2020 CBSSM COLLOQUIUM PRESENTATION ABSTRACTS

2020 Bishop Lecture in Bioethics

Promoting Gender Equity in Medicine: An Evidence-Based Approach

Presenter: Reshma Jagsi, MD, DPhil

Presentation

Stigma and Primary Care Access for Patients on Long-Term Opioids

Presenter: Pooja Lagisetty, MD, MSc

Co-authors: Colin Macleod, MA; Jennifer Thomas, BS; Stephanie Slat, BS; Amy S.B. Bohnert, PhD; Kipling Bohnert, PhD

Background: Recent data suggest many primary care physicians (PCPs) are unwilling to accept new patients receiving long-term opioid therapy (LTOT) for pain. This reluctance is commonly attributed to increased administrative burdens and fears of legal sanctions. However, previous studies have not quantified how stigma may influence clinical decision-making in caring for this patient population.

Methods: We used "secret shopper" methodology to audit primary care clinics across nine states with varying opioid overdose rates. To examine stigma, each clinic was posed two different scenarios involving a simulated patient on LTOT. In one, the patient's previous PCP had retired; in the other, they had stopped prescribing opioids for unspecified reasons. We asked whether a provider would see the patient and potentially prescribe opioids. If they were unwilling to prescribe, we attempted to schedule an appointment for non-pain related care (i.e. diabetes management). McNemar's test was used to assess differences between scenarios in proportions of prescription and acceptance potential.

Results: Of 452 clinics, 193 (43%) said their providers would not prescribe opioids in either scenario, 146 (32%) said their providers might prescribe in both, and 113 (25%) gave differing responses. Clinics providing differing responses had greater odds (OR=1.83 CI[1.23,2.76]) of indicating willingness to prescribe in the retired PCP scenario than the discontinued prescription scenario. In 8.5% of calls (n=904), clinic representatives said they would neither prescribe opioids nor accept the patient for diabetes management, after initially saying they were accepting new patients.

Conclusions: Clinic willingness to manage opioids for a new patient on LTOT varied significantly based on the stated reason for needing a new doctor. A sizeable portion of clinics also denied non-pain related care, which may constitute unethical and illegal discrimination. Our results indicate that stigma significantly influences clinic decision-making and treatment access for patients on opioids.

Presentation

The need for brevity during shared decision making for cancer screening: Can we compromise?

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Background: Detailed shared decision making (SDM) about cancer screening is difficult due to time-constraints and competing demands in primary care. A more feasible approach to SDM may thus require a compromise, but little is known about how patients feel about incomplete SDM that hits key elements. Using deliberative focus groups, this study assessed patient perspectives on a compromise solution (Brief SDM) where the PCP focuses on 3 key elements: 1) make a highly personalized recommendation; 2) briefly present qualitative information on the key tradeoffs for an individual; and 3) convey full support for decisional autonomy and desires for more information.

Methods: We recruited a stratified random sample of Veterans from one academic-affiliated VA health system who were eligible for lung cancer screening, oversampling women and minority patients, to a 6-hour deliberative forum. First, experts informed participants about basics of cancer screening and factors that influence heterogeneity in an individual's net benefit, including their preferences. Then, facilitator-led small groups elicited patient feedback and questions on the Brief SDM compromise proposal.

Results: 36 Veteran heavy smokers participated (50% male, 83% white, 47-79 years old). At final debriefing, all 5 small groups reached consensus that a Brief SDM approach is acceptable and strongly endorsed the importance of patients being final deciders. There was disagreement about the exact language clinicians should use during brief SDM. Surprisingly, despite pushback from expert presenters, patients broadly agreed that clinicians should not mention the potential of downstream, because this information was felt to be inappropriately "scary" and this conversation could take place at a later date.

Conclusion: Patients recognized the need for brevity during patient-clinician cancer screening discussions and endorsed a brief SDM approach as acceptable. These findings suggest that more feasible alternatives to detailed SDM may be useful and acceptable for routine cancer screening discussions.