
Goal of functional assessment	Assess if pain is severe enough to warrant treatment.	Help assess “worth” of treatment to patient.	Measure actual or potential benefit of treatment (to be balanced against risk).
Mindset framework promotes in patients who wish to continue opioids	“My pain is really terrible, so I need my pain meds.” “I am a good person, so I deserve pain meds.”	“I have done what you wanted me to do, so you should keep prescribing.”	“My opioids allow me to do X, so it is worth it to me to keep taking them despite the risk.”
What happens when opioids are not having desired benefit	Opioids often continued as patient has not committed an offense. Requests for increased opioids may increase suspicion that patient is drug-seeking.	Patient asks for more opioids. Physician may give in, increasing dose as little as possible or tying increase with other desired behavior (eg. agreement to seek counseling or comply with other therapies.)	Reconsideration of other treatment options. Short trial to see if increased dose will result in benefit. If still no benefit, then opioids tapered off since benefits do not outweigh harms.
Response to aberrant medication behaviors	Consider severity of infraction and level of proof. “Low level offense”: offer warning; “Mid level offense”: reduce dose; “High level offense”: discontinue opioids and possibly discharge from practice	Explain why this is a breach of contract. Renegotiate new deal depending on how well patient argues his or her case.	Consider differential diagnosis. Miscommunication: clarify expectations; Pseudo-addiction: test of dose increase; Addiction: referral to addiction treatment; discontinue opioids; continue non-opioid therapy; Diversion: discontinue opioids
Appropriateness of a short opioid prescription to “bridge” to provider or program after	Depends on severity of offense. Provider may bridge or taper if offense wasn’t very severe or may not if	May be part of a compromise in the new negotiation.	Depends on patient’s expressed treatment plan. May be potentially appropriate to

	<b>Law Enforcement Framework</b>	<b>Bargaining Framework</b>	<b>Benefit-to-Harm Framework</b>
decision is made to discontinue opioids due to concerns for addiction or “drug-seeking”.	offense was especially problematic.		continue to treat pain for short period while patient is waiting to enter addiction treatment program. Would not be appropriate if there is no intention to treat addiction.

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