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The dilemma of repeat weak opioid prescriptions – experiences from swedish GPs

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ABSTRACT

Objective: To explore general practitioners' (GP) experiences of dealing with requests for the renewal of weak opioid prescriptions for chronic non-cancer pain conditions.
Design: Qualitative focus group interviews. Systematic text condensation analysis.
Setting and subjects: 15 GPs, 4 GP residents and 2 interns at two rural and two urban health centres in central Sweden.
Main outcome measures: Strategies for handling the dilemma of prescribing weak opioids without seeing the patient.
Results: After analysing four focus group interviews we found that requests for prescription renewals for weak opioids provoked adverse feelings in the GP regarding the patient, colleagues or the GP's inner self and were experienced as a dilemma. To deal with this, the GP could use passive as well as active strategies. Active strategies, like discussing the dilemma with colleagues and creating common routines regarding the renewal of weak opioids, may improve prescription habits and support physicians who want to do what is medically correct.
Conclusion: Many GPs feel umcomfortable when prescribing weak opioids without seeing the patient. This qualitative study has identified strategic approaches to deal with that issue.

KEY POINTS

Opioid prescription for chronic non-cancer pain is known to cause discomfort, feelings of guilt and conflicts for the prescribing doctor. From focus group interviews with GPs we found that to deal with this:

- Doctors can use active strategies, such as confronting the patient or creating common routines together with their colleagues, or …
- They can use passive coping strategies such as accepting the situation, handing over the responsibility to the patient or choosing not to see that there is a problem.
- Opportunities for doctors to discuss prescription routines may be the best way to influence prescription habits.

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Introduction

Since the year 2000, drug-related mortality in Sweden has increased, and more than half of these deaths are related to opioids [1]. Legal prescription of opioids can also cause other side effects, besides death, such as sleep disorders, constipation, nausea, risk of falls, increased pain, addiction and abuse [2,3]. Awareness of these side effects creates a dilemma for the general practitioner (GP) when prescribing opioids for chronic non-cancer pain [4].

Traditionally, opioids have been divided into two categories, "weak" (e.g. codeine and tramadol) and "strong" (e.g. morphine). While weak opioids are indeed less potent, side effects and the risk for developing addiction are more or less the same [5].

Unlike acute pain, most chronic non-cancer pain disorders have multifactorial causes, and chronic pain is considered to be a disease in itself [6,7]. A multifactorial approach to treatment is required, as adequate pain relief is difficult to achieve by drug treatment alone [5,8]. According to Swedish national guidelines introduced in 2002, there are indications for both weak and strong opioids for the treatment of chronic non-cancer pain as a complement when first-hand

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treatments such as cognitive behavioural therapy and physiotherapy have not been sufficiently effective [5,6]. However, according to two recent reviews from 2010 and 2013, one of which is systematic, the scientific support for long-term weak and strong opioid treatment of chronic non-cancer pain is flimsy [9,10]. Both weak and strong opioids come with troublesome side effects after a 2–3 year treatment period and may induce pain sensitisation over time [9], which can lead to increased and prolonged pain [11]. Furthermore, weak opioids have little or no effect on around ten percent ot the Swedish population due to a genetic inability to metabolise them to morphine [12]. As a result, some regional drug committees no longer recommend the use of weak opioids for the treatment of chronic non-cancer pain [13].

According to some studies, the doctor's decision to prescribe weak and strong opioids does not seem to be influenced to any great extent by the actual physical pathology, the pain severity, or by whether a health centre has guidelines about prescribing them [14,15]. Instead, other factors, like the patients' non-verbal communication of pain (pain behaviour), social factors, such as the perceived risk of harming the doctor–patient relationship, and the doctor's personal opinion of whether opioids are appropriate, seem to influence the doctor's prescribing habits.

Prescribing weak opioids when treating chronic non-cancer pain is problematic for the GP in many ways. It is unclear whether the treatment will lead to tolerance and addiction, and it can be difficult to determine whether a patient is simulating pain in order to get a prescription due to personal addiction or in order to sell it to someone else [4]. The decision to prescribe often has to be based on incomplete, conflicting and unreliable information [16,17]. A Danish study found that opioids were frequently prescribed at out-of-office telephone consultations by general practitioners [18]. According to national guidelines, continuous treatment with weak and strong opioids is supposed to be subject to continuous follow-up and evaluation [5], which is not usually the case when routine repeat prescriptions are issued. When we searched the literature we were unable to find previous studies that had addressed the specific situation of repeat (weak or strong) prescriptions.

The aim of this study was thus to explore how GPs experience requests for the renewal of prescriptions for weak opioids unrelated to a consultation. Furthermore, we wanted to understand more about their strategies for handling such situations. We chose to focus on weak opioids in particular as our impression is that many doctors perceive weak opioids as less harmful and, therefore, easier to prescribe for non-cancer pain conditions.

Material and methods

In order to investigate the GP's experience of prescribing weak opioids without seeing the patient, an inductive qualitative approach was chosen. To generate discussions amongst the participants we chose to interview GPs in focus groups [19]. The managers of ten health centres in one county in the middle of Sweden were contacted by mail and asked whether the primary care doctors at the centre were willing to participate in the study. All but one of the health centres agreed to participate. There where no reasons given for not wishing to participate. Amongst those health centers that agreed to participate, two urban and two rural centres where selected, to provide more variety. Each focus group consisted of four to six GPs, GP residents and interns working at the same health centre, with a total of 21 participants. The interviews took place at the health centre where the participants were employed. For participant characteristics, see Table 1.

The manager of each health centre approved the study. The invited participants who chose to participate received written information about the study. Relevant parts of the COREQ checklist were used to ensure the validity and reability of the study [20].

Data collection

The members of each focus group were asked to describe a situation when they had been requested to renew a prescription for a weak opioid and how they felt about and dealt with the situation. Participants were then encouraged to freely discuss their experiences with each other. The interviews lasted between 35 and 60 minutes. They were

Table 1. Participant caracteristics.

Health centre and location	Date for interview	Mean age (range)	Years of experience working as a doctor	Intern/GP resident/GP	Female	Male	Total number of participants
A Urban	7 April 16	39 (27–46)	11 (0–20)	1/1/4	4	2	6
B Rural	8 April 16	47 (35–59)	17 (6–25)	0/0/5	1	4	5
C Urban	12 April 16	44 (26–58)	14 (0–29)	1/2/3	2	4	6
D Rural	16 June 16	50 (33–58)	21 (2–30)	0/1/3	1	3	4

moderated by EE. AH participated as an observer in the last two interviews [19]. The interviewers, who were very familiar with the phenomenon of receiving requests for prescriptions of weak opioids, were of the same profession as the informants. The interviews were recorded with an audio-recorder and transcribed verbatim, first one by EE and the other three by an administrator. EE and AH were previously acquainted with some of the participants in the focus groups.

Data analysis

The interviews were analysed using Malterud's systematic text condensation [21], a method that is based mainly on a phenomenological-hermeneutic approach. To get an overview, the interviews were first read through by both authors, and tentative themes were formulated and discussed [22]. Meaning units were identified, condensed and coded with labels based on similarities and differences. The coding was done by the authors, first separately and then together. The codes were sorted into categories and subcategories under which the condensed meaning units where recontextualised. A recurrent and underlying theme was identified and discussed between the authors. The categories, subcategories and themes were discussed in a seminar together with other researchers and thereafter modified to strengthen the credibility of the analysis.

Ethical considerations

Participants received written and oral information about the study. They were informed that participation would not involve any risks, that is, what was said in the room would not be passed on to third parties; that they could withdraw from the study at any time; that all material would be kept out of reach of unauthorised persons; and that their identities would not be disclosed in the final text. Participants had to leave verbal consent.

Results

A recurring theme throughout the interviews was a sense that, no matter how you acted as a doctor, some professional ethical rule or inner conviction could be violated. By renewing patient prescriptions for weak opioids, your inner professional code, namely to do what is medically correct and not to harm the patient in the long run, was violated. On the other hand, by refusing to prescribe weak opioids, you could cause the patient more suffering from severe pain, which is also against the doctor's ethical code. To this should be added the risk of losing the patient's confidence, or of being at loggerheads with your colleagues or the management of the health centre, as there are no resources to compensate for the extra time it would take to motivate patients to quit their addiction. The situation gave rise to a number of adverse feelings in most of the informants, which could be directed towards their patients, their colleagues or themselves personally. Passive and active strategies were used by the doctors to deal with this dilemma and the adverse feelings. These adverse feelings and their resulting strategies are listed in three main categories and nine subcategories in Table 2.

Table 2. Categories and subcategories emerging from the interviews.

Categories	Subcategories
Adverse feelings	Feelings of being manipulated
	Feelings of frustration
	Feelings of guilt
Passive strategies	To accept the situation
	Placing the responsibility with the patient
	Ignoring that there is a problem
Active strategies	Confronting the patient
	Referring patients back to their previous prescriber
	Creating and using common routines

Adverse feelings

Feelings of being manipulated

The informants described that they sometimes felt manipulated and sometimes lied to by the patient in order to be persuaded to renew a prescription. Related to this was a suspicion that the patient, in some cases a relative, could be dependent on the medication and, therefore, utilised the doctor in order to maintain his or her addiction. This could lead to a perception of lack of control and an atmosphere of suspicion, distrust, disagreement and conflict between patient and doctor. Not having the opportunity to examine the patient in these situations could give rise to further discomfort.

> … I have a feeling that someone is trying to control me, and that is exactly what they're doing. And sometimes they succeed. And then I feel bad because of it. I think, now I've sort of failed as a doctor. (Participant 16)

Some expressed that pain is a subjective experience and difficult to measure. This could reinforce the feeling of being manipulated when confronted by a patient seeking pain medication. There is also a risk

that patients will interpret their doctor's refusal to prescribe a medicine as evidence that the doctor does not believe them. However, the informants considered it to be worth the effort to stand by their position and for what they believe in. Some of them described how patients could come back at a later time, detoxified and grateful that the doctor had helped them get rid of their addiction.

> There was a patient who reported me to the Patient Advisory Committee at first because I decided to scale down (the medicine), who … thanked me six months later because I'd done this scaling down. (Participant 4)

Feelings of frustration

A common situation that could give rise to frustration, irritation and sometimes even anger was when the doctor was asked to renew a prescription of a drug previously prescribed by someone else. The worst situation seemed to be when the doctor had to take over the prescribing from a colleague with a more liberal prescribing habit. Many informants also expressed their frustration over how doctors at the orthopaedic clinic readily initiated prescriptions for both weak and strong opioids and then handed over the follow-up and renewal of prescriptions to GPs.

> It doesn't seem reasonable or right or medical. You can't really support this prescription that someone else has issued. You can't really take over this and stand for your own conviction. (Participant 3)

At one of the health centres that did not have established routines for the renewal of opioid prescriptions, it was the interns who opposed the renewal of prescriptions for addictive drugs, because they felt uneasy about it. More experienced colleagues could regard such an attitude as disloyal, because they felt that the unpleasant work was left for them to do. They expressed the importance of young doctors learning how to deal with difficult situations, instead of following their own will. At the same time, they could relate to how uncomfortable they could feel themselves when asked to renew a prescription that had been prescribed by a colleague with an overly liberal prescribing habit.

> At the same time, we've had some tendencies here with interns who have refrained from sending prescription renewals for benzodiazepines or weak opioids or strong opioids for that reason. Just for that very reason … – yes, that's what they claim – that it did not feel good, and then they referred them back to me or to one of the others. (Participant 9)

A frustrating situation was mentioned where the patient, having been denied a repeat prescription, could call the nurse again, and the nurse then asked another doctor with more liberal prescribing habits to renew the prescription, in order to avoid a conflict with the patient.

Another source of frustration was the contradiction between authorities' demands for stricter prescribing habits and management's requirements for high patient turnover at the health centre. Motivating someone to quit his or her addiction could take time, and that time does not exist, according to some of the informants.

> Running some kind of detox initiative via a health centre is … it requires so much work, so many hours of work, so much motivational work … and then you've got to be there to provide some kind of support all the time and we're not able to do that, we don't have the time to do it. (Participant 19)

Feelings of guilt

When it comes to painkillers, several informants expressed that doctors do not have very much to offer patients suffering from chronic pain disorders. As other drugs are seldom effective enough, an opioid might be the only option, which poses a dilemma.

The participants expressed that a doctor's main goal is to do what is best for the patient and to present them with the best treatment available. However, the fact that weak opioids are addictive subverts this ambition, and this cast doubts on the doctor's professional role. Some felt that perhaps their only contribution was to maintain an addiction. Prescribing weak opioids, especially to patients with psychosomatic illnesses, diffuse pain syndromes or fibromyalgia, thus, gave rise to a guilty conscience, especially if there was a suspicion that it was used to maintain a dependency or for illegal drug dealing. Another source of guilt amongst the participants was a suspicion that the opioid treatment could disguise an underlying anxiety within the patient which had been ignored and not treated properly.

> I get a bit of, you could say, a guilty conscience or some kind of bad feeling that I'm contributing to this patient being addicted to Citodon (codeine and paracetamol) and I haven't succeeded in helping them get off it, so to speak. (Participant 8)

On the other hand, some of the informants maintained that, by being restrictive with opioid treatment, there was a chance that you might undervalue the patient's actual pain, which also was a source of feelings of doubt and guilt.

Passive strategies

To accept the situation

Many informants reported different strategies that could be seen as ways of accepting the current situation with the continual prescription of weak opioids, as long as the consumption could be kept on an acceptable level and common agreements were followed. Some informants also expressed that they had come to the conclusion, more and more, that you cannot solve everyone's problems.

> … we agree that you should take this dose of Citodon, or this dose of Tramadol, and we'll stick with that. If it should be so that you need to increase it, then we should really talk about it so you'd need to make an appointment to visit. But for now we're agreed that this is the dose you will have … (Participant 7)

Placing the responsibility with the patient

Some described how they regarded weak opioids as an acceptable treatment for chronic non-cancer pain under the condition that the patient has previously been informed that the medication could be addictive and then, with this awareness, had made the choice to continue taking it. They considered the patients mature enough to decide whether to continue to take the medicine or not, even if there was a suspicion that they were becoming addicted.

> You can then make a contract with the patient about the level they want to be at; … talk about risk of addiction. Many times, when we meet them, they're already addicted … and they are grown-ups (so) you can make a contract with them, just like we do for blood pressure medicine … (Participant 19)

Ignoring that there is a problem

A few informants maintained that, as weak opioids are registred by the Swedish Medical Products Agency, they are not considered too harmful and, therefore, are legitimate to use. Weak opioids could even be considered as less harmful than alcohol. If they were prescribed to a few patients and under controlled circumstances, they could even be a better alternative than forcing patients to buy drugs illegaly.

> It is quite harmless if it's well-managed. It's like alcohol. We have lots of people who drink alcohol; a glass of wine with their meal maybe an extra glass at the weekends. They have a great life. It doesn't harm them and it doesn't make them feel bad in any way. (Participant 19)

Some informants indicated that a patient with chronic pain in need of a painkiller should not be questioned and that prescribing the drug should not lead to the doctor having a guilty conscience about it. Others said they felt emotionally unaffected by the requests for prescriptions. The standpoint that repeat weak opioid prescriptions are not a problem was more predominant amongst older and more experienced male doctors.

> Yes, I could think that if you have chronic fibromyalgia, you could need pain-relieving tablets, and so I don't like … the patient shouldn't feel that they are being challenged every time they should have it, because it's hard for them too. (Participant 7)

It was reported that it is easier to agree to renew a prescription if you know the patient well. One informant, for example, described how uncomfortable he felt about taking over a continuing prescription from a colleague at another clinic. However, one of his colleagues in the focus group objected, stating that he (the first informant) himself had quite liberal prescribing habits when it came to prescribing addictive sleeping pills to some of his own patients. The first informant then, in his turn, replied that this was no problem, as long as he knew the patients well.

Active strategies

Confronting the patient

Some doctors described having an inner belief that they did not want to harm the patients by contributing to their addiction, which made it worthwhile to confront the patient and facilitated the decision not to issue a prescription.

Before confronting the patient about his or her consumption of weak opioids, a common action reported by the participants was to verify that the patients' consumption did not exceed what they had agreed upon and to check the patient's medications using Sweden's National Pharmacy Register (*nationella läkemedelsförteckningen*) to ascertain that there were no prescriptions from other doctors. Then the doctor could try to establish a contract with the patient in order to bring about a reduction in their opioid intake.

> My approach for dealing with such patients is to try and build up trust, try to have a long-term relationship with the patient; so I might say something like: I think we should do it like this, like this and like this. We won't always agree, but I'm the one who decides. (Participant 16)

Referring patients back to their previous prescriber

When confronted with a request for the renewal of a weak opioid prescription that had previously been issued by a colleague, a common reaction was to refer the request back to the previous prescriber, irrespective of whether it was a colleague in the same unit or not. A small amount of the drug could, however, be prescribed temporarily if the patient was expected to have to wait to see their regular doctor. Referring the patient back to the previous prescribing doctor could also be used as a means to come to terms with an overly generous prescribing pattern at the health centre. Many informants also pointed out the need for continuity in the patient–doctor relationship as a prerequisite for dealing with problematic prescribing habits.

> But, yes, it is easier if the patient's registered with another doctor: I can only give you 20 Citodon tablets, or 10 for that matter, to tide you over for the weekend. (Participant 8)

Creating and using common routines

The informants reported that it could be of great help to the individual doctor, especially inexperienced ones, if the colleagues at the health centre had agreed on common routines regarding prescriptions of weak opioids and other addictive drugs beforehand.

> It's good that they (the patients) know that we have the same policy here – because they often think that they might get a little more from someone else and then they might change their doctor. (Participant 2)

One example of such a routine was to not allow interns or hired doctors to renew prescriptions for patients they had not previously met. Instead, the patient's own doctor would be responsible for this. Another way that was mentioned was to clearly document an agreement in the patient's medical record and in the prescription module. This could also make it easier for nurses to reject requests for repeat prescriptions as early as the first telephone contact, and also for colleagues dealing with requests from patients they were not responsible for.

The basis for common routines was collaboration and recurrent discussions about prescribing weak opioids and other addictive drugs amongst colleagues. It was also pointed out that, in order to facilitate common routines, the work had to be organised in such a way that doctors had time for tutorial talks and discussions within the group.

> We can also take different measures at the health centre. Everything from the manager understanding the problem to us creating time to discuss this, going in to see each other, having mentors, having discussions with our colleagues, having a plan about what to do with opioid addiction. (Participant 12)

Discussion

This is the first study, to our knowledge, that focuses on GPs' experiences of renewing weak opioid prescriptions without an in-person meeting with the patient. When a doctor is asked to renew prescriptions for weak opioids without a consultation, the doctor seems to experience various adverse feelings towards the patient or colleagues, or within the doctor's own conscience. To deal with this dilemma the doctor can use passive and active strategies.

Comments on methods

With focus group interviews, there is always a risk that participants will feel constrained in expressing themselves among their fellow colleagues, especially when they are from the same workplace. If the aim had been to attain more depth and more personal reflections from the interviewees, individual interviews would have been preferable. However, we were also interested in what could be learned from the discussion among colleagues and therefore chose to take the risk that the interviews might be on a more superficial level. Our impression is, however, that in most of the inteviews the atmosphere was open and permissive, allowing the participants to express themselves freely.

At the time for the interviews EE was working as a GP resident and AH as a specialist in family medicine. The informants were colleagues, although not at the same health centre. There is always a risk that the informants might view the researchers as external reviewers, which could prevent them from expressing themselves freely. On the other hand, as the interviewers were very familiar with the problems at hand, they could steer the discussion in the group in more fruitful directions, which could also be seen as an advantage [23].

Of course, what informants say during interviews can never be considered as complete descriptions of what they do or how they act in real life. For this, observational studies or taped consultations would have been preferable [24].

Comments on results

This was a relatively small study performed in one limited part of the country, and it may be questioned whether the results are transferable to a larger context. On the other hand, our results correspond well with findings in other studies. According to Bendtsen & Hensing, prescribing opioides gives rise to discomfort and conflicting feelings, not only within the doctor him or herself, but also between the doctor and the patient or between colleagues, and it can give rise to an atmosphere characterised by conflicts, guilt and even anxiety [17]. Refusing a patient's request for investigation, treatment, certification for welfare benefits or administrative matters often seem to lead to disagreements between the patient and the doctor, according to a Norwegian study [25]. This may have strong emotional impact for the doctor and could even mean the end of a long-lasting patient-doctor relationship. In another study, general practitioners reported feelings of discomfort, especially when requested to prescribe antibiotics and psychotropic drugs. Sources of discomfort were divided across patient-specific factors, such as feelings toward the patient, communication problems and the doctor's desire to preserve the doctor–patient relationship, and doctor-specific factors, such as doctors' role perceptions and expectations of themselves, peer influences, uncertainty, etc. [26]. A recent systematic review on the topic of healthcare professionals' experience of prescribing opioids when treating chronic non-cancer pain uncovers an overarching concept of ambiguity [27]. Healthcare professionals have to take many factors into account, and the decision whether to prescribe or not is influenced by intra- and interpersonal considerations.

Prescribing weak opioids may be experienced as an ethical problem, or even dilemma, because the doctor faces a conflict of values and may be forced to violate the principles of patient autonomy, nonmaleficence and beneficence [28]. For example, if a doctor is aware that the patient has an addiction and at the same time continues to prescribe weak opioids, he or she will violate the principle of nonmaleficience. At the same time, if a patient with a known addiction claims the right to decide over his or her own life and the right to continue to take the weak opioid with reference to the principle of patient autonomy, the doctor is forced to chose between respecting that principle or the principles of nonmaleficence and beneficence. Further, a conflict of interest may occur if the doctor identifies an addict in need of a comprehensive examination and treatment, but the doctor's organisation does not provide the time resources this would require.

Agreeing to renew prescriptions seemed easier if the doctor knew the patient well, which has also been observed in other studies [16]. There are indications that doctors are more reluctant to refuse the prescribing of weak opioids to patients they are more familiar withs, which could be explained by emotional and social factors being involved to a greater extent [17,26]. Our informants requested more continuity in their clinical practice in order to be better able to deal with the dilemma. However, McCrorie points out that continuity can also lead to stagnation [29]. Continuing opioid treatment can seem like an active and conscious choice but it might, at the same time, be a strategy to avoid dealing with the problem of chronic non-cancer pain.

To deal with the adverse feelings and the conflicts between one's actions and ethical values, passive coping strategies might be used in motivating the doctor's prescription habits. According to Festinger, cognitive dissonance occurs when an individual experiences a conflict between different values, attitudes, beliefs or behaviour [30]. The passive coping strategies, mentioned by our informants, could thus be seen as psychological defence mechanisms, used as a means to alleviate the cognitive dissonance that occurs when renewing prescriptions for weak opioids, in order to reach internal consistency. Of course, this could also be interpreted as the doctor giving the ethical principle of autonomy greater value than the principle of beneficence. For example, some doctors expressed that they usually got informed consent from the patient before choosing to continue the weak opioid treatment, even if they suspected that an ongoing addiction was in evidence.

Prescribing habits regarding weak and strong opioids seem to be influenced to a very small degree by pharmacological considerations and national guidelines [26,31]. Hutchinson et al., for example, found that health centre guidelines did not influence the decision as to whether any kind of opioid should be prescribed. Instead, specific doctor-related factors, like the doctor's beliefs and personal opinion of whether the use of opioids is a good treatment for chronic pain, and the doctor's worries that the patient has, or could develop, an addiction, seemed to have more influence on personal prescription patterns [15,32]. According to Bradley, doctors are often aware of whether or not a prescription is "inappropriate" [26]. Therefore, more information or guidelines, based on the assumption that inappropriate prescribing results from ignorance on the part of the doctor, seem to influence

prescribing patterns only to a limited extent. Instead, it is proposed that interventions targeting doctors' social skills, such as training in communication skills and logistic measures, for instance, how to deal with difficult patients and with uncertainty, could be more successful in improving the quality of the prescribing habits [33]. These suggestions are well in line with the experiences that our informants conveyed: the most preferable strategy when faced with the ethical dilemma of prescribing drugs against one's inner values is to discuss the problem within the professional workgroup. This, in turn, can lead to the creation of a common policy and local prescribing routines, which can provide support for the practitioner in each individual case. Continuing medical education, just like motivational consultations with patients, will take time from the everyday practice and will, consequently, require support and backing from the management at the health centre [34]. A nurse-led multicomponent intervention, Transforming Opioid Prescribing in Primary Care, has also proven to be effective in a recent RCT study [35].

Conclusions

The renewal of weak opioid prescriptions without a consultation is experienced as an ethical dilemma for the GP and leads to various adverse emotions. It seems that most GPs would welcome a better way to solve this inconvenient situation. In this study, we have identified some approaches that seem adequate. Active strategies, such as discussing the dilemma with colleagues and the creation of common routines regarding the renewal of weak opioids, may improve prescription habits and can be a support for the doctor who wants to do what is medically correct. However, a prerequisite is that primary-care management takes the matter seriously and ensures that staff at each health centre allocates time for further education and staff meetings to discuss such strategies. In addition, it will be necessary to clarify in further studies how such strategies should best be designed and what support primary care doctors will need in order to change their prescribing habits.

Disclosure statement

No potential conflict of interest was reported by the authors.

Notes on contributors

Elsa Ekelin was a GP resident when this study was performed and obtained her credentials as GP in May 2017. She is intrested in working with children with mental illness and completed the first step of education in psychodynamic psychotherapy in 2015.

Anders Hansson has worked as GP since 1992. Disertation 2008 on thesis about GP:s' professional role and team-work in general practice. Has since then worked partly as supervisor and teacher. Special interest in elderly health care.

References

[1] Socialstyrelsen. *Narkotikarelaterade dödsfall [Drug related deaths]*. 2016. Available from: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/20091/2016-2-32.pdf

[2] Benyamin R, Trescot AM, Datta S, et al. Opioid complications and side effects. Pain Physician. 2008;11: S105–S120.

[3] Söderberg KC, Laflamme L, Möller J. Newly initiated opioid treatment and the risk of fall-related injuries. A nationwide, register-based, case-crossover study in Sweden. CNS Drugs. 2013; 27:155–161.

[4] Fields HL. The doctor's dilemma: opiate analgesics and chronic pain. Neuron. 2011; 69:591–594.

[5] Läkemedelsverket. *Användning av opioider vid långvarig icke-cancerrelaterad smärta – Rekommendationer [Use of opioid therapy in long-term non-cancer pain - recommendations]*. 2002. Available from: https://lakemedelsverket.se/upload/halso-och-sjukvard/behandlingsrekommendationer/opioider_rek_bokm.pdf

[6] Statens beredning för medicinsk utvärdering. *Metoder för behandling av långvarig smärta [Methods for treatment of long-term pain]*. 2006. Available from: http://www.sbu.se/contentassets/81ea041f1bc2441aa09868a4f29d3f1a/smarta_fulltext.pdf

[7] Läkemedelsverket. *Läkemedelsbehandling av långvarig smärta hos barn och vuxna - behandlingsrekommendationer [Pharmaceutical treatment of long-term pain in children and adults - treatment recommendations]*. 2017. Available from: https://lakemedelsverket.se/upload/halso-och-sjukvard/behandlingsrekommendationer/Information_fran_lakemedelsverket_nr_3_2017_behandlingsrekommendation.pdf

[8] Turk DC, Wilson HD, Cahana A. Treatment of chronic non-cancer pain. Lancet. 2011; 377:2226–2235.

[9] Noble M, Treadwell JR, Tregear SJ, et al. Long-term opioid management for chronic noncancer pain. Cochrane Database Syst Rev. 2010; CD006605. doi: 10.1002/14651858.CD006605.pub2

[10] Sullivan MD, Howe CQ. Opioid therapy for chronic pain in the United States: promises and perils. Pain. 2013;154:S94–S100.

[11] Lidbeck J. Central sensitisering bakom svårbehandlad specifik smärta [Central sensitization behind specific pain difficult to treat]. Lakartidningen. 2016; 113: 1866–1870.

[12] Lundgren C. *FAS UT 3: Att utvärdera, ifra˚gasätta och skonsamt avsluta läkemedelsbehandling [PHASE OUT 3: To evaluate, question, and discontinue drug treatment]*. Umeå: Läkemedelskommitén i Västerbotten, 2010.

[13] Landstinget i Värmland. *Rekommenderade läkemedel 2017 [Recommended drugs 2017]*. Karlstad. 2016. Available from: http://www.liv.se/Global/För vårdgivare och samarbeten/Läkemedel/Förskrivning/Rekommenderade läkemedel/rekommenderade lakemedel webben.pdf

[14] Turk DC, Okifuji A. What factors affect physicians' decisions to prescribe opioids for chronic noncancer pain patients? Clin J Pain. 1997; 13:330–336.

[15] Hutchinson K, Moreland AME, de C Williams AC, et al. Exploring beliefs and practice of opioid prescribing for persistent non-cancer pain by general practitioners. Eur J Pain. 2007; 11:93–98.

[16] Harle CA, Bauer SE, Hoang HQ, et al. Decision support for chronic pain care: how do primary care physicians decide when to prescribe opioids? a qualitative study. BMC Fam Pract. 2015; 16:48.

[17] Bendtsen P, Hensing G, Ebeling C, et al. What are the qualities of dilemmas experienced when prescribing opioids in general practice? Pain. 1999; 82:89–96.

[18] Christensen MB, Nørøxe KB, Moth G, et al. Drug prescriptions in Danish out-of-hours primary care: a 1-year population-based study. Scand J Prim Health Care. 2016; 34:453–458.

[19] Morgan DL. Focus groups as qualitative research: planning and research design for focus groups. In: Focus groups as qualitative research. London: SAGE Research Methods; 2013. p. 32–46.

[20] Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Heal Care. 2007; 19:349–357.

[21] Malterud K. Systematic text condensation: a strategy for qualitative analysis. Scand J Public Health. 2012; 40:795–805.

[22] Malterud K. Shared understanding of the qualitative research process. Guidelines for the medical researcher. Fam Pract. 1993; 10:201–206.

[23] Coar L, Sim J. Interviewing one's peers: methodological issues in a study of health professionals. Scand J Prim Heal Care. 2006; 24:251–256.

[24] Silverman D. A very short, fairly interesting and reasonably cheap book about qualitative research. 2nd ed. London: Sage Publications Ltd; 2013.

[25] Nilsen S, Malterud K. What happens when the doctor denies a patient's request? A qualitative interview study among general practitioners in Norway. Scand J Prim Health Care. 2017; 35:201–207.

[26] Bradley CP. Factors which influence the decision whether or not to prescribe: the dilemma facing general practitioners. Br J Gen Pract. 1992; 42:454–458.

[27] Toye F, Seers K, Tierney S, et al. A qualitative evidence synthesis to explore healthcare professionals' experience of prescribing opioids to adults with chronic non-malignant pain. BMC Fam Pract. 2017;18:94.

[28] Beauchamp TL, Childress JF. Principles of biomedical ethics. 7th ed. New York: Oxford University Press; 2013.

[29] McCrorie C, Closs SJ, House A, et al. Understanding long-term opioid prescribing for non-cancer pain in primary care: a qualitative study. BMC Fam Pract. 2015; 16:121.

[30] Festinger L. A theory of cognitive dissonance. Stanford: Stanford University Press; 1957.

[31] Tell D, Engström S, Mölstad S. Adherence to guidelines on antibiotic treatment for respiratory tract infections in various categories of physicians: a retrospective cross-sectional study of data from electronic patient records. BMJ Open. 2015;5:e008096.

[32] Kothari A, Rudman D, Dobbins M, et al. The use of tacit and explicit knowledge in public health: a qualitative study. Implement Sci. 2012; 7:20.

[33] Milos V, Westerlund T, Midlöv P, et al. Swedish general practitioners' attitudes towards treatment guidelines - a qualitative study. BMC Fam Pract. 2014; 15:199.

[34] Cantillon P, Jones R. Does continuing medical education in general practice make a difference?. Br Med J.1999; 318:1276–1279.

[35] Liebschutz JM, Xuan Z, Shanahan CW, et al. Improving Adherence to long-term opioid therapy guidelines to reduce opioid misuse in primary care - a cluster-randomized clinical trial. JAMA Intern Med. 2017; 177:1265–1272.