Trust and Distrust in Opioid Decision-Making: A Qualitative Assessment of Patient-Doctor Relationship

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Purpose Surgeons often prescribe opioid analgesics for pain management after surgery. However, we understand little about how patients perceive opioid prescribing and make decisions to use opioids for postoperative pain management. In this study, we aimed to gain an understanding of patients' decision-making process on postoperative opioid use.

Methods We conducted semi-structured interviews with 30 adult patients undergoing elective surgery at our institution. The interviews were content-coded for thematic analysis. We used trust in the medical setting as a conceptual framework to interpret and find the inherent theory in the data.

Results We found that participants based their opioid decisions on their trust or distrust toward various elements of their postoperative pain management. Participants believed that the surgeons "know," thereby, reinforcing their trust in surgeons' postoperative opioid prescribing to be in the participants' best interest. Moreover, the positive reputation of the institution strengthened the participants' trust. However, participants conveyed nuanced trust because of their distrust toward the opioid medications themselves, which were viewed as "suspicious," and the pharmaceutical companies, that were "despised." Despite this distrust, participants had confidence in their inherent ability to protect themselves from opioid use disorders.

Conclusions Understanding how patients perceive and form decisions on postoperative opioid use based on their trust and distrust toward various factors involved in their care highlights the importance of the patient-doctor relationship and building trust to effectively address postoperative pain and reduce opioid-related harms.

Clinical relevance Through a strengthened therapeutic alliance between patients and surgeons, we can improve our strategies to overcome the ongoing opioid epidemic through patient-centered approaches. *(J Hand Surg Am. 2022;47(2):151−159. Copyright © 2022 by the American Society for Surgery of the Hand. All rights reserved.)*

Key words Opioid decision-making, opioid reduction policies, patient-doctor relationship, postoperative pain management, trust.

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The opioid epidemic in the United States has been fueled by diverted prescription opioids from postoperative prescribing, with large quantities of excess opioids generated from outpatient surgical procedures.[1–5] Patient-centered care remains a top health care priority, and prior research has demonstrated the importance of aligning opioid prescribing practices with patients' needs and preferences to achieve safe, effective pain control. However, current policies and guidelines on postoperative prescribing often assume a "one-size-fits-all" approach that is not tailored to the individual patient.[6,7]

Despite the emphasis on the need for individualized pain management strategies and the common use of opioids for acute pain control, little is known about the nature and the process through which patients decide to use opioid pain medications after surgery. Wide media coverage of the opioid epidemic and related public service announcements have increased public awareness of the opioid-related harms, but we do not understand how that knowledge has influenced the way patients perceive postoperative prescribing practice. Furthermore, we lack understanding of how patients' relationship with the surgeon influences their choice to use opioids after surgery.

In this context, we sought to investigate patients' decision-making process on postoperative opioid use to determine the important factors that influence their choices, including the individuals involved in the care and other elements of the care pathway. Specifically, we sought to explore the role that the patient-doctor relationship plays in shaping patients' beliefs and attitudes toward opioid use after surgery. Our findings will help frame opioid prescribing guidelines to be more patient-centered and aligned with patients' needs in postoperative pain control.

MATERIALS AND METHODS

Participants/cohort selection

We recruited adult patients scheduled to undergo surgery at one tertiary care center. Using a purposive sampling strategy, we narrowed our inclusion criteria to outpatient, elective hand surgeries such as carpal tunnel release and trigger finger release. These procedures are low-risk with few complications and associated with variable pain levels and opioid prescribing practices. Therefore, we would be able to observe a wider range of how patients make decisions on postoperative opioid use because the variable prescribing practice would let patients have more personal input in the decision-making process. We excluded those with a history of substance misuse disorder or inability to sign their consent. This study was approved by the medical center's institutional review board and written informed consent was obtained.

Interviews

The interviews were scheduled between the preoperative outpatient visit and before surgery to accurately capture patients' decision-making processes regarding potential opioid use after surgery. We constructed a preliminary interview guide from a literature review and expert consultation on the factors that patients potentially consider when making the choice to take opioids for pain control, such as the amount of pain relief, side effects, risk of opioid misuse, and opioid use disorder (the persistent use of opioids despite the adverse consequences of its use[8]), cost, trust in the prescriber, and the stigma associated with opioid use and opioid use disorders.[9–16] Two investigators conducted semi-structured interviews in person from February 2019 to November 2019. After 5 pilot interviews, the interview guide was revised to improve on content and face validity, including clarification of language (Appendix E1, available online on the *Journal*'s website at www.jhandsurg.org). Interviews were conducted until saturation, the point at which additional data collection does not yield any new information, was reached.[17–20] Interviews were transcribed verbatim.

Data processing and analysis

Coding of the data was completed through an iterative and team approach. First, 3 investigators independently content-coded the transcripts. They then met to discuss the emergent codes and collectively developed a working codebook. This codebook was tested on 3 interviews and then the investigators met again to revise it. NVivo 12 (QSR International) was used for the storage and coding of the narratives. Via thematic analysis, we developed a conceptual framework that explained the inherent theory in the data.[17] In our explanation of the methods, we followed the Standards for Reporting Qualitative Research guidelines.[21]

RESULTS

We conducted interviews with 30 participants with various demographic characteristics (Table 1) until we reached saturation. From the interviews, we found that participants both directly and indirectly described trust as a major influence in their decision-making for postoperative opioid use; therefore, we referred to the

TABLE 1. Study Cohort Characteristics

Demographic Variables	Number of Patients	% Total
Sex		
Male	15	50.0%
Female	15	50.0%
Age (y)		
18−34	4	13.3%
35−44	1	3.3%
45−54	3	10.0%
55−64	10	33.3%
>65	12	40.0%
Race		
White	26	86.7%
African American	2	6.7%
Asian	1	3.3%
Other	1	3.3%
Ethnicity		
Hispanic	0	0.0%
Non-Hispanic	30	100.0%
Planned procedure		
Carpometacarpal arthroplasty	3	10.0%
Carpal tunnel release	8	26.7%
Trigger finger release	9	30.0%
Hand mass excision	9	30.0%
De Quervain's release	1	3.3%

discussions of trust in medicine to interpret our findings. The participants expressed strong beliefs in the idea that their surgeons, the participants themselves, and the medical institution will act in their best interest in vulnerable times, whereas they displayed a lack of faith in pharmaceutical companies, opioids as a drug, and other people to use opioids judiciously. Therefore, we arrived at 2 themes, "trust" and "distrust" with 3 subthemes (represented by the direct quotes from interviews that embodied the subthemes best) that were most pervasive in our participants' responses (Table 2).

Trust

"They know": Participants expressed that they have strong faith in their surgeons. They conveyed that even though they only had one meeting, they trust the surgeon simply because he/she is a physician.

> *If the doctor says to go in the corner and stand on your head, then that's what you do.* (Interview 21)

> *They would know, given the number of people they've dealt with… Yes, even though I didn't spend a lot of time with her, I trust her and her decisions.* (Interview 26)

To patients, surgeons represented the field of medicine and embodied the authority stemming from their expert knowledge and experience. Participants understood that physicians treat many patients similar to them and that the prescribed treatment plan is right for them.

> *If they're not writing the [opioid] prescription, I assume that's because they don't think you should need it… "Hey, I've done surgeries like this, you're going to be in a lot of pain" or "Eh, it's a Tylenol thing."* (Interview 24)

Participants recognized that their trust in surgeons had an impact on their approach to postoperative pain control as patients. In awareness of the risks and harms related to opioids, participants weighed their feelings of uncertainty regarding the amount of pain expected after surgery and the benefits and risks of opioid pain medications. Whether the surgeon prescribed opioids or not, participants wanted to understand the reasoning behind prescribing through honest discussions.

TABLE 2. Themes and Definitions

Theme/Subtheme	Definitions
Trust	Belief that in most vulnerable time a person/entity will perform in my [as the patient] best interest.
”They know”	Participants had faith in their surgeon for their clinical expertise and his/her treatment decisions, and that they would follow the prescribed plan.
”I’m not worried [about myself]”	Participants conveyed that they had confidence in their ability to protect themselves from becoming addicted to opioids.
”I drive a long way to come here”	Participants reported that they believe they are in a good system of health care and have confidence in the doctors from the institution.
Distrust	Lack of faith in the efficacy of a product, person, or system.
”There’s this low level of corruption”	Participants expressed their disapproval of the pharmaceutical companies and thought that they were to blame for the opioid epidemic.
”I don’t want anything to control me”	Participants conveyed their fear of the opioid medications themselves which had inherent properties related to misuse, abuse, and addiction.
”People are always going to try to abuse it [opioids]”	Participants believed that people have behavioral tendencies to abuse things including opioid pain medications, but that they were different from those people.

If a doctor you have confidence in recommends that you do something, you are more inclined to do it. But I am that person who will push back and say please help me understand that the benefit really truly outweighs the risk because these are pretty strong risks. (Interview 10)

Well, if he says it’s not necessary, then I’d want to know why… There’s this kind of subtle “everybody’s guilty of being a drug user until proven innocent.” Like a doctor says “I’m not going to give you [any pain meds] after surgery, call me if you need” versus giving the patient the script upfront and having the faith that that’s going to be properly managed. (Interview 18)

Although they conveyed trust in surgeons for their clinical expertise, participants displayed more nuanced trust in surgeons with the decision to use opioids for postoperative pain control (Table 3).

“I’m not worried [about myself]”: Despite being doubtful toward using opioid medications, participants conveyed self-confidence that they would be able to protect themselves from opioid addiction. They strongly believed that they would not become addicted to opioids because of their personalities and previous experiences.

I’m not worried that I would ever be addicted to them… I’ve taken them before and I’ve had no problem just stopping them when I needed to. (Interview 11)

I’m not concerned on a personal level about addiction… I mean I am not much of a drinker, never smoked. (Interview 21)

Because of past experiences, participants were confident that they would not become addicted to opioids. Some participants stressed that their attitude toward pain and approach to pain control would allow them to limit their opioid use after surgery.

A pain level of 5. Okay, it’s a pain level of 5. That doesn’t mean it needs to go to 3. With a pill. So that is my approach. (Interview 29)

Although participants acknowledged that they were unsure of how much pain they would be in after the surgery, the uncertainty did not have an impact on their faith in their ability to stay away from opioid-related harms (Table 3).

“I drive a long way to come here”: A pervasive theme in our data was how patients trusted the surgeons and their treatment decisions because of the confidence in the medical institution of their choosing.

I have a lot of faith in their departments and all the things that they do to make sure that clinicians are the very best. (Interview 18)

I met him once… Sure, I trust the [institution], so I trust him. (Interview 8)

Because they were satisfied with the care they had received at the institution, they believed that they were in “good hands” despite having met the

TABLE 3. Thematic Analysis of Trust

Theme	Exemplar
"They know"	I am going to trust him because he is a doctor. He has done medicine many years. (Interview 2)
	I've only met with him once. Came highly recommended from someone that had seen him for similar surgery. From my OT and my PT, both recommended that he is the one. (Interview 22)
	I'm trusting the surgeon to be a good surgeon… but I'd have to apply my own judgment [regarding opioids]. But it would be a mutual kind of decision of what to take… [If the pain is bad] you're not likely to want to go out and go to the pharmacy and get it [opioids]. So I probably would request a script, just in anticipation of the Oh crap moment that night. (Interview 29)
"I'm not worried [about myself]"	I did have a broken bone in my other hand this winter and I took ibuprofen. I made it through that, so I would be able to avoid opioids. (Interview 7)
	It's up the individual, because people deal with pain differently. So, some people, you know, have more pain. And it's hard for me to judge somebody else's pain and tolerance on it… I have a fairly high pain tolerance, so I don't usually need it… I try to go to alternative things, like going to warm water pools and exercising. PT is my friend, and I'm not- I'm more likely to ask for PT than medication. (Interview 22)
	So if it's, you know, it's three in the morning, I'm going to call the person on call and be like "Look, I am dying and you need to write a prescription."… And again I'm not likely to make that call because that's just not my personality. (Interview 24)
"I drive a long way to come here"	I have a doctor friend. I would typically ask "is this the guy to see" but here, I just called and went to the appointment. (Interview 21)
	I had come here for gynecology and had that surgery and really had a good experience. So I found a hand surgeon from [this institution]… I try to do all my doctors here now…. like even if I have to come for an emergency, I will come here. I'm closer to [another hospital], but I would prefer to come here. (Interview 26)
	I have a very positive view of the whole system. I've had excellent doctors. (Interview 30)

OT, occupational therapist; PT, physical therapist.

surgeon only once. Some participants noted that they will sacrifice their time and convenience to be treated at their preferred hospital.

> *I made a very conscious choice to drive a long way to have a simple surgery that can probably be done ten minutes from my house.* (Interview 10)

> *I'm not sure what hospital they were part of, but it was not [this institution]. No wonder it was a bad experience. I didn't go to the next appointment; I came here instead.* (Interview 26)

Institution as a brand influenced patients' satisfaction with the provided care both positively and negatively. By reflecting their perception of the health care institution onto the surgeon, the participants decided if they could trust the surgeons' decisions and the prescribed plan of care (Table 3).

Distrust

"There's this low level of corruption": Participants conveyed a universal distrust in pharmaceutical companies. They believed that "big pharma" was to blame for the current opioid epidemic. Participants explained that pharmaceutical companies had advanced knowledge of the negative consequences of opioid consumption including its addiction potential.

> *The pharmaceutical companies knew what they were doing…It does bother me that they made so much money on this. And now they're trying to hide it away and that's not right.* (Interview 22)

> *I hate what's going on with the epidemic of opioids, but I blame the pharmaceuticals. They're out to make a lot of money, and they are.* (Interview 27)

TABLE 4. Thematic Analysis of Distrust

Theme	Exemplar
"There's this low level of corruption"	I despise drug companies. I despise drug companies for a variety of different reasons, but mostly because it is all about just exactly what you're talking about, doing everything they can to promote and profiteering. They make a ton of money and they promote. As long as people are willing to buy it, they want to sell it and they'll put out whatever price the market will pay. (Interview 29)
	I don't know what the pharmaceutical companies are putting in those drugs that are making them so addictive. (Interview 1)
	I do think that there was a big push by the drug companies to, you know, here's some miracle drug for you… they really did push it on people and make billions of dollars from it. (Interview 30)
"I don't want anything to control me"	I probably won't use [opioids]… I want to be functional the whole time. I am a control freak; I don't even let anybody else drive. (Interview 29)
	I think that there's an objectionable side effect to it, that they may or may not be aware of how addictive they [opioids] are. (Interview 12)
	I think it was maybe first from being naïve and not-thinking oh, here is a miracle drug that will take away your pain, and it was too easy. And maybe patients didn't realize what was going to happen if they kept taking it and then couldn't not take it… I don't like the feeling [you get] if you take a lot of things… I don't like not being in control. (Interview 30)
"People are always going to try to abuse it [opioids]"	But there again, I tried the medication. I don't even like that—it's hard for me to believe that people really like that stuff, you know. (Interview 28)
	I understand the issue is addiction, so it's more than an issue, it's a problem. But I don't believe it has ever impacted me, or I don't think anybody I know. (Interview 21)
	I think it's going back to the addictive personalities. You know, whether they allow themselves to go down that path so readily, whereas others will have enough self-control reserve to not. And realize that it's not a good thing to go down that path. (Interview 29)

Participants believed that the pharmaceutical companies were realizing profits from the opioid epidemic. This selfishness instilled complete distrust in the pharmaceutical industry. Moreover, participants felt that physicians were victims of the pharmaceutical companies' tactics to increase their corporate financial gains.

> *Well, it started with the drug manufacturers; I believe that. They coerced the doctors and I think they were really good at it.* (Interview 28)

By perceiving the physicians as victims of drug manufacturers, participants reinforced their underlying support in the medical community. Most participants "despised" the pharmaceutical companies and had a genuine wariness of their motives (Table 4).

"I don't want anything to control me": This distrust spanned beyond the pharmaceutical companies, and included the opioid medications as products made by "the bad guys." Participants felt that opioid medication had some intrinsic quality that negatively transformed "good" people into addicts, which gravely concerned the participants.

> *I was always worried that maybe I will get dependent on these, so I want to get off of these as fast as possible.* (Interview 19)

> *People that have been addicted…They'll do anything to get the drug. All reason goes.* (Interview 16)

The addiction associated with opioid medications "sneaked up" on people, which alarmed participants

and influenced their decision to forego opioids after surgery. More specifically, participants who had previous experience with opioids acknowledged worries of continued dependency if they were to take these medications after surgery.

> *Just because I've taken them in the past…I think of it as like psychological addiction versus physical dependence.* (Interview 11)

> *I know my wife worried about it a lot. I don't think she developed a dependency on it, but she worried about it.* (Interview 9)

The potential risks of opioid medication preoccupied participants' thoughts. Opioids themselves, caused distrust for participants as they did not know "what was put in the drugs to make them so addictive" (Table 4).

"People are always going to try to abuse it [opioids]": Participants described their distrust in "other" people who were at risk of opioid addiction. These "others" had inherent personality traits predisposing them to opioid addiction.

> *I think it's going back to the addictive personalities.* (Interview 29)

> *Some people, you can see, they need to be really careful because they're a user… You can't know another person's mind. But you can watch for symptoms and you can watch for the traits.* (Interview 22)

Participants actively separated themselves from these "other" people, highlighting their own protection against opioid addiction. "Other" people had identifiable traits with a tendency toward "using" or abusing opioids. Moreover, participants were concerned that these "other" people would preclude them from receiving appropriate pain management.

> *There's always going to be some people who are going to try to abuse it. I guess I don't feel that that should preclude people who actually need it from having it in the right quantities and the right dosage for the time they need it.* (Interview 18)

This inherent distrust in "others" was pervasive and pitted the participants against other members of society. The addiction of "others" would limit the participants' ability to obtain opioids if they needed them, such as after surgery (Table 4).

DISCUSSION

In our investigation, participants demonstrated the process through which they decided on future postoperative opioid use, and we found that trust plays an integral role in decision-making. Trust is an essential element in establishing treatment relationships that influences satisfaction, communication, competency, and privacy.[22,23] It is the core attribute that describes and empowers the physician-patient therapeutic alliance, and as an instrument, it influences patients' willingness to seek care, reveal sensitive personal information, and adhere to treatment regimens. Lack of trust, or distrust, brings forth wariness and uncertainty within patients to follow the prescribed treatment course.[22] The participants evaluated and negotiated their feelings of trust toward those involved in their care to make the best decision. Trust toward the surgeon, institution, and their own protection from addiction compared to other people allowed them to perceive postoperative opioid use as safe. In our thematic analysis, we saw that the principles of bioethics would provide the framework that would help us interpret our findings.[24,25] Under the principles of beneficence and nonmaleficence, patients believed that the prescribed pain regimen would be the most appropriate one balancing benefits and risks. However, the participants' distrust toward the pharmaceutical companies and the opioids themselves discouraged them from using opioids after surgery as they did not abide by justice. Despite the generalized trust in surgeons, patients often expressed nuanced trust toward opioid prescribing. They wanted to discuss postoperative pain management and the benefits and risks of using opioids with their surgeons. Autonomy was reflected in patients' wish for surgeons to trust them with opioids. Our findings highlight the importance of trust in the patient-doctor relationship for postoperative opioid prescribing.

Several studies have described trust as a central element in successful treatment relationships. For example, higher levels of trust were associated with improved adherence to colorectal screening guidelines, satisfaction with providers' communication, and a sense of involvement in the treatment decision-making.[26–29] These results demonstrate that trust in medical settings is built on fidelity (or allegiance), technical and interpersonal competence, and honesty, and that trust promotes patients' adherence to the providers' recommendations and leads to improved outcomes.[22,30–37] However, when it comes to opioid prescribing and use for acute pain control after surgery, there is little evidence on how trust plays a role in decision-making for postoperative pain control. Furthermore, although it is widely accepted that a patient-centered approach for effective pain

management while minimizing risks is required, there is not a good understanding of how patient-doctor relationships and trust between them can have an influence on the patients' perception of opioids and, ultimately, their choice of drug for postoperative pain control. In our qualitative investigation, we identified that patients not only factor their trust in the surgeon into their decision-making process but also include how they feel about the medical institution, pharmaceutical companies, the medication itself, and others' opioid use. It may seem incongruent that the patients would take opioid medications, which they distrust, just because they were prescribed by the surgeons, who they trust. However, this relationship actually highlights the importance of trust in the patient-doctor relationship and how much it can influence the patients' decision-making process. Our findings demonstrate the complex nature of patients' decision-making process regarding postoperative opioid use and emphasize the importance of harnessing the trust in the doctor-patient relationship to develop patient-centered strategies to reduce opioid-related harms.

Current guidelines on postoperative opioid prescribing impose a rather uniform restriction on the size of opioid prescriptions, which can harm the therapeutic alliance and reduce patients' trust in the provider.[35,38] It has been demonstrated that for patients on long-term opioid therapy for pain, implementation of policies restricting the prescription sizes leads to lower levels of rapport and trust in the patient-doctor relationship.[10,35,39,40] We found that even in the case of short-term opioid use, some patients may feel stigmatized and misjudged that the surgeons do not trust them and assume that they will abuse the medications. In fact, patients expressed a strong desire for honest discussions with their surgeons about postoperative pain management and the risks and benefits of using opioids for pain management, to develop informed trust in the care that they were prescribed.[41,42] Policies based on "one-size-fits-all" models may invoke distrust in the patient-surgeon relationship and lead to suboptimal outcomes.[6,7] To effectively reduce opioid-related morbidity and mortality while providing adequate pain control, strategies that encourage informed communications to strengthen the patient-doctor relationship through building trust are required.

Our study has a few limitations. Owing to the inherent nature of qualitative research and thematic analysis, our findings of 6 major themes may not be applicable to all patient populations. There may be other ways patients perceive and make decisions on postoperative opioid use based on their trust and distrust in the surgical and pharmaceutical providers. Nevertheless, our investigation provides insight into understanding how patients process various factors that influence their postoperative pain decisions. Second, our study participants were recruited from patients who received care at a tertiary care institution with an excellent reputation.[43] Therefore, it is possible that our participants placed greater levels of trust in the institution and the surgeons affiliated with the system and were more likely to participate in the study. However, our thematic analysis results demonstrating that the concept of trust and distrust governs patients' decision-making process on opioid use is still valid and thus offers an opportunity to approach postoperative pain management from a patient-centered perspective. Third, our study participants were those who underwent outpatient, elective hand surgeries and may not have expected to receive many opioid medications, if any were to be prescribed. This may have resulted in selection bias. Lastly, qualitative research carries an inherent risk of subjective bias by the investigators, especially in coding and thematic analysis. We have mitigated this bias by having 3 investigators perform the coding independently and discuss to agree on a codebook before the full thematic analysis was performed.

From a qualitative approach, we found that patients form their preferences based on the inherent trust and distrust toward those involved in their care, including themselves. Our findings emphasize the importance of harnessing trust and patient-doctor relationships in our approach to postoperative opioid prescribing while minimizing the opioid-related harms. Surgeons should seek to build informed trust with their patients through effective communications that strengthen the therapeutic alliance for postoperative pain control.

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APPENDIX E1. Qualitative Study on Postoperative Opioid Use

Semi-structured Interview Guide

1. Could you tell me a little about how your hand bothers you?
    a. How does it bother you?
    b. What makes it better?
        i. Have you tried any pain medications? (prescription or over the counter)
    c. How has it affected you?
        i. Any changes in activities of daily living? (eg, dressing, eating, grooming)
    d. What do you do for work?
        i. How has your current condition affected your ability to work?
    e. Anything else about your condition and how it affected you?
2. Have you taken opioid pain medication in the past?
    a. What were you taking them for? (eg, dental)
    b. How was your experience with it?
        i. What did you like or not like about opioids?
    c. How do you feel about opioid pain medications in general?
3. In your opinion, what are the pros and cons of taking opioid pain medications for pain after surgery? (*let them talk freely, then cover the topics below (if not mentioned)*)
    a. How important is the amount of pain relief to you in your decision-making process?
        i. How well do you think you tolerate pain? Well? Not so well?
    b. How important are the side effects to you in your decision-making process?
        i. For example, cannot drive, nausea, cramps, constipation.
    c. How important is the addictiveness of opioids in your decision-making?
        i. What are your thoughts on opioid addiction?
    d. Do you care what other people may think of you for taking opioids for pain?
        i. How people may judge you for taking opioid pain medications, would that matter in your decision to take opioids for pain after your surgery?
    e. What about cost?
    f. How bad do you think the pain will be after this surgery?
    i. Do you think you'll need opioids for pain control after your surgery?
4. Tell me about your relationship with your surgeon.
    a. Do you trust him/her?
    b. How does that impact your decision to take opioids or not, if he/she prescribed them to you after surgery?
    c. If your surgeon prescribed opioids for your pain control after the surgery, would you take them?
        i. Why or why not?
    d. If your surgeon did NOT prescribe you opioids after the surgery, would you request them?
        i. Why or why not?
5. Anything else that influences your decision to use opioid pain medications?
6. Anything else you want to talk about pain control, opioids, etc?