Study objective: To inform the development of interventions that could improve patient engagement around the risks and benefits of alternative approaches to pain management in the emergency department (ED), we seek to capture the perspectives and experiences of patients treated for pain in this setting.

Methods: Three trained interviewers conducted semistructured open-ended telephone interviews with patients discharged from a single urban academic ED after presenting with acute pain related to fracture, renal colic, or musculoskeletal back injury. We recruited subjects until achieving thematic saturation according to periodic review of the interview transcripts. Interviews were audio recorded, professionally transcribed, and uploaded into QSR NVivo (version 10.0) for coding and analysis using modified grounded theory. An interdisciplinary team double coded the data and convened to review emerging themes, ensure interrater reliability, and establish consensus on discrepancies.

Results: We had 23 completed subject interviews, the majority of which were women. Interrater reliability for coding exceeded 90%. The major themes elicited centered on domains of patient awareness of the potential for opioid dependence and patient-provider communication relating to pain management. From the patient perspective, emergency physicians typically do not present alternative pain management options or discuss the risks of opioid dependence. Patients with negative experiences related to pain management describe deficiencies in patient-provider communication leading to misunderstanding of clinical diagnoses, fragmentation of care among their health care providers, and a desire to be involved in the decisionmaking process around their pain management. Patients with positive experiences commented on regular communication with their care team, rapid pain management, and the empathetic nature of their care providers. Patients communicate fears about the risks of opioid addiction, beliefs that following a prescribed opioid regimen is protective of developing opioid dependence, and an understanding of the broader tensions that providers face relating to the prescription of opioid therapy.

Conclusion: Patients identified a deficit of communication around opioid risk and pain management options in the ED. [Ann Emerg Med. 2015; -:1-7.]

Please see page XX for the Editor’s Capsule Summary of this article.

INTRODUCTION

During the last 15 years, governing bodies such as the Joint Commission emphasized recognition of pain in patients, labeling pain assessment as a fifth vital sign. The prevalence of pain as the presenting complaint in emergency departments (EDs) ranges between 38% and 78%. Up to 70% of patients with acute pain fail to receive any analgesics in the ED. Previously noted barriers to adequate pain management included provider failure to acknowledge pain, failure to document pain, inadequate training on analgesia, and sociodemographic biases.

Criticism of emergency physicians for insufficiently treating pain now is crossing with concerns about an opioid epidemic, the latter accounting for the greatest number of current injury-related deaths in the United States. Emergency physicians are confronted with the challenge of how to alleviate pain in a manner appropriate and adequate, which requires balancing the analgesic needs of patients with the potential risks associated with opioid therapy, including diversion, misuse, and dependence. During the course of the last decade, the federal government through the National Drug Control Strategy pushed for a multipronged approach to address the opioid epidemic, deploying initiatives that focus on drug monitoring, proper opioid disposal, physician education, and law enforcement.
Editor’s Capsule Summary

What is already known on this topic
Providers in the emergency department (ED) often give opioids to patients with pain. Little is known about patients’ knowledge and perceptions about analgesia after a visit to the ED.

What question this study addressed
What are the patient perspectives on their care after an ED visit for acute pain?

What this study adds to our knowledge
Open-ended interviews with 23 patients with selected acute pain complaints at 1 urban ED revealed themes of opioid addiction fear, perceived lack of provider concern, and opportunity for better communication about analgesia options.

How this is relevant to clinical practice
If sustained by research in other settings and conditions, these observations will inform analgesic protocols and care plans in an ED, targeting the opportunities noted.

Few of these initiatives examined or implemented interventions that engage patients around understanding of the risks and benefits associated with opioid and other alternative treatments.16 In the context of competing public health priorities presented by the 2 larger issues of patient oligoanalgesia and opioid misuse, the patient voice has been omitted.

We sought to inform potential patient-centered interventions that can both provide adequate pain management and decrease the potential for opioid misuse. We chose a qualitative approach to uncover patient perspectives and attitudes related to pain management in an ED setting.

Selection of Participants
Patient recruitment occurred between July 25, 2014, and October 3, 2014. We approached a convenience sample of all patients presenting during data collection periods with complaints of one of the following: acute renal colic, acute musculoskeletal back pain, or an extremity fracture. We used trained assistants to screen patients for eligibility by study personnel using the electronic medical record. Data collection periods were limited to weekdays in the mornings and afternoons for staffing reasons. We excluded patients who were pregnant or currently receiving opioids for a chronic medical condition. Because we were particularly interested in opioid treatment, we also excluded patients younger than 18 years or older than 65 years because of age-based recommendations about outpatient use of opioids.19 After consenting, enrolled subjects completed a basic verbal survey relating to their pain status and demographics. We sought to complete a follow-up semistructured telephone interview for all subjects finishing the initial survey, compensating them with a $30 gift card. To take a patient-centered approach to the study, allow meaningful recovery time, and limit recall bias, we conducted the telephone interviews 1 to 2 weeks after the ED visit. We enrolled until reaching thematic saturation, defined as the point when additional interviews stopped providing novel experiences and opinions.

Data Collection and Processing
We used a semistructured guide developed by the study team and pilot tested to conduct the interviews (Appendix E1, available online at http://www.annemergmed.com). Three qualitatively trained investigators (R.J.S., B.P., and S.K.) conducted the interviews, which we audiotaped, professionally transcribed, and entered into NVivo (version 10.0; QSR, Doncaster, Australia) for qualitative data management and analysis. We used Stata (version 13.0; StataCorp, College Station, TX) for quantitative analyses.

Primary Data Analysis
We approached the analysis with modified grounded theory. This approach included the use of an a priori set of codes that addressed our research questions, as well as a set of codes that emerged from the data de novo through iterative line-by-line reading of the interviews. The entire team of investigators reviewed early interviews and developed consensus on the list of codes that corresponded to emerging themes. Each code was then clearly defined and applied to all transcripts by 2 study investigators (R.J.S. and S.K.). We measured interrater reliability with the function in NVivo designed for this purpose, noting
agreement surpassing 90%. Consensus meetings resolved any discrepancies in coding. Three investigators (R.J.S., B.P., and Z.F.M.) summarized codes and examined relationships among codes to develop a theory about the themes that emerged from the data. Themes that emerged from the de novo codes correspond to the results domain of awareness of opioid dependence risk. Themes that emerged from a priori codes correspond to the results domain of communication around pain management.

RESULTS

Characteristics of Study Subjects

We approached 74 eligible patients in the ED, 48 (65%) of whom agreed to complete a verbal survey related to their pain management. Of these, 36 subjects (75%) consented to follow up by telephone interview and 23 (64%) completed the telephone interview. Table 1 illustrates the characteristics of patients approached and those subjects who participated in the interview portion of the study. Most of the participants were women (18/23). There was variation in age, race, presenting complaint, yearly income, and whether opioids were prescribed during the ED visit. Interview participants were more often women than the full group of patients approached but otherwise were similar with regard to age, presenting complaint, and whether they received opioids in the ED and at discharge.

Main Results

Although patients discussed many topics, novel themes arose in 2 broader domains: awareness of opioid dependence and addiction, and patient-provider communication around pain management. Representative quotes within each theme are listed in Table 2.

Patients vary in their attitudes and understanding of the addictive potential of opioids. They provide a range of ideas relating to how addictions develop and describe many avenues that inform their beliefs. Four major themes within this domain are described, with supporting quotations as evidence, as follows: (1) fear of developing dependence or addiction, (2) prescribed dosing preventing the possibility of addiction, (3) unofficial channels as sources of information about opioids, and (4) patients recognizing physician tension between adequate pain management and opioid stewardship.

Some patients describe hesitancy when receiving medication, both generally and more specifically for pain relief. Their hesitancy often stems from concern about the potentially addictive nature of opioids. As one patient noted, “I always look at people that started with some medicine and they end up being addicted to it and that’s something I never want.” Many patients report that they alter the prescribed regimen (ie, by receiving fewer pills) to diminish the risk of becoming addicted. They describe a fear of becoming dependent on medication to alleviate their pain and seek to avoid overuse. Some patients acknowledge risk factors (such as a family history of addiction) that may increase their likelihood of developing an addiction: “I get that fear of anything happening, like that has happened with my brother. Not that I know, okay, well, you took extra Percocets today; tomorrow you’re going to be buying crack in Camden. I know that’s not the case, but it just always sets in my head, so I’m always extra cautious.”

A number of patients believe that receiving pain medication as prescribed and to alleviate pain precludes an individual from becoming addicted: “I only take it as needed. So I don’t get addicted to it. I don’t have to have it every 5 minutes or every 10 minutes. You know how some people get addicted. They take painkillers and they just get addicted. They got to take it on and on every single day, every hour or so. I only take my medicine as needed.”

There is a perception among patients that individuals who become addicted have chosen to become so because they did not take their medications as prescribed or because

Table 1. Patient characteristics.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Interview Participants (n=23)</th>
<th>All Patients Approached (n=74)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>18 (78)</td>
<td>43 (58)</td>
</tr>
<tr>
<td>Male</td>
<td>5 (22)</td>
<td>31 (42)</td>
</tr>
<tr>
<td>Age, y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18–29</td>
<td>4 (17)</td>
<td>15 (20)</td>
</tr>
<tr>
<td>30–39</td>
<td>4 (17)</td>
<td>14 (19)</td>
</tr>
<tr>
<td>40–49</td>
<td>7 (30)</td>
<td>18 (24)</td>
</tr>
<tr>
<td>50–59</td>
<td>4 (17)</td>
<td>20 (27)</td>
</tr>
<tr>
<td>60–65</td>
<td>1 (4)</td>
<td>7 (9)</td>
</tr>
<tr>
<td>Condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal colic</td>
<td>5 (22)</td>
<td>9 (12)</td>
</tr>
<tr>
<td>Extremity fracture</td>
<td>5 (22)</td>
<td>21 (28)</td>
</tr>
<tr>
<td>Musculoskeletal back pain</td>
<td>13 (56)</td>
<td>44 (59)</td>
</tr>
<tr>
<td>Given opioids in the ED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>11 (48)</td>
<td>32 (58)</td>
</tr>
<tr>
<td>No</td>
<td>12 (52)</td>
<td>42 (43)</td>
</tr>
<tr>
<td>Given opioids on discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>9 (39)</td>
<td>22 (30)</td>
</tr>
<tr>
<td>No</td>
<td>12 (52)</td>
<td>46 (62)</td>
</tr>
<tr>
<td>Admitted</td>
<td>2 (9)</td>
<td>6 (8)</td>
</tr>
<tr>
<td>Yearly household income, $</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;100,000</td>
<td>3</td>
<td>n/a</td>
</tr>
<tr>
<td>50,000–99,999</td>
<td>6</td>
<td>n/a</td>
</tr>
<tr>
<td>25,000–49,999</td>
<td>4</td>
<td>n/a</td>
</tr>
<tr>
<td>&lt;25,000</td>
<td>5</td>
<td>n/a</td>
</tr>
<tr>
<td>Declined to answer</td>
<td>5</td>
<td>n/a</td>
</tr>
</tbody>
</table>

n/a, Not available.
they “enjoyed” the medication. Many of these patients believe that they have full agency over not developing an addiction by simply declaring that they do not want to become addicted. For example:

“I do know that pain medication can become very addicting. I’m not afraid of that for myself, because I don’t find it enjoyable, but it’s just something that’s in the back of my mind, that’s all.”

“I mean, you know, some pills or medication; they said you can get addicted if you rely on it so long. So I try to do it how the doctor prescribed it.”

Patients describe many avenues that inform their beliefs and understanding related to opioids and addiction. Much of their understanding has developed from popular media exposure or experiences with friends and acquaintances. When asked about where she developed her understanding of the addiction risks of opioids, one patient answered, “I go to college, so I just hear stories about people having a pill addiction and it usually is a narcotic that they get addicted to; also it’s on TV shows and stuff.” Many patients describe “hearing stories” about people with addictions without describing specific incidents. Because of this, some patients explicitly express the desire for instructions on how to minimize their risks of addiction. Some are able to ask questions to elucidate those answers: “I’ve never had a history with any kind of addiction in terms of myself at all. But you hear stories of people being addicted, and you’re nervous about wanting to make sure that that doesn’t happen. So for me, it was about trying to ask all the right questions and being cautious about making sure that, what is overuse, how hard is it if you’ve been on it for 3 full days to get off.”

Some patients describe the broader tension that they perceive among care providers about wanting to balance adequate pain management with the addictive risks of opioids. Some express feeling that they suffer the brunt of that tension because “other patients” have become addicted. In a sense, they blame these “addicts” for clouding the physician’s ability to distribute pain medication to those who most need it: “people who take pills a lot or drug addicts, they just find it for the high, but the people that are in real pain don’t get prescribed what they need because of the people that abuse the medicine.” Other patients describe awareness of individuals who are pain medicine seekers, but they do not think that such individuals should stop other patients from receiving adequate pain care: “[P]eople are just so afraid of these drugs. So then maybe they

Table 2. Themes and representative quotations.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Theme</th>
<th>Representative Quotation With Patient ID, Age, and Presenting Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid dependence awareness and risk (de novo domain)</td>
<td>Fear of developing dependence or addiction</td>
<td>“I am getting afraid that my tolerance to pain medicine is getting lower because I feel the pain coming a lot more strongly, quickly, but I don’t want to step anything up a notch because I don’t want to have any further issues than the main ones that I’m having.” (1023, 45F, renal colic)</td>
</tr>
<tr>
<td>Prevention of addiction</td>
<td>Prescribed dosing prevents the possibility of addiction</td>
<td>“I only take it as needed. So I don’t get addicted to it. I don’t have to have it every 5 minutes or every 10 minutes.” (1082, 28M, fracture)</td>
</tr>
<tr>
<td>Unofficial channels are sources of information about opioids</td>
<td>Unofficial channels are sources of information about opioids</td>
<td>“I learn about it from just general knowledge. Usually my mom talking about that kind of stuff, TV shows, movies.” (1149, 19F, back pain)</td>
</tr>
<tr>
<td>Patients recognize provider tension</td>
<td>Patients recognize provider tension</td>
<td>“Give patients something for the pain right then and there because I don’t think too many people are going to play around like that. I mean, you do have people do that, probably, but you need to give them something for the pain to knock it out.” (1186, 50M, back pain)</td>
</tr>
<tr>
<td>Communication around pain management (a priori domain)</td>
<td>Desire for autonomy and engagement in treatment plan</td>
<td>“That’s why I felt that, like none of the topics, it was open to discussion. It was just sort of assumed that the hospital knows best. And I don’t really care for that kind of point of view.” (1092, 43M, fracture)</td>
</tr>
<tr>
<td>Poor communication around testing</td>
<td>Poor communication around testing leads to dissatisfaction and misunderstanding of pain cause</td>
<td>“I would want them to look more in depth and do more research to figure out why I’m having such bad pain, not just thinking that it’s similar to every other minor back pain case. I want them to look more direct at me, you know, have more conversations about the pain, and do, like, X-rays or something to figure out and see if this is deeper than what I’m thinking it is because it could be worse; it could just be back pain, but it could be something more serious.” (1032, 34F, back pain)</td>
</tr>
<tr>
<td>Preference for communication around</td>
<td>Preference for communication around functional pain status and pain quality</td>
<td>“...just for the doctor to be a little bit more in tune to what the patient is saying about the pain and how it is affecting their life...” (1035, 46F, back pain)</td>
</tr>
<tr>
<td>Patients recognize care fragmentation</td>
<td>Patients recognize care fragmentation</td>
<td>“[It doesn’t seem like there’s great communication between some of the times, the nursing team or the doctor on call and the observation area and some of the other specialist teams.” (1082, 28M, fracture)</td>
</tr>
<tr>
<td>Desire for empathy</td>
<td>Desire for empathy</td>
<td>“I was just disappointed. I was disappointed in the lack of empathy and feeling of support. And I was disappointed and feeling like there was a lot of miscommunication and not realistic expectation setting.” (1038, 41F, renal colic)</td>
</tr>
</tbody>
</table>
should prescribe something else because there are other drugs to prescribe. So it’s just—it’s like they have one thing in their tool kit for pain, which is Percocet or Vicodin, and they won’t believe you because they’re afraid you’re going to get addicted to it.”

Similarly, some patients are afraid to be perceived as drug seeking. To avoid being judged by physicians for requesting pain medication, they minimize communication of the amount of pain they are experiencing. “I feel in my head that I’m going to be judged or something, so I just kind of deal with it [the pain]. I just always have it in my head.”

Major themes related to the patient experience of communication around pain management in the ED emerged from the interviews. Five major themes within this domain are described with supporting quotations as evidence: (1) autonomy and engagement in treatment plan are desired, (2) poor communication leads to dissatisfaction and misunderstanding of pain cause, (3) communication around functional pain status is preferred, (4) fragmentation is noted by patients as a detriment to their care, and (5) empathy is desired.

Many patients want to be actively involved in making decisions around their care. As one patient noted, “I think that’s important because we’re not professionals or anything, but we got to know our body to a certain degree.”

When physicians do not acknowledge patients’ perspective, they can feel patronized and disrespected by the medical system: “[N]one of the topics [were] open to discussion. It was just sort of assumed that the hospital knows best. And I don’t really care for that kind of point of view.”

Patients emphasize their desire to be heard by physicians, and they want to spend more time with them. Patients want physicians to create opportunities for them to ask questions and provide input related to pain management. Their suggestions for change frequently surround criticism relating to communication both between the physician and the patient and also between health care providers. When physicians have ruled out concerning causes of a complaint, patients want that information communicated to them. Many patients describe wanting “more tests run” or “more stuff done.” They often believe that their issues are dismissed by physicians if providers choose not to pursue further diagnostic investigations. For example, one patient noted, “[O]rder a little bit more tests as opposed to just saying that this is what it could be without really knowing what it is .”

Many patients express concern that providers do not really know what is causing their pain. They also relay anxiety around the lack of communication and information relating to their care plan within the ED. Instead of the classic 1-to-10 pain scale, patients wish that physicians could delve into what the pain means for the patient, focusing on functional impairment and the source of pain: “[F]ind out…how the patient really feels about the pain and how they are trying to cope with the pain. So asking them what are you doing, how are you handling the pain, how is it affecting your personal life, as well as your employment history, does it stop you from going to work, and stuff like that.” Similarly, patients wish to discuss their pain in an iterative fashion with their providers during the course of their emergency stay.

Patients also want providers to do a better job tracking the nature, quality, and progress of their pain: “[A]fter I’d been given my first dose of the morphine, it probably would have been a lot easier for the doctor to come in soon after I’d been given that medication. That way they can get some feedback on how well it’s working.”

Patients notice when teams, nurses, and physicians fail to communicate with one another, leading to care fragmentation. They see this lack of coordination as a detriment to their care: “[T]here was a lot of miscommunication and not proper expectation setting, which really wore on me.” One patient suggested the creation of a role for a “nurse navigator” in the ED to help guide patients through the various stages of their stay.

Patients see nurses as individuals who can advocate for them, particularly as it relates to pain management: “[T]he nurses may be able to convey more to doctors, that, ‘Hey, it’s been a couple of hours since we gave her pain medicine’.”

Patients recognize that the ED is a hectic environment and that there are often more severe or urgent cases that deserve provider precedence. However, they also emphasize their vulnerabilities, wishing that physicians would minimize judgment and maximize patient comfort. As one patient suggested, when asked how to optimize care: “…just to be taken care of, be seen by a doctor, get the attention that every other patient deserves, not just come in the room for a second, ask me a couple of questions and then come back with the prescription. Show a little empathy.”

Some patients described their ED visit holistically in a very positive light. These patients emphasized that their pain was well managed and treated quickly: “[T]here was definitely sympathy from the minute I walked in, in terms of empathy ‘I’m so sorry you’re feeling like this.’ They were able to get me right in, which I know isn’t always the case with emergency rooms. The care felt very compassionate, very quick.” Satisfied patients also describe frequent and regular contact with health care providers during their ED stay. These individuals have materials “explained to them” and often describe the physicians and nurses as “caring”: “[T]hey talked to me in a way that I could understand, [using] layman’s terms, as a human and not like I was a textbook. So they explained the side effects and the benefits...
of the pain [medication] and how often I should take it, and if I don’t have to take it, don’t take it.”

LIMITATIONS

As is common to all qualitative research, our observations are exploratory, not definitive. We can generate or refine hypotheses for future interventions around pain management and communication in EDs. We chose a convenience sample of patients presenting to one ED with one of 3 common complaints known to cause acute pain; although these selected conditions present with distinct pain profiles and distinct risks for conversion to chronic pain, they may not reflect all possible patient presentations or experiences. Individuals opting to participate may differ in their desire to share specific complaints related to their experiences compared with nonparticipants.

DISCUSSION

The patient experience with acute pain in ED settings is affected by many complex factors. Although studies have aimed to quantify patient satisfaction with pain management in the ED, we uncovered some patient experiences and attitudes related to pain management, use of opioids, and understanding of the risks of developing opioid dependence. The patient’s overall experience is not guided by mere satisfaction or dissatisfaction with pain management. The dynamics of provider empathy, care coordination, active patient-provider communication, and patient agency all contribute to a patient’s understanding of their pain and pain management strategies. Patient narratives reveal areas of possible intervention for moving beyond patient satisfaction as a metric for understanding the optimal way to manage pain.

A notable finding from the interviews is that many patients are aware that addiction is a risk with opioid use and are wary of that risk. Patients want their pain to be treated, but their narratives suggest that there are many methods for approaching the issue of adequate pain control. It seems possible that increased communication and education in the ED could alleviate many of the concerns that patients express relating to their pain. This finding is consistent with previous research indicating that some patients do not desire pharmacologic analgesics, even when they express feeling pain.20 Additionally, patients voice a fear around the possibility of long-term dependence, having experienced addiction through family, friends, acquaintances, or merely popular media. Given patient fears and misunderstandings of opioids in combination with the deficit of communication around pain and pain management in the ED, it seems natural that future interventions could involve tools that simultaneously target both issues, enhancing patient-provider engagement around opioid risk awareness.

Patient dissatisfaction with ED visits frequently stemmed from a fear that providers did not know what was causing their pain and that therefore pain might be a signal for a serious or unrecognized problem. Given that all these patients leave with diagnoses, it seems more likely that providers did not optimally communicate their understanding of the patient’s pain cause. If that information were communicated more effectively, patients might be more satisfied with their care. Our interviews also illustrate that patients recognize the existence of many systems-level pressures within the medical system, such as the difficulties of care coordination within a hectic ED environment. They wish for empathetic care, but they realize that a provider’s time and attention are precious resources. It is, perhaps, because of these structural limitations that patients voice such strong desires to be actively heard and involved with the decisionmaking process around their pain. Additionally, by describing the reality of prescription drug abuse, many patients in our sample actually recognize the stress that providers face relating to prescribing opioids. This further suggests that ED providers can draw on the broader conversation around opioid stewardship to communicate with patients about opioid prescription practices. Although the intent of this study was to gather patient pain perspectives, it is likely that physician perspectives will also inform this conversation. How physicians perceive that they approach issues of pain, pain management, and opioid risk assessment in the ED will contribute to the eventual development of interventions to improve pain communication and diminish opioid misuse.

Although patients acknowledge the addiction risk associated with opioids, many of their beliefs and attitudes are not congruent with current evidence. Some people believe that developing an addiction to opioids is a choice or a weakness, or that addiction and other adverse events will not develop if opioids are received “as directed” or “as needed.” Previous research noted that 60% of individuals who die from complications related to opioids were initially prescribed medication within the scope of recommended guidelines.21 Another study showed that 8% of opioid-naive patients are still receiving opioids 1 year after their initial prescription.19 The individual risk for prescription drug abuse is related to a complex set of factors, including younger age, previous illicit drug use, family history of drug and alcohol use, unemployment, history of sexual abuse, and history of depression, anxiety, or posttraumatic stress disorder.22 Much of what patients
learn about opioids is through either popular media or word-of-mouth. This suggests an opportunity to use popular media as an avenue for dispersing public health messages related to the various risks associated with opioid use, whether prescribed or not.

Patients provided a number of feasible suggestions to medical providers for improving communication around pain management, including iterative communication relating to pain levels and emphasis on functional status, as opposed to just using the pain scale. They advocated use of lay language and avoidance of medical jargon, increased time spent with the provider, improved communication between care teams, rapid treatment time, rapid pain relief, and increased provider empathy. Patients desire to be involved with the decisionmaking process.

Our qualitative observations detailed that many ED patients desire to be more involved in conversations relating to their pain management options, and they want to know more about the risks associated with opioids.

The authors acknowledge Cjloe Vinoya, BA, and Maureen McCauley for their help with patient recruitment, and Jeffrey Bell, RN, Melissa Rodgers, BA, and Michael Zyba, BS, for serving as patient representatives for our study and piloting the interview guide.

Supervising editor: Donald M. Yealy, MD

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Author contributions: KR, JP and ZFM conceived the study and recruited and data collection and management, including quality control. RJS conducted data analysis and drafted the article, and all authors contributed to its revision. ZFM takes responsibility for the paper as a whole.

Funding and support: By Annals policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article as per ICMJE conflict of interest guidelines (see www.icmje.org). The authors have stated that no such relationships exist and provided the following details: Funding was provided by a grant from the Agency for Healthcare Quality and Research to Drs. Meisel and Rhodes in the Center for Emergency Care Policy & Research, R15HS021956.

Publication dates: Received for publication February 18, 2015. Revisions received March 18, 2015; and March 19, 2015. Accepted for publication March 23, 2015.

REFERENCES


APPENDIX E1

Interview guide

1. Tell me about your experience with low back pain (or) kidney stones (or) fracture.
   a. Can you tell me how you managed your pain before coming to the ED?
2. What made you decide to seek care in the ED?
3. Tell me about the treatment or care you received at the hospital.
   a. How well was your pain managed in the hospital?
4. Describe how your physician talked to you about your options for managing your pain.
   a. How did you feel about that interaction?
   b. What were your concerns when you were discussing your pain?
   c. Were your questions about pain treatment addressed by the physician? What were those questions?
   d. What questions do you still have about treating your pain for this injury?
   e. What would you like to be different next time you speak to a provider about pain management?
   f. Was there anything else you hoped the physician would do [or ask]?
5. Before leaving, were you prescribed any medications specifically for managing pain?
   a. If yes:
      i. What medication were you prescribed? Did you receive all, some, none of this medication? (or specify quantity)
      ii. How long did you continue receiving this medication after your ED visit?
      iii. Did you do anything else to address your pain?
      iv. How long did your pain last?
   b. If no:
      i. Tell me more about that. How was that decision made?
         1. Whose decision was it?
         2. Did you discuss these options with the treating physician?
         3. Did you choose not to receive prescription pain medication for this pain? If so, why did you make this decision?
      ii. How did the treating physician recommend you manage the pain you were experiencing?
      iii. How did you manage your pain without pain medication?
         1. Tell me about your experience with this.
6. Tell me about any previous experiences you have had with pain.
   a. How did that pain compare with the pain that brought you to the ED?
7. Before you came for care, how did you hope your physician would manage your pain?
8. If you could share your experience with pain management with all physicians, what would you want them to know?
9. What do you find most helpful when physicians talk to you about pain?
10. When physicians talk to you about your pain, what are some things that are unclear or perhaps confusing?
11. If you had known then what you know now, would you have wished for anything to be done differently in the management of your pain?
   a. Would you have chosen the same or a different medicine to treat your pain?
   vi. Tell me about your current use of this medication.
   1. How have you managed your use of this medication? What prompted you to receive the medicine (ie, receive it on a regular schedule or only when needed)?
   2. If you stopped the medication, how was your experience?
   3. Was this process difficult? If so, what was difficult about this transition?