Perspectives on the Use of Prescription Opioids in
Chronic Non-Malignant Pain

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Abstract

Chronic non-malignant pain is defined as a persistent or recurring pain lasting greater than three months and is not related to cancer pathology. Prescription opioid medication continues to be a controversial form of treatment, with practitioners and patients expressing dissatisfaction with chronic pain management. Questions remain regarding an evidence base for long-term prescribing of opioids for chronic pain, possible side-effects from long-term prescribing, greater oversight regarding opioid prescribing in chronic pain and increased rates of prescription opioid misuse. Examination of the literature from the patient, practitioner and societal/political perspective using Conflict Theory suggest there is conflict within the practitioner-patient relationship related to unequal power, and conflicts of interest regarding prescribing opioid medication for chronic pain. The significance and implications for nursing practice are discussed as well as recommendations for future research.

Key Words: chronic pain management, opioids, perspective, provider, patient, society, addiction

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According to The National Center for Health Statistics (2006), 25% of Americans suffer from chronic or recurrent pain. Up to 40% of Americans report that pain has a moderate or severe impact on their quality of life. Chronic low back pain alone accounts for billions of dollars per year in the United States in relation to time off work, disability and healthcare costs (Ehrlich, 2003). For the purposes of this paper, chronic pain is defined as persistent pain lasting greater than three months and is not related to cancer pathology (Chapman et al., 2010). As the use of opioids in the treatment of chronic pain has increased over the years, concerns have been raised regarding lack of an evidence base for long term prescribing of opioids in chronic non-malignant pain, possible side effects for long-term prescribing, more regulatory oversight and increased rates of prescription opioid misuse making this a contentious form of treatment (Chapman et al., 2010). The literature suggests a mutual dissatisfaction between practitioners and patients surrounding chronic pain management (Arnstein, 2010). The purpose of this paper is to present perspectives from practitioners, chronic pain patients and society regarding the use of opioids in chronic pain management in the context of the practitioner-patient relationship and elucidate what factors practitioners can influence during patient interactions to increase satisfaction for themselves and their patients.

Literature Search Strategies

The literature review was conducted primarily on an on-line database to include search engines CINAHL and Cochrane Library. Key search terms “chronic pain management” and “opioids” revealed 109 references on CINAHL published in the last five years. After additional terms “perspective”, “attitude”, “provider-patient relationship” “addiction” “society” and “prescribing” were used to modify and focus the search, the number of studies was reduced to approximately 20. Additional focusing consistent with my theoretical framework further
narrowed the focus to 11 studies. Eleven studies were chosen for review: five from the patient perspective, three from the practitioner perspective and three from the societal and political perspective.

**Theoretical Framework**

The practitioner-patient, as well as the societal and political perspectives presented in this paper were examined using Conflict Theory as a framework. According to Conflict Theory, human societies contain elements of inequality, power/authority, domination/subjugation, interests and conflict (McEwen & Wills, 2011). The practitioner-patient relationship is influenced by societal factors regarding power over prescribing of controlled substances that create conflict and thus dissatisfaction for both parties (Fontana, 2008). Critical Social Theory, a conflict theory, asserts that individuals need to use self-reflection to question what they believe are fundamental truths about their social surroundings so that inequalities can be identified (McEwen & Wills, 2011). For example, in the context of the practitioner-patient relationship, practitioners not only must consider the patients' subjective symptoms of pain in the decision whether to prescribe opioid medication, but also how unequal power distribution and conflicting interests between the practitioner, patient, and social/political forces influence the decision to prescribe.

**Literature Review**

**The Patients’ Perspective**

Upshur, Bacigalupe, and Luckmann (2010) used a qualitative design to examine the views of a diverse, convenience sample of 72 adult patients recruited from four primary care clinics. Participants with any type of chronic non-malignant pain complaint for at least three months in the last year, or had been receiving prescription medications for chronic pain for more
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than three months were included. Participants included in the study reported chronic pain complaints from arthritis, headache, abdominal pain, fibromyalgia, neuropathic pain, musculoskeletal pain, and generalized pain. Complaints of acute or malignant pain were excluded from the study. Researchers conducted oral interviews using scripted questions with 17 groups, each containing three to seven participants. Interpreters were used for the Spanish speaking participants. Analysis of the questions from the 17 patient focus groups revealed both English (n=11) and Spanish (n=6) speaking groups reported barriers to treatment within the care provider domain as feelings of distrust and suspicions of drug seeking. Further, 91% of English and 50% of Spanish speaking groups identified provider trust in patient as an element of good provider-patient relationship. Strengths of the study are diversity of sample (68% female and 48% Latino) and size making it generalizable to other patient populations. Limitations are a convenience sample from one geographic area and possible cultural differences relating to medical mistrust were not included in the study (Upshur et. al., 2010).

Vallerand and Nowak (2009) conducted a qualitative, phenomenologic study using 16 women and six men recruited from two outpatient pain clinics where they were receiving opioid therapy for chronic pain. Age range of the study participants was 29 to 84 years and the range of opioid therapy treatment length varied from one to four years. The study does not include past medical history information regarding participants’ chronic pain complaint. Researchers conducted individual oral interviews with each participant on two separate occasions in which five scripted questions were used to guide the interview. Findings prior to beginning opioid therapy included patient reports of: a) desperation, b) thoughts of suicide and, c) a willingness to endure humiliation. Findings after beginning opioid therapy included patient reports of: a) balancing self-care, b) exchanging physical pain for emotional burden, c) keeping their pain
medication a secret from practitioners out of fear of disapproval, d) thankfulness for a regained life and, e) fear of losing opioid medication while receiving opioid therapy (Vallerand & Nowak, 2009). Strength of the study included conducting two participant oral interviews to enhance credibility and validity. Limitations of the study are small sample size, the study does not state how much time elapsed between each interview, the lack of a rigorous prospective methodology and the potential for patient recall bias.

In part two of their phenomenologic study, Vallerand and Nowak (2010) offered patient narratives surrounding barriers related to opioid prescribing. This second paper was published separately using the data collected from the same participant oral interviews and is described above in the review of the first paper. One patient described an interaction with a practitioner in which the patient was accused of selling drugs because of the amount of opioid being prescribed and their appearance being judged as too healthy to require the medication (Vallerand & Nowak, 2009). Another patient described being told, “You’re a young woman, get off this garbage” (Vallerand & Nowak, 2009, p. 129). In addition, patients described feeling unduly labeled a “drug addict” or morally weak by family, friends, employers and health care providers for taking opioids for chronic pain. Strength of the study included conducting two participant interviews to enhance credibility and validity. Limitations are small sample size, lack of a rigorous prospective methodology and the potential for patient recall bias.

Werner and Malterud (2003) conducted a qualitative study of ten women with chronic pain in Oslo, Norway: four from a primary care clinic and six from a pain clinic. Researchers used a purposeful sample approach in order to represent women with different socioeconomic, demographic backgrounds and their experiences regarding illness. All the women participants were being treated for chronic musculoskeletal pain that could not be directly attributed to a
medical disorder. Study data was collected through semi-structured participant oral interviews with a researcher over a period of three years. The study does not state how many interviews were conducted, only that the interview averaged 2 ½ hours in length. The researchers described patient accounts of “work” in establishing credibility with their practitioners, so that their symptoms were believable. The women described a balancing act of trying not to appear “too strong or too weak, too healthy or too sick, too smart or too disarranged” (Werner & Malterud, 2003, p. 1409). According to Werner and Malterud (2003), the participants used strategies of appearance, surrendering and appropriate self-assuredness when interacting with their practitioner to project credibility, preserve self-esteem and minimize shame. Strength of study is a purposive sampling strategy for participant background diversity and validity of participants’ stories. Limitation to the study is its sample size, women only participants, and generalizability to other countries related to differences in accessibility to health care.

Arnstein (2007) offered a descriptive case study of a 76-year old woman named Mrs. Tandy who suffers from chronic pain related to diabetic neuropathy. The case study documents Mrs. Tandy’s treatment in a multidisciplinary pain clinic over a five year period. Upon presentation, Mrs. Tandy described a six year period of burning pain in her feet that progressed to the point of wanting to have her doctor “...just cut them off” (Arnstein, 2007, p 3). Mrs. Tandy’s reported experience with opioid medication prior to her presentation at the clinic provided little relief for her and had been limited to Tylenol # 3 and Darvocet N100, both of which she stopped because of side effects of constipation, and her head feeling “goofy”. Mrs. Tandy also described a hesitancy to use opioid medications for her pain due to concerns about addiction and disapproval from her children. Mrs. Tandy’s concerns about opioids in the treatment of chronic non-cancer pain were addressed by clarifying the term “addiction”,
reassuring her that she would be monitored for an emerging addiction disorder and that opioid medication was only one aspect in the treatment of her chronic pain. Working with her provider in a therapeutic relationship, using a multi-disciplinary approach, Mrs. Tandy was able to gain meaningful pain relief, thereby increasing her quality of life by using: a) adjuvant medication in addition to her opioid medication, b) cognitive behavioral therapy for assistance with coping skills, c) physical therapy, and d) diabetic education to gain better control of her diabetes. The strength of this study is its contribution to nursing practice. Limitation is sample size.

Practitioners' Perspective

Barry et al. (2010) conducted a qualitative study using grounded theory in which 23 physicians were interviewed for approximately one hour, face-to-face using a semi-structured approach to identify barriers and facilitators to opioid treatment of chronic pain. Researchers used a purposive sample strategy to recruit physicians from New England office-based clinics who: a) provide primary care, b) are not affiliated with an academic institution, c) practice within the community, d) no prior experience with addiction care in the opioid-dependent patient and e) may have experience with buprenorphine treatment or office based methadone maintenance as part of a research program. In regards to physicians experience, interest, and concerns regarding caring for patients dependent on opioids for chronic pain, physician’s identified related factors as absence of objective findings to explain patients’ pain intensity, lack of formal training in pain management, patients’ narrow focus on opioid medication, and difficulty discussing opioid abuse with patients. Additional findings include physician’s perceptions of patient related factors as motivation by the patient to divert prescription opioids, physicians not listening to patients pain reports and concerns about addiction potential. According to Barry et al. (2010), lack of interest in treating patients with chronic pain is closely
associated with physicians' negative perceptions of these patients, thus possibly contributing to the problem of under treatment. Strength of study is its use of a standard qualitative method using Grounded Theory and thematic saturation was achieved. A limitation to the study is the sample is from one geographic area may decrease the generalizability to other clinical practices located within the U.S.

Dobscha, Corson, Flores, Tansill and Gerrity (2008) conducted a cross-sectional study using a convenience sample of 45 Veterans Affairs (VA) primary care clinicians participating in a randomized clinical trial called the Study of the Effectiveness of A Collaborative Approach to Pain (SEACAP). A 23 item written survey designed to examine attitudes regarding chronic pain management, job satisfaction and satisfaction with local pain management resources was completed by the clinicians. Findings included 73% of clinicians moderately or strongly agreed that patients with chronic pain are a major source of frustration. Further, 52% of clinicians moderately or strongly agreed that previous experiences with patients addicted to drugs influenced their management of pain. Researchers found these two responses had meaningful correlations of \( r = +0.427 \) (\( P = 0.004 \)). Finally, 40% of clinicians moderately or strongly agreed that their management of chronic pain is influenced by fear of contributing to physical dependence on opioids, with 20% reporting that more than half of their patients treated with opioids became addicted. These findings were also found to have a positive correlation with clinicians perception of chronic pain patients being a source of frustration with values of \( r = +0.434, P= 0.003 \) and \( r = +0.393, P= 0.008 \), respectively. Strengths of the study are statistically significant correlations. Limitations include small sample size that did not allow for analysis of factors and items included on the survey had not been validated.
Fontana (2008) conducted a qualitative study using critical methodology to examine opiate prescribing practices using semi-structured oral interviews from a convenience sample and snowball technique of nine advanced practice registered nurses. The sample included six family nurse practitioners, one acute care nurse practitioner, one adult health nurse practitioner and one geriatric nurse practitioner. All participants were interviewed at least two times and subsequently asked to comment on data to minimize misinterpretation. Results showed participants viewed the decision to prescribe opioids for chronic pain as a clinical one based on objective findings, rather than one of responsibility to relieve subjective suffering of the patient. Other themes identified regarded concerns of “causing addiction”, scrutiny from regulatory agencies such as the Drug Enforcement Agency (DEA) and the responsibility to protect society from drug abuse and diversion (Fontana, 2008). Fontana (2008) concluded that practitioners are defensive in their prescribing, because of outside social and political factors that compromise trust in the nurse practitioner-patient relationship, as patients are viewed as potential criminals when considering prescribing opioids. Strengths of study include use of thematic saturation and at least two interviews. Limitations are small sample size.

Social and Political Perspective

Gilson (2010) used a 46-item self-report questionnaire to survey 277 state medical board members from a national sample for the purpose of examining four variable domains: a) beliefs about opioid addiction, b) beliefs and knowledge about state and federal policy, c) clinical beliefs about opioid prescribing, and d) demographic characteristics using descriptive statistics. Binomial logistic regression revealed predictive significance of 12 factors related to these four variable domains with separate models used for chronic opioid therapy in chronic non-cancer pain and chronic non-cancer pain with history of addiction. Study data was collected in 2006
and of the completed surveys received from state medical board members, 71% were from physicians, 4% were from other health care professionals and, 20% were from members of the public. Results revealed three variables with statistical significance in both models when considering the extent to which knowledge and beliefs contribute to attitudes about the legality of chronic opioid therapy in chronic non-cancer pain with and without history of drug abuse. First, board members that described addiction using physiologic characteristics were 12% more likely to view prolonged opiate prescribing as an unlawful or unacceptable medical practice (OR=0.118, 95% CI: 0.021, 0.649), where as board members were 25% more likely to have this view in the non-cancer pain group with history of drug abuse (OR=0.247, 95% CI: 0.079, 0.774). Secondly, when board members indicated that their medical board policies were beneficial to the improvement of the treatment of pain, they were significantly more likely to hold the attitude that prolonged prescribing was both lawful and acceptable medical practice in chronic non-cancer pain (OR=9.151, 95% CI: 1.619, 51.725) and 11% more likely in chronic non-cancer pain with history of drug abuse (OR=11.300, 95% CI: 1.616, 79.015). A percentage was not stated in the chronic non-cancer pain group without history of addiction. Thirdly, incorrectly believing federal law limits the amount of Schedule II medication that can be prescribed at one time increased the chances that board members would construe prolonged prescribing of opiates as unlawful and unacceptable practice in chronic non-cancer pain with and without history of abuse (OR=0.168, 95% CI: 0.043, 0.648 and OR=0.083, 95% CI: 0.023, 0.303, respectively). Finally, additional factors found to impact board members when considering the legality of prescribing opioids in the treatment of chronic non-cancer pain were: a) perceiving addiction as common when treating pain with opioids (P=0.030), b) considering it very important for a board to have a regulatory policy about pain treatment (P=0.038), c)
doubting the legitimacy of more than one opioid prescription for a single patient (P<0.0001), and
d) younger age (P=0.0380). Further, the respondents reported adequacy of their pain
management training as "poor" (P=0.012) was found to significantly influence their perception
of the legality of prescribing opioids in chronic non-cancer pain with history of abuse group.
Strengths of the study include a 45% pseudo-R2 value regarding goodness-of-fit with the
logistic regression model used for the chronic non cancer pain model and a response rate of 38%
with 277 board members of the total sample of 734 completing the self-response questionnaire.
Limitation of the study is a lack of external validity of the questionnaire.

Birnbaum et al. (2010) used a quantitative and apportionment methodology to estimate
the costs of prescription opioid drug abuse in the United States. Prevalence data was collected
from the Substance Abuse and Mental Health Services Administration (SAMHSA) and included
the National Survey of Drug Abuse and Health (NSDUH), Treatment Episode Data Sets (TEDS)
from state licensed substance abuse treatment facilities, Drug Abuse Warning Network (DAWN)
reports of drug abuse related deaths from emergency room admissions as well as medical and
drug claims data from a privately insured company database of 600,000 people. Data was
collected from the year 2001 as it was the most current data at the time of the study. The study
does not rely on a single concept of prescription opioid abuse due to a lack of consensus between
different data sets regarding the definition of abuse and addiction. The terms "prescription
opioid abuse” and “prescription opioid addiction” were used when discussing data that
corresponded with that respective data source and their accepted definition. The term abuse is
used to apply to medical and non-medical abuse of opioids and addiction is defined as the
displaying one or more of the following behaviors: a) impaired control or compulsive drug use,
b) continued use of drug despite harm and c) craving of the drug. The costs connected with
prescription opiate abuse were grouped into the three categories healthcare, criminal justice and workplace. Results estimated the cost in healthcare as 2.6 billion, 1.4 billion in criminal justice and 4.6 billion in the workplace for a total cost of 8.6 billion U.S. dollars in 2001. Researchers utilized The Medical Care Consumer Price Index (CPI) and the Hourly Compensation Index to adjust medical costs and earnings to reflect total costs as 9.5 billion in U.S. dollars in 2005. Strength of the study is an established methodology used in previous studies and a limitation of the study is inability to differentiate costs from prescription opioid and non-prescription opioid abuse, such as heroin because there are not ICD-9 diagnostic codes to differentiate between the two conditions.

Denisco, Chandler and Compton (2008) conducted a review of major clinical and epidemiological databases regarding opioid misuse while examining strengths, weaknesses and different methodological frameworks. For the purposes of this paper, Denisco, Chandler and Compton (2008) use the “umbrella” term of misuse that can entail one time use of a prescription opioid not authorized by a practitioner to cases of extreme drug abuse and addiction involving impaired control over and compulsive use of the prescription opioid with unmanageable drug craving and continued use despite harm. The authors found the prevalence of opioid misuse increased substantially through the 1990’s and early 2000 where it has since maintained at a high prevalence level. The National Survey on Drug Use and Health (NSDUH) estimated that in 2006, 2.1% of the population or 5.2 million persons over the age of 12 used a prescription pain reliever that was not prescribed for them or was taken for the “…experience or feeling they caused” (Denisco, Chandler & Compton, 2008, p. 418). Researchers note this prevalence rate has remained statistically unchanged since 2002. Multiple contributing factors to the problem were found in the literature and included medication formulation changes, pharmaceutical
industry marketing and the aging population (Denisco, Chandler & Compton, 2008). According to Denisco, Chandler & Compton (2008), the increased use of prescription opioids in the treatment of chronic pain is the most commonly associated factor in regards to opioid misuse. Thus, the increased amount of opioids circulating in the environment increases the potential for exposure to these medications and the potential for misuse. According to Denisco, Chandler & Compton (2008), 55% of misusers reported obtaining opioids from friends and family, while 80% of family reported obtaining opioids from a physician. Further, only 20% of misusers reported obtaining opioids from a physician, thus implying the environmental exposure through an indirect route, poses a health risk to a greater number of people (Denisco, Chandler & Compton, 2008). Strengths of the paper were the review and inclusion of multiple databases with strengths and weaknesses identified. Limitation of the paper was inconsistency between sources reviewed in regards to the definition of addiction.

**Significance to Nursing Practice**

The supporting research suggested much conflict in the practitioner-patient relationship surrounding the use of opioids in chronic pain and could in part explain the dissatisfaction expressed by both practitioner and patient. Themes identified in the literature from the patient perspective were feelings of distrust, suspicion of being accused of drug seeking and diversion of their opiate medication, concern regarding addiction, feeling labeled as morally weak for taking opioids, as well as being too healthy or young to take the medication (Upshur et al., 2010; Vallerand & Nowak, 2010; Arnstein, 2007). Other themes identified in the literature are desperation, suicidal thoughts, and humiliation prior to receiving opioid therapy and thankfulness, fear of losing therapy, exchanging physical pain for emotional burden, keeping the fact that one receives opioid medication for chronic pain a secret and trying to achieve balance
after beginning opioid therapy (Vallerand & Nowak, 2009). Finally, one study described the
effort put forth by women in chronic pain to appear legitimate to the practitioner using strategies
of appearance, surrender and appropriate self-assuredness (Werner & Malterud, 2003). The
patient perspectives presented support the concept of conflict and unequal power found in the
theoretical framework as patients are expected to prove they are not misusing opioid medication
and are “sick enough” to receive it.

Themes identified in the literature that support the theoretical framework from the
practitioner perspective include a general lack of interest and negative appreciation of chronic
pain patients related to practitioner identified factors of the absence of objective findings to
explain patients pain intensity, lack of formal training in pain management, patients’ narrow
focus on opioid medication, and difficulty discussing opioid abuse with patients. Further,
practitioner perception of patient related factors as motivation by the patient to divert
prescription opioids, concern over addiction potential, and failure to listen to patient’s pain
reports (Barry et al., 2010). In addition, Dobscha et al. (2008) found meaningful correlations
between practitioners’ frustration with chronic pain patients and practitioner’s admission that
previous experiences with addicted patients influenced their management of chronic pain, fear of
contributing to physical dependence on opioids and the perception that greater than half of their
patients treated with opioids became addicted. According to Fontana (2008) practitioners
viewed the decision to prescribe opioids for pain as a clinical one based on objective findings as
opposed to a responsibility towards the patient to relieve subjective suffering. Fontana (2008)
concluded that practitioners are defensive when prescribing opioids, giving social and personal
concerns regarding opioid addiction and misuse priority over patient interests, thus destroying
nurse practitioner-patient trust.
Themes found in the literature in support of the theoretical framework from the societal/political perspective were statistically significant variables of state medical board members associating the description of addiction with physiologic characteristics, belief that medical board policies are helpful to improving treatment of chronic pain and incorrectly believing federal law limits the amount of Schedule II medication prescribed at one time, thus influencing board members attitudes about legality and chronic opioid therapy in chronic non-cancer pain with and without history of drug abuse (Gilson, 2010). According to Gilson (2010), additional factors found to influence board members attitudes toward the legality of prescribing opioids for chronic non-cancer pain were perception of addiction as common when treating with opioids, considering it important that a board have a regulatory policy, doubting the legitimacy of more than one opioid prescription per single patient, younger age of board member and reported adequacy of their pain management training as “poor”. Birnbaum et al. (2006) estimated societal cost of prescription opioid abuse at 9.5 billion U.S. dollars when considering the categories of healthcare, criminal justice and workplace. Further, Denisco, Chandler and Compton (2008) concluded the increased treatment of chronic pain to be the most common factor linked to opioid misuse through increased environmental exposure. With 55% of misusers reportedly obtaining opioids from friends or family and 80% of misusers’ family reportedly acquiring opioids from a physician, practitioners are left to consider the implications beyond treating their patients’ chronic pain (Compton, 2008). According to critical social theory, practitioners must consider the societal concerns of cost, addiction and diversion as well as regulatory policy and legislation’s influence on the use of opioids in chronic pain as the perspective of society and the patient are in direct conflict. In summary, regulatory power and the good of the many take precedence over the good of the few.
Having presented perspectives from practitioners, chronic pain patients and society, the question now becomes: What can practitioners do to address conflict, thusly increasing satisfaction for themselves and their patients? First, the literature suggested that from the patient perspective, things that could reduce conflict and increase satisfaction would be 1) the practitioner projects sincere acknowledgement of their suffering as an individual, 2) the practitioner does not suspect patient of drug abuse, unless substantive proof exists, 3) practitioner “listening” to individual needs and life circumstances, and 4) practitioner trusting in the patient and shared decision making in treatment decisions (Werner & Malterud, 2003; Upshur et al., 2010; Vallerand & Nowak, 2009). Secondly, from the practitioner perspective, successful chronic pain management involved distinguishing boundaries, emphasis on function rather than pain intensity, increased training in pain management, and good practitioner-patient communication (Barry et al., 2010). Findings from Dobscha et al. (2008) suggest that practitioner frustration can be reduced and satisfaction increased when caring for patients with chronic pain by developing standardized methods for treating those at risk for or with previous history of addiction. According to Fontana (2008), practitioner-patient conflict could be addressed through acknowledgment of the social and political forces at play in regards to prescribing opiates for chronic pain and educating practitioners regarding their ethical responsibility in the treatment of chronic pain. Finally, practitioners should avoid the unintended consequences of the under treatment of pain by not withholding opioids from patients with legitimate medical needs, while the problems of opioid misuse and the possible side effects of long term prescribing are further investigated (Denisco, Chandler & Compton, 2008).

**Recommendations for Future Research**
Additional research is needed regarding the practitioner-patient relationship in the setting of chronic pain to gain additional insight into contributing factors to the conflict and dissatisfaction experienced. Areas for future research could include strategies to attenuate stigma experienced with the use of opioids in the care of chronic pain. Further research using a chronic disease model and a patient-centered approach when caring for chronic pain patients may improve practitioner and patient satisfaction. Finally, another area of interest could be the influence of social and political policy on practitioner prescribing of opioids in chronic pain.
References


