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Patient Satisfaction, Prescription Drug Abuse, and Potential Unintended Consequences

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Patient-centered care can improve treatment outcomes and its implementation has become the focus of national and local efforts to optimize health and health care delivery. Patients' satisfaction with care is one of the pillars of patient-centered care.¹ As such, results from patient satisfaction surveys (i.e., "patient experience of care measures") can be a driving force behind changes in health care delivery - with institutions and individual clinicians hoping for and actively seeking optimal survey scores. Although such initiatives generally promote improvements in practice that are responsive to patients' expressed needs, they may paradoxically promote prescribing of opioids and other addictive medications.

Complaints of chronic pain are increasing in the aging, sedentary population. Although opioid management for severe acute pain is often beneficial, the effectiveness of long-term opioids for chronic non-cancer-related pain is controversial and may have significant negative effects on individuals and society.² The United States is facing an epidemic of prescription drug misuse and diversion resulting in increased rates of addiction, health care utilization, and overdose deaths.³ Prescribed opioids constitute the main supply of these drugs for 70% of opioid abusers.⁴ Federal³ and addiction specialty⁵ policy statements recommend implementation of measures to decrease inappropriate prescribing, including enhanced physician training in opioid-based pain management, tailored patient education, and development of safer treatment strategies for pain. Thus, authorizing fewer prescriptions for opioids in some instances could constitute an improvement in medical practice, according to some analyses.

The complexity, as well as competing interests of clinical practice often do not lead to straightforward answers. Some patients diagnosed with non-malignant chronic pain have no identifiable underlying organic pathology.⁶ Care of these patients is difficult and can involve practice patterns that are not used for other conditions. For example, opioid prescribing guidelines⁵ suggest patient adherence monitoring, urine drug testing, pill counts, or written treatment agreements that bind the clinician as well as the patient to specific behaviors. Medical quality committees and even licensure boards can determine that care is substandard if clinicians exclude these components. Before prescribing opioids, clinicians may be expected to recommend non-opioid interventions and refer patients to consultants even if what the patient wants is an opioid prescription. Combined with overall poor treatment outcomes in chronic pain and difficulties reported by most clinicians regarding issues surrounding prescription drug abuse, it is not surprising that clinicians' satisfaction

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and comfort level with management of care for patients with opioid-treated chronic pain are low.⁷ This general picture sets a stage for the following considerations.

First, office visits in primary care are brief and the pressure on clinicians to maximize “throughput” to meet patient volume benchmarks has intensified. In the context of these time pressures, how should a clinician respond to the patient's request for inappropriate opioid pain medication? Guidelines⁵ suggest discussion of treatment alternatives such as pharmacological alternatives, lifestyle changes, and a clear statement that opioids are not the best choice. However, such patient encounters are challenging, time-consuming, and exact an emotional toll on clinicians, contributing to diminished practice satisfaction and burn-out.⁷ Given that compensation favors interventional procedures and high patient volume rather than time-consuming discussion, many physicians may behave in a way even they think is questionable: write the requested opioid prescription, and move on. The clinician saves time, but may be left with emotional and moral distress.

Second, patient expectations shape the health encounter. Many patients expect to receive an intervention that only a clinician can provide, a prescription for a medication. Patients may not be interested in alternatives to opioids and may be dissatisfied if their requests are not met. Research suggests this is a common pattern and confirms that fulfillment of patient expectations usually results in a more satisfied patient. Conversely, nonfulfillment correlates to patient dissatisfaction, which can translate to lower treatment satisfaction scores.⁸ In addition to reporting their dissatisfaction on a survey, patients may also file a complaint about the physician with a patient ombudsman.

Third, clinicians are experiencing increased pressure to produce positive results from their clinical activities. For example, a portion of a physician's compensation may depend on the “quality” of services provided, part of which may be based on patient satisfaction targets. Patients can report dissatisfaction based on real or perceived problems including whether a clinician did or did not prescribe a desired medication. In some institutions, the first question on the patient satisfaction survey queries the extent of agreement with the statement: “I was satisfied with the way my doctor treated my pain.” Many health care systems set benchmarks and provide normative values for patient satisfaction scores, in addition to considering them when reviewing a physician's salary. Of even greater importance, a physician's job retention or ability to be promoted may be directly linked to satisfaction-related results.

What is the effect of these conflicting forces simultaneously occurring in a brief office visit? On an individual level, patients may be frustrated or angry when they do not receive the treatment they want and have a misperception that receiving the treatment they want equals good medical care. Physicians who comply with unreasonable requests may find themselves in the role of “customer service” providers rather than medical professionals or healers⁹; physicians who do not comply with patient requests may be the recipients of poor ratings on patient satisfaction scores, possibly resulting in emotional, financial, and professional penalties. These issues may be inadvertent but powerful disincentives for physicians to provide medically correct care and may contribute to the erosion of trust needed in a healthy patient-physician relationship. These factors may also encourage difficult patients to be referred out of a clinician's practice (“patient dumping”) thus shifting the burden from those clinicians to others. From a societal perspective, inappropriate prescribing may contribute to increased availability of circulating opioids and the national problem of prescription opioid diversion, misuse, and related harms.¹⁰

Although behavioral techniques (e.g., motivational interviewing, conflict resolution), knowledge of the diagnosis, and management of chronic pain and addiction can improve

clinician and patient satisfaction, patient dissatisfaction may not always reflect lower-quality medical care; it should be assessed more carefully. Patient satisfaction and its assessment are essential.

However, unintended consequences may result from inappropriate use of patient satisfaction scores and it is important to ensure that incentives for clinicians are consistent with good medical practice. Although there is no single solution, an initial first step is to acknowledge the potential conflict in patient-physician interactions at the intersection of patient satisfaction and controlled substance prescribing. This will enable health care systems to move beyond the rigid use of quality measures, examine the issue locally, and develop realistic quality management systems to balance patient satisfaction with appropriate medical care.

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