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## “I’m Not Gonna Pull the Rug out From Under You”: Patient-Provider Communication About Opioid Tapering

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### Abstract

In response to increases in harms associated with prescription opioids, opioid prescribing has come under greater scrutiny, leading many health care organizations and providers to consider or mandate opioid dose reductions (tapering) for patients with chronic pain. Communicating about tapering can be difficult, particularly for patients receiving long-term opioids who perceive benefits and are using their medications as prescribed. Because of the importance of effective patient–provider communication for pain management and recent health system-level initiatives and provider practices to taper opioids, this study used qualitative methods to understand communication processes related to opioid tapering, to identify best practices and opportunities for improvement. Up to 3 clinic visits per patient were audio-recorded, and individual interviews were conducted with patients and their providers. Four major themes emerged: 1) explaining—patients needed to understand individualized reasons for tapering, beyond general, population-level concerns such as addiction potential, 2) negotiating—patients needed to have input, even if it was simply the rate of tapering, 3) managing difficult conversations—when patients and providers did not reach a shared understanding, difficulties and misunderstandings arose, and 4) nonabandonment—patients needed to know that their providers would not abandon them throughout the tapering process.

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## Keywords

Chronic pain; opioids; opioid tapering; patient-provider communication; patient-centered care

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Chronic pain affects approximately 100 million Americans and is associated with deleterious outcomes such as reduced quality of life, depression, and anxiety.<sup>17</sup> In recent years, use of opioid analgesics to treat chronic pain has increased dramatically. From 2007 to 2012, total opioid prescriptions increased almost 12%, with the greatest increases in physical medicine, pain medicine, family practice, internal medicine, and general practice.<sup>20</sup> These increases have been paralleled by increases in opioid-related harms—in particular deaths and abuse.<sup>19,28,29</sup> In response, numerous organizations and federal agencies, including the American Pain Society/American Academy of Pain Medicine,<sup>7</sup> the Department of Veterans Affairs/Department of Defense,<sup>32,33</sup> and the Centers for Disease Control and Prevention,<sup>11</sup> have developed guidelines for opioid prescribing, and states and institutions have developed their own laws and policies governing opioid prescribing.

Increased scrutiny of opioid prescribing for chronic pain and lack of evidence supporting long-term efficacy of opioid therapy<sup>27</sup> has led providers and health care organizations to consider or mandate opioid dose reduction (tapering) for patients with chronic pain.<sup>1,15,25,33</sup> This mandate creates communication challenges between patients and providers, particularly for patients who have been taking long-term opioids, receiving benefit from them, and are using them as prescribed. These challenges may be exacerbated by the inherent difficulties identified in the literature with respect to communicating about pain and its treatment.<sup>24,31</sup> Because of the importance of effective patient–provider communication for pain management,<sup>23,26</sup> and recent opioid tapering initiatives, it is essential to understand the communicative processes surrounding tapering, to identify best practices as well as opportunities to improve the process (and ultimately, outcomes) for patients as well as providers.

To examine communication about opioid tapering in depth, we conducted a qualitative analysis of audiorecorded primary care clinic visits with patients taking opioids for chronic pain, and then conducted in-depth interviews with patients and their primary care providers (PCPs) to identify communicative challenges and best practices associated with opioid tapering.

## Methods

### Study Design

These data are part of a larger study focused on understanding communication about opioid management. The study involved audio-recording up to 3 primary care appointments per patient with patients prescribed an opioid for chronic musculoskeletal pain. Patients and their PCPs also participated in individual qualitative interviews.

## Setting and Participants

The study was conducted in 4 of the 9 primary care clinics at an academic, safety-net hospital serving primarily low-income patients. Procedures were approved by the local institutional review board, and all participants signed an informed consent; patients also signed a Health Insurance Portability and Accountability Act authorization to allow access to protected health information.

## Eligibility

PCPs were eligible to participate if they practiced in one of the medical center's primary care clinics and had patients with chronic pain for whom they were prescribing opioids. Patients were eligible if they met the following criteria: 1) at least 18 years of age, 2) patient of participating PCP, 3) had chronic musculoskeletal pain (defined by International Classification of Diseases, Ninth Revision codes: 715, 719, 721, 722, 723, 724, 726, 729.0, 729.1, 729.3, 729.5, 738.4, and 738.5), 4) currently taking a prescribed opioid for pain, 5) speaks English with PCP.

## Recruitment

We mailed a letter explaining the study to patients who met inclusion criteria, and the project coordinator followed up with a phone call. If patients agreed to participate, study staff met patients in the clinic waiting room before their next PCP appointment, further explained the study, answered questions, and obtained informed consent.

## Data Collection Procedures

Data collection occurred over 20 months, from 2015 to 2017, until theoretical saturation was reached (ie, additional data no longer led to new theoretical insights or revealed new properties in themes identified during analysis<sup>5</sup>). Data sources consisted of: 1) audio recordings of primary care visits (up to 3 per patient), 2) patient qualitative interviews, and 3) PCP qualitative interviews. For clinic recordings, an audio recorder was placed in the examination room, with the research staff member waiting outside the room. Recorders were collected at the conclusion of each visit and arrangements were made for contacting the patient about recording his/her next PCP visit. After completing at least 2 PCP visits, the patient's qualitative interview was scheduled. PCPs were interviewed after all or most of their patients' visits had been recorded, on the basis of availability. Part of the interview protocol for patients and PCPs included playing a portion of a recorded clinic visit pertaining to pain and/ or opioid management, to elicit participants' perceptions of the communication in the visit. All interviews were one-on-one, face-to-face, and audio-recorded. All audio recordings (clinic visits and interviews) were transcribed, deidentified, and checked for accuracy.

## Interviews

The project coordinator (M.H.), an experienced qualitative interviewer, conducted all interviews. We asked patients and PCPs about the patient-provider relationship, pain/opioid management, opioid monitoring practices, and policies/laws governing opioid prescribing.

## Data Analysis

A total of 95 clinic visits (up to 3 per patient) and 31 (9 PCP, 22 patient) interviews were recorded and analyzed. The first author (M.S.M.), working with 2 other experienced qualitative data analysts (N.L.J., M.H.), led data analysis, which consisted of an inductive approach using the method of constant comparison.<sup>5,21</sup> This is an iterative process with 2 broad phases: open coding and focused coding.<sup>5,21</sup> During open coding, team members read all transcripts analyzing them for common and recurrent themes. This step elucidated aspects of opioid management and tapering. During focused coding, analysts developed additional conceptual domains by describing comparisons between themes, within and between transcripts.

Throughout this process, procedures established in the literature on qualitative methods were used to ensure rigor and validity. These procedures included practicing reflexivity (continually questioning interpretations, seeking answers in the data to verify or challenge interpretations, becoming aware of one's own preconceptions and biases), depth of description (seeking out the rich, particular details of participants' words), and searching for alternative explanations or interpretations of the data.<sup>3,5,8,9</sup> All authors participated in final interpretations of the data.

## Results

Nine PCPs and 37 of their patients participated. PCPs ranged in age from 30 to 62 years. Seven PCPs were white; 1 was black, and 1 was Asian. Eight were female, and all PCPs were non-Hispanic. Patients were aged 22 to 74 years (mean=58; SD =10.4). Seventeen patients were black, 15 were white, 1 was American Indian/Alaskan Native, and the remainder did not provide race data. All patients were non-Hispanic; 12 were male. See Table 1 for demographic characteristics. One patient withdrew from the study after the first clinic visit, citing lack of time.

Notably, this study's purpose was to understand communication about opioid management for chronic pain, and tapering appeared as an emergent theme. Four themes revealed different aspects of patient-provider communication that appeared central to the tapering process: 1) explaining reasons for tapering, 2) negotiating the tapering plan, 3) managing difficult conversations, and 4) assuring patients that they will not be abandoned.

### Explaining Reasons for Tapering

Patients as well as PCPs emphasized the need for understanding individualized reasons for tapering, especially if patients were using their opioids as prescribed. In several clinic visits, PCPs explained in detail reasons for tapering, including risks and side effects of opioids. For example, the following PCP provided a long explanation of why she was tapering this patient, including emphasizing that it was not because of concerns of abuse or diversion. A short excerpt is as follows.

"I don't have a concern with you abusing or selling them. I mean, we know each other and we know that's not an issue. The issue is that over time they stop working. the higher and higher doses of pain medications people are on, it can

cause side effects, bad constipation, it can cause depression, it can cause decrease in your drive to breathe, and these are in people who are not trying to do anything wrong, they just want relief.” (Clinic: PCP 3, patient 3)

However, as the following clinic excerpt illustrates, patients and PCPs did not always agree on the need to taper:

PCP: So what we were planning on doing is continuing to wean you.

Patient: And my pain gets worse and worse and worse.

PCP: But the oxycodone, that wasn't the thing that.

Patient: They were helping me to move around, get more like it wasn't even so stiff and achy.

PCP: But it's just, it's not safe. It is just not safe.

Patient: Ok I understand that too, but I don't think it is fair to me and my pain.

PCP: We can try some stuff today, but an opiate or narcotic pain medication is not a safe option for you right now. (Clinic: patient 5, PCP2)

Frequently patients told us that they did not understand why their opioid doses were being reduced. Some patients said they had no discussions with their PCPs about reasons for tapering. Others described having conversations with their providers that addressed general reasons for tapering but did not apply to them specifically (eg, addiction is a potential risk). In fact, many patients told us that they understood global risks such as addiction potential, but they did not believe that these risks applied to them personally, either because they were genuinely in pain, or because they were not engaging in aberrant behaviors (eg, asking for early refills, taking more than prescribed, or losing their prescriptions). For example, one patient said:

“She had me down from 10 to 5 [mg], and I didn't understand because I was still in the same amount of pain. I asked her and she said that a lot of people was OD'ing on pain medication and getting addicted. but I told her I was in a lot of pain, and this was not addiction. because I do be in a lot of pain.” (Interview: patient 6).

Other patients expressed similar sentiments:

“I'm not taking a high dose, not asking for more. it's not like I go to them every 6 months and say hey, I need more. I don't do that. I know what they say is correct for some people. but that's not gonna work for me.” (Interview: patient 2).

“[My doctor] treated me like I was a druggie or something, and I don't take anything that's not prescribed or more than is prescribed. I've been on [the opioids] for years and years, and what [another doctor] prescribed me, I wasn't even taking all of it. [Now the dose] is cut to less than half of what I used to take.” (Interview: patient 20)

PCPs recognized that patients often have difficulty understanding how concerns about opioid risks apply to them:

“The argument about narcotics is sometimes difficult because patients look from their perspective. They are looking at it from an N of 1, right? And so they’re thinking, especially because we have a lot of patients who’ve been on narcotics for years, ‘So I’ve taken this medicine, I’ve been fine for 10 years. It works for me. why in the world would you change it?’ And from my point of view, you know, we’re looking at millions of people and data.”(Interview: PCP 5)

Another PCP stated more bluntly:

“Everybody thinks they’re unique and they’re not gonna overdose, and they’re not addicted, and they never did anything wrong, and they need their medicine, and they’ve never had any of those side effects, and [the opioid] helps them.”  
(Interview:PCP7)

In response to this disconnect between knowledge about opioid risks and its application to individual patients, some PCPs successfully tailored their messages about opioid tapering to their patients’ individual circumstances. For example, the following PCP described how she helped a patient with pulmonary disease better understand why she was reducing her opioids:

“We were able to very directly talk about the [opioid] medication’s effects potentially on her respiratory system. So that was very clear to her. [I said], ‘Listen, you have a decreased respiratory drive. You are on oxygen. We don’t want anything else to suppress that.’ So I think having that tangible, kind of helped her to buy into it, instead of abstractly talking. She really can see, I’m on oxygen and I don’t really breathe well. And then once we got her to two a day and she feels good, then she can, again, kind of buy into that.” (Interview: PCP 2)

The following PCP took a similar approach in clinic with a patient by explaining how aging played an important role in the need to reduce opioids:

“Just something to think about because it’s gonna happen at some point. [The opioid] is gonna build up in your system and cause you problems, so we might as well get ahead of it. I’ve been through this with other folks. You know you get older. You’re a few years older than you were before, and the organs just don’t work as quickly to break it down, and so you’re still left in pain. It’s tricky. It’s really tricky ‘cause you’ve still got the pain but we have to attack that in different ways because you’ve got this drug on board that will eventually likely cause you problems.” (Clinic: PCP 1, patient 7)

### **Negotiating the Tapering Plan**

While helping patients understand the individual reasons that tapering was important, patient input in the tapering process also emerged as an important theme. Patients as well as PCPs described a desire for patients to be given options and thereby have some control over the tapering process. Sometimes patients and their PCPs were able to successfully negotiate tapering. Other times they believed the other person was not listening; thus, communication broke down.

One patient described a process of successful negotiation with her provider:

“She put me down to 2 and a half [pills per day]. Then she said, okay, we’ll go down to half a pill. I told her I didn’t think that just 2 a day would do it, and she said okay, we’ll try 2 and a half, are you agreeable with that? I said that’s fine. I mean, we can discuss stuff. It doesn’t have to be a disagreement because we can talk about it. It’s not an argument. We’re 2 adults having a conversation, figuring out what to do.” (Interview: patient 3)

This patient’s PCP described a similar process of collaboration:

“I try to give them options. We could go down this month from 4 a day to 3 a day, or to 3 and a half a day, or we can switch from oxycodone to hydrocodone. So I try and give them different options and I think that has helped me actually get people more on board. These are the ways that we can do it together and then, I have really listened to people when I’ve been weaning a little bit and if they say, this is not working I’m in a lot of pain, I’ve gone back up for a little while and tried to figure out a different way to bring them down.”(Interview:PCP3)

In this patient’s clinic visit, we see the provider giving the patient options:

Provider: Yeah, so you have the 7.5[mg]. You’re on the higher doses of them, so in trying to cut back, we could do a couple of things. We could cut back the numbers, the amounts that you get, or we could cut back how much is in each pill. So you have 7.5 now, so we could try to go to 5’s. What I’m thinking now is, let’s just do this really slowly. Why don’t you do 1 in the morning. Let’s keep the same 7.5’s that you have now.”

Patient: Yeah.

Provider: This is my suggestion. You do 1 in the morning, half in the afternoon, and 1 at night. Do you think you would be able to do that? It’s not such a big change.

Patient: Yeah, I think so. (Clinic visit: patient 3, PCP 3)

Another clinic excerpt with the same provider and a different patient also shows this provider’s efforts to involve the patient:

Provider: I want to make sure that you’re on board with this too.

Patient: Yeah, I’m on. I’ll do what I can do. I never liked to take medicine, period.

Provider: I know. (Clinic visit: patient 9, PCP 3)

Not all patients felt involved in the process. One patient believed that her doctors were conferring with each other and making decisions without her: “I would like for [my doctor] to listen to me rather than listen to what my rheumatologist says to her, and how they communicate without me” (interview: patient 17). Another patient believed she had not been told her opioid dose was being lowered: “He had lowered it and I didn’t even realize it. he didn’t even tell me it was getting lowered again. I wondered why I ran out even earlier than what I normally did. Nobody is telling me that.” This patient went on to say of her doctor, “I just don’t feel that he’s understanding. he don’t seem to care what I’m saying, because he’s lowering it down anyway, even though I’ve told him. that I didn’t agree with it being lowered.” (Interview: patient 2)

Another patient described trying to be involved, but that his doctor would not listen:

Patient: I can't hardly walk in the mornings. I think [opioids] help with spasms.

Interviewer: Did you tell him that?

Patient: Yeah, but he don't want to. I couldn't get him to look me in the eye when I was trying to explain. He didn't even look up. He just wrote on the paper.

(Interview: patient 20)

It was not only patients who felt they were not being heard. Providers, too, described trying to explain tapering and discuss options with patients, often without success:

"It's really bad because they have 1 specific thing that they want and they aren't really listening, most of them, to the other options. Yet I've got the law, hospital policy, my own good judgement, and it's saying I can't just—I want to try and help you get better, but only under certain circumstances." (Interview: PCP 7)

### Managing Difficult Conversations

As the previous themes suggest, conveying understanding and negotiating about tapering were not always successful, and the result was conversations that could be contentious and frustrating. The following clinic visit involved a lengthy discussion about opioid tapering, including arguments and threats to obtain opioids elsewhere:

Patient: But, like it is not fair.

PCP: Well, but my goal for you is to keep you safe and to also make sure that I'm not actually hurting you by giving you the medicines that I'm doing.

Patient: It's not because you give them to me and you feel guilty for yourself?

PCP: Oh what? Hang on, say it again.

Patient: You feel guilty about prescribing them to me because of your feelings about them?

PCP: It's not a matter of guilt or a matter of my feelings about them. It is a matter of actually facts. We know that these medications can be harmful. It is not just my opinion. We know that these medications can actually potentially even worsen pain and worsen depression. We know that they can be used as a way to hurt yourself.

Later in the visit, the following exchange took place:

Patient: I was just going to tell you to be honest with you. If I can't get my own script, then they are going to make me go out and ask for people, do you have any pain medicine? You know? I don't want to go that far.

PCP: No and...

Patient: But if I have to I will. I'm in so much pain... Because you cut me, all I got was 56 [pills per month]. Oh well, I'm just saying oh ok we will have to do this. (Clinic visit: patient 5, PCP 2)



Not surprisingly, conversations such as this one can have an effect on PCPs. One PCP expressed her frustration with an elderly patient who was beginning to experience falls and show symptoms of confusion:

“Oh, my gosh, 45 minutes every visit to explain to her the whole concept of first do no harm and what harm means for her and what harm has already—I literally read at our last visit, another 45 minute visit, I literally read the geriatric consult. She has called my nurse at least 3 times, and that’s a half-hour discussion every single time. I clench my shoulders, I feel tension in my spine and neck when I go in to see her. It’s this battle, and we both want what’s best for her. Oh my goodness, it keeps me up at night.” (Interview: PCP 1)

For patients who are using their opioids as prescribed and believe they are doing well, conversations about tapering can be especially difficult, because it is not usual practice to discontinue a medication that appears beneficial. The same PCP as above explained:

“It automatically sets up this punitive conversation when you say, you know you were doing great, [but] I’m going to cut off your medicines. Because we don’t do that in any other disease. We don’t do that in hypertension. We don’t do that with insulin... So this is what people are coming in with, and it’s like if I’m doing great, she’s going to keep giving my medicines. And that’s a hard conversation.” (Interview: PCP 1)

Although not all conversations were overtly contentious, situations when PCPs had trouble justifying, even to themselves, the reasons to taper a particular patient sometimes exacerbated the difficulty of these conversations. The following PCP described her own internal conflict about tapering an 85-year old patient for whom she was not sure tapering was appropriate:

“Sometimes I have to just check myself in terms of, you know, is this my issue? Is this just that I don’t like the numbers? Because, there’s data and we know that [opioids are] not good for elderly, but then people are also individuals... This guy seems to be thriving. And so maybe he’s one of the people I leave alone... But then I see him and I talk to him, and I’m like, I don’t know, maybe [tapering] is the right thing. I think it’s more of an internal conflict than a conflict when he’s in the room. There’s not arguing. It’s more of, I sort of ruminate on it.” (Interview: PCP 3)

PCPs also described conversations that went well. A typical example is the PCP who said:

“The woman I had to wean, she accepted it. She said, ‘You know, I don’t think I did anything wrong. I used my own medication, but I understand what you have to do, and I think I’ll be okay without them.’ And that was kind of it.” (Interview: PCP 3)

One PCP actually described surprise when conversations go well:

“I’ve been pleasantly surprised when people don’t get angry, and they say, ‘Well, I guess that’s a reasonable place to start.’ And I’m a little bit bowled over because there were years when I would just get beat up.” (Interview: PCP 9)

Similarly, this PCP explained that opioid tapering conversations have become easier:

“Sadly I guess I’ve gotten rather... Good at [conversations about opioid tapering]... I’m comfortable with it. I mean it’s never fun. I do kind of plan ahead—this is what we’re gonna have to do today and how can I set the stage. I just know that it works better if you know you got your plan in mind and basically can kind of follow it through. And you’ve got a relationship.” (Interview: PCP 7)

### **Assuring Patients That They Will Not be Abandoned**

An important part of productive opioid tapering conversations, for patients as well as for providers, was ensuring that patients did not feel abandoned during tapering. As PCP 7 said, the relationship is an important factor in tapering discussions. PCPs frequently reassured patients that they would be with them through the entire tapering process, and sometimes even told patients that if the pain became intolerable, they could discuss increasing the opioid dose again for a time. This seemed to provide an important safety net for patients. For example, one patient said:

“I knew she wasn’t just going to take me completely off of [the opioids] because I would be miserable... She just said, ‘We’ll try this, but if you need to go back to where you were, I’ll do that.’” (Interview: patient 20)

PCPs frequently described reassuring patients that they would not experience tapering alone:

“[Patients sometimes say], I’m not sure I believe this is gonna work... That’s the vibes that they’re giving. And I just try and reassure them that I hear them, how bad the pain is, and... What we do have to offer, and some kind of hope, and try and you know I want to work with you... and... If I’ve been able to build some rapport by really listening and asking lots of good questions and trying to be empathetic, then often they’re [willing to] give it a chance... Most of these people I’ve been taking care of for a long time, so there’s at least that relationship, and they know I’m not going to cut them off.” (Interview: PCP 7)

Another PCP described a conversation in which she relied on the long relationship she has had with the patient:

“She was nervous about [tapering], and I said this is a trial, you know, I’m not leaving, I’m not going anywhere. You know I’m with you. We’ve been together a long time, so I’m not going to disappear on you.” (Interview: PCP 1)

These sentiments were illustrated in clinic excerpts, such as the following when a patient’s PCP said:

“The hope would be next time to be done [tapering]. So, the hope is that this is your last prescription. Now, I’m not gonna leave you, you know, out to, what is it? Out to dry... I forgot the expression. So, you know, work with me and if things aren’t working, then we can revisit that, okay?” (Clinic: PCP 3, patient 9)

More bluntly, one PCP reassured her patient in clinic, “I’m not gonna pull the rug out from under you. It’s not gonna happen, okay? Not gonna happen.” (Clinic: PCP 1, patient 7)

## Discussion

In response to widespread concerns about opioid-related harms, tapering has become common practice; however, despite the surge in tapering, we know little about how patients and their providers communicate about this process. Because pain and opioid management are communicative activities and this communication is sometimes challenging,<sup>22–24,31</sup> it is critical to learn more about how tapering occurs. These lessons learned will help to inform future clinical communication about tapering, to optimize patients' understanding of and experiences with tapering, and to avoid unintended negative consequences.

In recorded clinic visits and individual interviews with patients and PCPs, 4 themes emerged related to opioid tapering: 1) explaining reasons for tapering, 2) negotiating the tapering plan, 3) managing difficult conversations, and 4) assuring patients that they will not be abandoned. Patients as well as PCPs recognized that patients needed to understand reasons for having tapering discussions. Patients acknowledged generally that opioids could be harmful and that some people misused them, but often did not see how this was applicable to them, because they legitimately had pain and were taking their medications as prescribed. Previous research has corroborated the notion that patients generally understand the risks of opioids, but most do not think that these risks apply to them.<sup>12</sup> PCPs acknowledged this gap in understanding, noting that patients only have their own experiences for perspective (“an N of 1”). These findings point to potential benefits of shifting the conversation about opioid tapering from the current opioid crisis, which is abstract and distant for patients, to a patient's own unique medical history and the particular risks that opioids can pose on the basis of their history. Future research should seek to identify optimal ways for PCPs to frame messages about opioid tapering. Educational efforts should seek to help PCPs individualize opioid tapering to facilitate patients' understanding of tapering as an effort to protect their health, and not as punishment.

Involving patients in tapering was critical, both to patients and to PCPs. In an environment of state and institutionally mandated tapering, patients and providers often have little control over whether tapering happens. Nonetheless, patients expressed a desire to have input into these decisions, and many providers agreed and were willing to work with patients on details such as the rate of tapering. Unsurprisingly, breakdowns in communication still occurred. Patients described trying unsuccessfully to negotiate their tapering, and PCPs described patients who persistently resisted tapering efforts. Difficult interactions about pain are well documented,<sup>2,10,12,14,18,24,31,34</sup> and widespread opioid tapering is likely to place additional strains on already difficult patient-provider relationships.

When communication broke down, either because of disagreements on the tapering plan, lack of understanding about tapering, or other reasons, this often led to difficult conversations in which patients argued, or even threatened to obtain their opioids illegally. Some PCPs described the emotional toll of these conversations. Further exacerbating this difficulty, PCPs were not always convinced that opioid tapering was best for certain patients. Although this skepticism emerged in interviews, it did not manifest in clinical communication in this study. It is unclear why this was the case; one possible explanation is that institutional pressure for overall reductions in opioid doses superseded PCPs' doubts,

leading them to remain silent. PCPs have previously described pain management as challenging.<sup>10,24</sup> Breakdowns in communication about tapering can exacerbate these challenges, particularly when PCPs themselves are unconvinced that tapering is appropriate for some patients. Unvoiced provider skepticism about opioid tapering for particular patients, and how providers approach this skepticism, is an important area for further research.

Assuring patients that their PCPs would not abandon them during opioid tapering was identified as critical, by patients as well as PCPs. Beyond the general, abstract concept of “trust” that is often discussed, patients and providers pointed to nonabandonment as key for productive communication about opioid tapering. Patients needed to know that their providers were not going to reduce their opioids and then disappear. PCPs were acutely aware of this need and repeatedly responded with reassurances that they would not abandon their patients. Some PCPs even expressed a willingness to increase an opioid dose temporarily if a patient was having difficulty adjusting to a lower dose. This notion of nonabandonment expands on the important role of the patient–provider relationship in chronic pain care.<sup>24,31</sup> Strong relationships may be especially valuable when difficult decisions about opioid treatment are made. For example, when doctors showed genuine concern for their patients’ health and well-being, patients with chronic pain seemed more willing to accept decisions to limit or deny opioids.<sup>22</sup> In a recent study involving interviews with patients being tapered off of opioids, Frank and colleagues<sup>13</sup> reported that patients believed having a trusted physician was essential. Studies have shown that when patients and their PCPs have similar concerns about opioids, they can approach these concerns collaboratively.<sup>4,16,23</sup> Collaboration and trust are especially important as nonopioid treatments are explored and as patients face fears of opioid withdrawal or uncontrolled pain. Indeed, in Frank and colleagues’<sup>13</sup> interviews, patients revealed that withdrawal and uncontrolled pain were major barriers to opioid tapering. Further corroborating the importance of provider support during opioid tapering, a recent pilot study reported that patients randomized to a taper support intervention involving psychiatric consultation and weekly meetings with a physician assistant showed greater improvement on pain interference, pain self-efficacy, and perceived opioid problems, than control patients.<sup>30</sup> Support, further elaborated as nonabandonment in the current study, appears to be a critical element of communication about opioid tapering.

Findings from this study add to the small but growing body of research revealing how patients and providers experience opioid tapering. In Frank and colleagues’<sup>13</sup> recent study involving interviews with patients at various stages of tapering, patients noted that their current pain was more urgent than potential future risks of opioids, expressed skepticism about the efficacy of nonopioid analgesics and fear of withdrawal, and described the central role of social support during tapering. The current study illuminates the communicative processes surrounding opioid tapering, exploring patients’ as well as PCPs’ perspectives, and actual clinical communication. Through these multiple data sources, the patient–provider relationship during tapering emerges as fundamental. Indeed, the current study not only underscores the centrality of this relationship, but illuminates critical aspects of this relationship that appear important to patients and providers during tapering. Providers have pivotal roles in helping patients to understand why they are being tapered, giving them input

into the process, and assuring them that they will not be abandoned while their doses are being reduced.

This study has some limitations. Although theoretical saturation was reached, a larger sample might have facilitated a fuller range of perspectives, particularly from PCPs. Some PCPs may have declined to participate in the study because of their views or approaches toward opioid tapering; consequently, we may have missed some aspects of clinical communication and perspectives related to opioid tapering. In addition, we did not assess dose, type, or duration of opioid treatment, or history of substance use disorder, all of which might influence communication about tapering. Finally, this study took place in the primary care clinics of one safety net hospital system; results should be corroborated in other settings.

This study has a number of strengths. Qualitative methods enable the capture of rich, particular details of participant experiences that may not be available using other methods.<sup>6</sup> In addition, because interview accounts by themselves are subject to recall bias and are shaped by participants' own experiences and perspectives, combining interviews of patients as well as providers with analysis of actual clinical communication allows for the fullest exploration of communication related to opioid tapering, providing insights from multiple perspectives.

## Conclusions

Communication about chronic pain and its treatment is challenging, particularly when opioids are involved. Clearly, these communicative challenges can be exacerbated when patients are being tapered down or off opioids, oftentimes against their wishes. The current study highlights some important clinical implications as more patients experience tapering. Specifically, if clinicians tailor their messages to help each patient understand why tapering may be beneficial to them, based on their own unique circumstances and medical history, conversations about tapering could be more productive. In addition, our findings indicate that encouraging patients to have input into the tapering process, even if it is simply the rate of tapering, can help patients feel as if they have some control over their treatment. Finally, although the centrality of the patient-provider relationship in pain management is recognized, the specific notion of nonabandonment emerged as critically important to patients as well as providers. Patients experienced tapering more positively when they felt assured that their providers would remain with them through the entire process.

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## References

1. Berna C, Kulich RJ, Rathmell JP: Tapering long-term opioid therapy in chronic noncancer pain: Evidence and recommendations for everyday practice. *Mayo Clin Proc* 90: 828–842, 2015 [PubMed: 26046416]
2. Bieber C, Muller KG, Blumenstiel K, Schneider A, Ritcher A, Wilke S, Hartmann M, Eich W: Long-term effects of a shared decision-making intervention on physicianpatient interaction and

outcome in fibromyalgia: A qualitative and quantitative 1 year follow-up of a randomized controlled trial. *Patient Educ Couns* 63:357–366, 2006 [PubMed: 16872795]

3. Borkan J: Immersion/crystallization In: Crabtree BF, Miller WL (eds): *Doing Qualitative Research*. Thousand Oaks, CA, Sage, 1999, pp 179–194
4. Buchbinder M, Wilbur R, McLean S, Sleath B: “Is there any way I can get something for my pain?” Patient strategies for requesting analgesics. *Patient Educ Couns* 98: 137–143, 2015 [PubMed: 25468395]
5. Charmaz K: *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. Thousand Oaks, CA, Sage, 2006
6. Chen V, Pearce WB: Even if a thing of beauty, can a case study be a joy forever? A social constructionist approach to theory and research In: Leeds-Hurwitz W (ed): *Social Approaches to Communication*. New York, Guilford Press, 1995, pp 135–155
7. Chou R, Fanciullo GJ, Fine PG, Adler JA, Ballantye JC, Davies P, Donovan MI, Fisbain DA, Foley KM, Fudin J, Gilson AM, Kelter A: Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. *J Pain* 10:113–130, 2009 [PubMed: 19187889]
8. Davies D, Dodd J: Qualitative research and the question of rigor. *Qual Health Res* 12:279–289, 2002 [PubMed: 11837376]
9. Denzin NK, Lincoln YS: Introduction: The discipline and practice of qualitative research In: Denzin NK, Lincoln YS (eds): *Strategies of Qualitative Inquiry*, 2nd ed. Thousand Oaks, CA, Sage, 2003, pp 1–45
10. Dobscha SK, Corson K, Flores JA, Tansill EC, Gerrity MS: Veterans Affairs primary care clinicians’ attitudes toward chronic pain and correlates of opioid prescribing rates. *Pain Med* 9:564–571, 2008 [PubMed: 18777608]
11. Dowell D, Haegerich TM, Chou R: CDC guideline for prescribing opioids for chronic pain—United States, 2016. *MMWR Recomm Rep* 65:1–49, 2016
12. Esquibel AY, Borkan J: Doctors and patients in pain: Conflict and collaboration in opioid prescription in primary care. *Pain* 155:2575–2582, 2014 [PubMed: 25261714]
13. Frank JW, Levy C, Matlock D, Calcaterra SL, Mueller SR, Koester S, Binswanger IA: Patients’ perspectives on tapering of chronic opioid therapy: A qualitative study. *Pain Med* 17: 1838–1847, 2016 [PubMed: 27207301]
14. Frantsve LM, Kerns RD: Patient-provider interactions in the management of chronic pain: Current findings within the context of shared medical decision making. *Pain Med* 8:25–35, 2007 [PubMed: 17244101]
15. Gallad WF, Good CB, Shulkin DJ: Addressing the opioid epidemic in the United States: Lessons from the Department of Veterans Affairs. *JAMA Intern Med* 177: 611–612, 2017 [PubMed: 28288245]
16. Hughes HK, Korthuis PT, Saha S, Eggly S, Sharp V, Cohn J, Moore R, Beach MC: A mixed methods study of patient-provider communication about opioid analgesics. *Patient Educ Couns* 98:453–461, 2015 [PubMed: 25601279]
17. Institute of Medicine of the National Academies: *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*. Washington, DC, National Academies Press, 2011
18. Kenny DT: Constructions of chronic pain in doctor-patient relationships: Bridging the communication chasm. *Patient Educ Couns* 52:297–305, 2004 [PubMed: 14998600]
19. Kuehn BM: CDC: Major disparities in opioid prescribing among states. *JAMA* 312:684–686, 2014 [PubMed: 25099564]
20. Levy B, Paulozzi LJ, Mack KA, Jones CM: Trends in opioid analgesic prescribing rates by specialty, U.S., 2007–2012. *Am J Prev Med* 49:409–413, 2015 [PubMed: 25896191]
21. Lindlof TR, Taylor BC: *Qualitative Communication Research Methods*, 2nd ed. Thousand Oaks, CA, Sage, 2002
22. Matthias MS, Krebs EE, Bergman A, Coffing JM, Bair MJ: Communicating about opioids for chronic pain: A qualitative study of patient attributions and the influence of the patient-physician relationship. *Eur J Pain* 18: 835–843, 2014 [PubMed: 24921073]

23. Matthias MS, Krebs EE, Collins L, Bergman A, Coffing JM, Bair MJ: "I'm not abusing or anything": Patient-physician communication about opioids. *Patient Educ Couns* 93: 197–202, 2013 [PubMed: 23916677]
24. Matthias MS, Parpart AL, Nyland KA, Huffman MA, Stubbs DL, Sargent C, Bair MJ: The patient-provider relationship in chronic pain care: Providers' perspectives. *Pain Med* 11:1688–1697, 2010 [PubMed: 21044259]
25. Morasco BJ, Cavanagh R, Gritzner S, Dobscha SK: Care management practices for chronic pain in veterans prescribed high doses of opioid medications. *Fam Pract* 30: 671–678, 2013 [PubMed: 23901065]
26. Nicolaidis C: Police officer, deal-maker, or health care provider? Moving to a patient-centered framework for chronic opioid management. *Pain Med* 12:890–897, 2011 [PubMed: 21539703]
27. Noble M, Treadwell JR, Tregear SJ, Coates VH, Wiffen PJ, Akafomo C, Schoelles KM: Long-term opioid management for chronic noncancer pain. *Cochrane Database Syst Rev* CD006605, 2010
28. Paulozzi LJ, Budnitz DS, Xi Y: Increasing deaths from opioid analgesics in the United States. *Pharmacoepidemiol Drug Saf* 15:618–627, 2006 [PubMed: 16862602]
29. Substance Abuse and Mental Health Services Administration: Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-41, HHS Publication No. (SMA) 11–4658. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2011
30. Sullivan MD, Turner JA, DiLodovico C, D'Appollonio A, Stephens K, Chan Y: Prescription opioid taper support for outpatients with chronic pain: A randomized controlled trial. *J Pain* 18:308–318, 2017 [PubMed: 27908840]
31. Upshur CC, Bacigalupe G, Luckmann R: "They don't want anything to do with you": Patient views of primary care management of chronic pain. *Pain Med* 11: 1791–1798, 2010 [PubMed: 21029353]
32. U.S. Department of Veterans Affairs: VA/DoD Clinical Practice Guidelines: Management of Opioid Therapy For Chronic Pain. Available at:<http://www.healthquality.va.gov/guidelines/Pain/cot>. Accessed January 23, 2017
33. U.S. Department of Veterans Affairs, Office of Public and Intergovernmental Affairs: VA Initiative Shows Early Promise in Reducing Use of Opioids for Chronic Pain. Available at:<https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2529>. Accessed January 26, 2017
34. Werner A, Malterud K: It is hard work behaving as a credible patient: Encounters between women with chronic pain and their doctors. *Soc Sci Med* 57: 1409–1419, 2003 [PubMed: 12927471]

**Perspective:**

Although opioid tapering can be challenging, helping patients to understand individualized reasons for tapering, encouraging patients to have input into the process, and assuring patients they would not be abandoned all appear to facilitate optimal communication about tapering.

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**Table 1.**

## Demographic Characteristics of the Patients and Providers

VARIABLE	PATIENTS	PROVIDERS
Gender		
Male	12 (32)	1 (11)
Female	25 (68)	8 (89)
Race		
White	15 (41)	7 (78)
Black	17 (46)	1 (11)
American Indian	1 (2.5)	
Other	3 (8)	
Don't know/refused	1 (2.5)	
Asian		1 (11)
Education		
Some high school or less	14 (38)	
High school/GED	11 (30)	
Some college/technical or business school	10 (27)	
College degree or above	2 (5)	
MD		8 (89)
Physician Assistant		1 (11)
Employment		
Employed	6 (16)	9 (100)
Not employed	3 (8)	
Retired	7 (19)	
Unable to work	20 (54)	
Other/refused	1 (3)	
Income		
Comfortable	4 (11)	
Just enough	16 (43)	
Not enough	16 (43)	
Refused to answer	1 (3)	
Mean age, y	58	45

Abbreviations: GED, general equivalency diploma.

NOTE. Data are presented as n (%) except where otherwise noted.