Patient Engagement Survey Regarding Future Double-Blinded, Randomized Controlled Trial of Tapering of Chronic Opioid Therapy

Jared James1*, Benjamin Lai2, and Terrence Witt1*

Abstract
Objective: There is a lack of evidence regarding tapering opioid medications in patients with chronic non-cancer pain. The purpose of this survey was to gather perspectives on future research into opioid tapering from utilizers of chronic opioid therapy (COT) or other people affected by chronic noncancer pain. Methods: The survey was distributed in paper form to patients on COT and via an online platform to patients self-enrolled in the chronic pain patient engagement group. The survey included a layman’s description of a possible tapering trial of opioid medications and elicited binary responses regarding willingness to participate and reasoning as well as qualitative freeform responses. Thematic analysis was performed to identify themes in narrative responses. Results: A total of 190 surveys were returned with 72.1% of all respondents answering positively regarding their willingness to participate in a proposed study. The most common reasons for participating in the study included concerns regarding opioid dependence, adding to society’s knowledge of opioid medications, and determining if the respondent would personally receive benefit from opioid medications. Patients recently on COT felt it was important to be able to withdraw from the study and return to usual care at any time (41.8% for recent COT and 15.5% for no recent COT, P < .05). The most common reason for unwillingness to participate was that respondents did not feel they had enough information to feel comfortable participating. The narrative responses showed a group of respondents felt COT was the only answer to their or their loved ones’ chronic pain and that a study would demonstrate the need to continue these medications long-term. There were also stories of side effects and dependence with decreasing effectiveness of opioids for pain control. When prompted to comment on study design, respondents indicated the study should include alternative pain management options. This was accompanied by responses with the assumption that pain will worsen as opioid medications are decreased. Conclusion: Patient concerns regarding opioid medications and discontinuation reflect the lack of evidence available to prescribers. There appears to be patient support for future research into the effects of tapering opioid medications.

Keywords
chronic opioid therapy (COT), chronic noncancer pain (CNCP), primary care, deprescribing, opioid crisis, tapering, down titration

Introduction
Chronic noncancer pain (CNCP) and the challenges in treating patients suffering from it are pervasive in primary care. At the peak of opioid prescriptions in 2010, approximately 20% of patients would be prescribed opioid medications at visits for noncancer-related pain.1 The amount of opioid prescriptions has since plateaued, likely related to growing awareness of the opioid crisis; this eventually led to the US Department of Health and Human Services declaring a nationwide public health emergency in 2017.2 However, opioid medication for CNCP tripled from 1999 to 2015, and opioid prescriptions per capita increased 7.3% from 2007 to 2012, with opioid prescribing rates increasing

1Mayo Clinic, Eau Claire, WI, USA
2Mayo Clinic, Rochester, MN, USA

Corresponding Author:
Jared James, Mayo Clinic Family Medicine Residency–Eau Claire, 1400 Bellinger Street, Eau Claire, WI 54702-4105, USA.
Email: james.jared@mayo.edu

Creative Commons Non Commercial CC BY-NC: This article is distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 License (http://www.creativecommons.org/licenses/by-nc/4.0/) which permits non-commercial use, reproduction and distribution of the work without further permission provided the original work is attributed as specified on the SAGE and Open Access pages (https://us.sagepub.com/en-us/nam/open-access-at-sage).
more for family practice, general practice, and internal medicine compared with other specialties. The United States had the largest per-capita consumption of opioid medications in the world between 2013 and 2016. This prolific prescribing has contributed to illicit substance use, but prescription opioids continue to constitute a significant portion of drug overdose deaths with 17,087 deaths in 2016 alone compared with 15,469 due to heroin.

Despite this widespread use of opioid medications for CNCP, there is little evidence supporting their efficacy in this role. Systematic reviews have shown no or only modest improvement in functional status and long-term pain control with chronic opioid therapy. Furthermore, there is a lack of high-quality randomized controlled trial evidence regarding the effects of slow tapering of opioid medications when prescribed for CNCP. Despite this, high numbers of practices have required patients to decrease medication doses or discontinue opioid use altogether. From 2009 to 2017, there has been an annual decrease of 9.5% in prescriptions for high dose (≥90 MME [morphine milligram equivalent]) opioid medications. The 2016 CDC guideline on prescription of opioid medications for chronic pain suggests a gradual 10% MME per week taper of opioid medications with adjustment based on response. This same guideline notes that tapering opioid medications is not associated with increased pain and may contribute to increased quality of life. Currently, there is a lack of high-quality randomized controlled trial evidence regarding the effects of slow tapering of opioid medications when prescribed for CNCP. Prior to developing a trial to examine the effects of tapering chronic opioid therapy (COT), information regarding its feasibility and patient engagement is needed. The incorporation of patients and stakeholders into initial study design has been identified as a key component in decreasing research waste through incomplete studies or studies that do not address relevant issues for target populations. Methods to minimize this research inefficiency and increase the likelihood successful study performance have been described in other disease states. In order to assess the willingness of patients to participate in a randomized and blinded study and improve on the proposed design, our team developed and distributed a survey to a population that included the target population of sufferers of CNCP currently using COT.

Methods

In order to gauge the applicability of the study and interest in participation, the study group solicited patient responses via a self-administered survey. These surveys were distributed in paper form to patients on COT when picking up prescriptions from their primary care provider's office as well as via an online patient engagement platform managed by the study group’s sponsoring organization (Mayo Clinic Connect). Distribution of the survey took place from June 28, 2019 through August 10, 2019. The online platform consisted of more than 70,000 registered users who self-identify in patient categories with the understanding that they will be able to provide anonymous feedback on topics related to each group. This population included opioid utilizers and nonutilizers that self-identify as belonging to the chronic pain group. This group consisted of individuals suffering from chronic pain as well as family members of patients with chronic pain and other interested individuals. The survey was preceded by a brief description in layman's terms of the proposed future study with a clear explanation that the survey did not require enrollment in the study and would not be used to identify potential study participants (see the appendix). Therefore, no patient data or identifying information were gathered through this survey. The survey allowed both binary check box and freeform answers for participants to provide feedback that could be incorporated into any future study design. The format of the survey first stratified patients by use of at least 1 month of opioid medication in the past 6 months. They were then asked if they would consider participating in a study such as that described in the introduction and directed to preset binary checkbox and freeform responses based on this answer. Respondents could choose as many or as few options as they desired. Data from electronic surveys was automatically formatted into a spreadsheet for analysis and paper survey results were then manually compiled with the electronic platform data. \( \chi^2 \) analysis was employed to assess for differences between recent opioid utilizers versus nonutilizers using a threshold of \( P < .05 \) for statistical significance. Thematic analysis was performed manually following initial automatic stratification by respondents willing to participate and those expressing unwillingness to participate. A reviewer categorized responses by open coding method utilizing grounded theory to identify specific recurring phrases provided in narrative responses that were relevant to the research question regarding motivation or hesitancy to participate in an opioid tapering study. Given the small data set, the most commonly identified codes were grouped as common themes which were then reviewed by each author to ensure adequate representation of each identified code in narrative responses.

This study was reviewed by the Mayo Clinic Institutional Review Board and determined to constitute minimal risk research under section 45 CFR 46.109, item 1.

Results

The preset responses provided comparable data on common concerns related to opioid therapy and research. A total of 72.1% of all respondents answered positively regarding their willingness to participate in a study such as that proposed. The subset of this group that had recently utilized
Figure 1. Percentage of respondents indicating they would participate in the described study grouped by whether they had used opioid medications for a 1-month period or more over the past 6 months.

Opioid therapy was higher at 84.0% as shown in Figure 1. Between the 2 groups (those who had utilized chronic opioids in the past 6 months and those who had not), there were similar reasons for participating in the study, including concerns regarding opioid dependence (36.7% and 43.1%, respectively), adding to society’s knowledge of opioid medications (68.4% and 65.5%, respectively), and determining if the respondent would personally receive benefit from opioid medications (39.2% and 36.2%, respectively). The primary difference between groups was that respondents recently on COT felt it was important to be able to withdraw from the study and return to usual care at any time (41.8% for opioid utilizers and 15.5% for nonutilizers, \( P < .05 \)). Of those that expressed unwillingness to participate, there were no significant between-group differences in reasons given. The most common reason in each group was that respondents did not feel they had enough information to feel comfortable participating. The financial compensation did not appear to be a clear factor in the decision to participate among respondents in either group. There was some small attrition due to respondents that did not select any of the preset responses or provide a freeform comment as represented in Figure 2.

The narrative responses from each group did not differ significantly between recent opioid utilizers and nonutilizers. Several themes emerged through code evaluation and these are provided in Figure 3. The first had respondents that felt COT was the only answer to their or their loved ones’ chronic pain and that this study would demonstrate the need to continue these medications long-term. Another focused on anecdotal stories of side effects and dependence with decreasing effectiveness of opioids for pain control. The narrative responses contained many related stories of being suddenly cutoff of opioids by providers that would no longer prescribe them without guidance on what to expect for withdrawal symptoms, safety of discontinuing the medications, or alternative pain management strategies. Related to the recent drive to decrease opioid doses, a group of respondents described being judged or negatively labeled by providers due to their opioid use. In addition to identified themes driving motivation or unwillingness to participate, when respondents were prompted to provide possible ways to improve the study and comment on study design, the majority of responses reflected that the study should include alternative pain management options aimed at mitigating the reasons for opioid use. Underlying this was a prevailing sentiment that respondents desired a better alternative to opioid medications to help manage pain. This was accompanied by several responses with the assumption that pain will worsen as opioid medications are decreased and that no other substitute would be given to treat participants’ pain.

**Discussion**

An evidence gap exists in the understanding of the effects of tapering opioid medications. The survey results indicate that this lack of knowledge is seen by both prescribers and patients alike. This was reflected by the majority of respondents indicating they would be willing to participate in a study such as that proposed to add to society’s knowledge of opioid medications. The percentage of participants that would be interested in participating in such a study was reassuring for the feasibility of recruitment and retention of patients through study completion. While the opioid-utilizing group had a slightly higher likelihood of participation, the difference between groups was largely explained by the narrative comments that nonopioid users recognized they could not participate in the study. Of note for any future research group, the ability to withdraw from the study and return to usual care at any time was very important to recent utilizers of opioid
medications. This was not an unexpected difference for the investigators and underlined the importance of allowing autonomy for each participant in any future trial. This also highlighted the need for close collaboration with the primary care providers at study sites to continue high-quality care, alternative forms of pain management, and follow-up for the duration of the study. Regarding respondents that were unwilling to participate in the proposed study, the primary concern was that there was not enough information provided. Given the brief description of the study, this was an expected finding and emphasized the importance of a clear and comprehensive consent process as well as the meetings with a research coordinator to ensure participants can make fully informed decisions consistent with high-quality, ethical research practices.

The narrative comments revealed prevailing underlying sentiments that many providers encounter in practice. Many patients and their loved ones have had poor outcomes related to chronic opioid therapy, escalating doses, or sudden discontinuation. These stories reflect the current lack of evidence and study-based guidance for the use of chronic opioid therapy in providers’ current work environments. With the growing body of evidence for alternative forms of management for chronic pain, the respondents’ desire for incorporation of opioid-sparing pain treatment aligns well with current guideline-based models of care and the importance of trials targeted at nonopioid treatments of CNCP. For a future opioid tapering study, results of our survey emphasize the need to maintain ongoing alternative pain management treatment with the participants’ primary care

---

**Figure 2.** Survey responses compiled from Mayo Clinic Connect Platform and printed surveys. Patient categories were determined by an initial question regarding opioid use for at least 1 month in the past 6 months followed by willingness to participate in the study and selected reasoning options. Numbers in parentheses represent the number of respondents in each group.

*Indicates significant difference between groups by $\chi^2$ test with $P < .05$. 

| Number of Patients Responding to Survey | Opioid Last 6 months | No Opioid last 6 months |
|-----------------------------------------|----------------------|-------------------------|
| 94                                      | 96                   |

| If you did use chronic opioid medications, would you consider participating in a study like the one described? | Opioid Last 6 months | No Opioid last 6 months |
|-------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------|
| 79 would participate (84.0%)*                                                                                                 | 58 would participate (60.4%)* |

| For those that indicated that they would participate, reason indicated | Opioid Last 6 months (79) | No Opioid last 6 months (58) |
|------------------------------------------------------------------------|---------------------------|------------------------------|
| Not paying for my medications.                                          | 8.8% (7)                  | 15.5% (9)                    |
| Determine if I benefit from opioid medications.                         | 39.2% (31)                | 36.2% (21)                   |
| Being paid for my participation.                                        | 10.1 (8)                  | 10.3% (6)                    |
| Being concerned about dependence to opioid medications                  | 36.7% (29)                | 43.1% (25)                   |
| Avoid monthly visits to my pharmacist to pick up medications.           | 21.5% (17)                | 19.0% (11)                   |
| Add to society’s knowledge of chronic opioid medications.               | 68.4% (54)                | 65.5% (38)                   |
| Ability to drop out of study at any time and go back to my primary care provider for my medications. | 41.8% (33)* | 15.5% (9)*          |

| For those that indicated that they would not participate, reason indicated | Opioid Last 6 months (27) | No Opioid last 6 months (27) |
|--------------------------------------------------------------------------|---------------------------|------------------------------|
| I know I need my opioid medications and would not want to risk having it decreased. | 51.8% (14)                | 7.4% (2)                     |
| I don’t have enough information to feel comfortable participating.        | 40.7% (11)                | 25.9% (7)                    |
| I don’t have confidence in the goals of the study.                       | 29.6% (8)                 | 0.0% (0)                     |
| I only trust my primary care provider to manage my medications.           | 18.5% (5)                 | 14.8% (4)                    |
| I only trust my personal pharmacist.                                     | 0.0% (0)                  | 3.7% (1)                     |
| The financial reimbursement is not enough to make it worthwhile.          | 7.4% (2)                  | 7.4% (2)                     |
provider, counseling on side effects and withdrawal, contingencies for increased pain or withdrawal symptoms, and multidisciplinary treatment team involvement throughout any study targeted at examining opioid medications and chronic pain treatment. This allows for recognition of the need for research into alternative modalities for pain, but simultaneously emphasizes that the proposed study is targeted at the effects of slow tapering of opioids. To avoid confounders, standard of care with alternative forms of pain treatment should continue for the duration of any future study. This study was limited due to the short duration of administration of the survey, the use of a population of convenience, and the limited data on respondents. Had demographic data been collected on participants, additional variables may have been identified for a more in depth understanding of motivations regarding decisions to participate in a tapering trial. Currently, these survey data add to the understanding of what topics are most important to patients on COT as well as their concerns with the current practice changes surrounding the prescription of opioids. This creates opportunities for further study including a possible dedicated focus group to gather further qualitative data, an expanded Likert scale quantitative survey reaching a larger population, incorporation of additional patient demographic data to identify characteristics that may influence perceptions of opioid prescribing practices, as well as development of a high-quality trial aimed at determining the effects of slow tapering of opioid medications on quality of life, mood symptoms, pain, and function.

---

| Themes                                                                 | Example Responses                                                                                                                                 |
|----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| Opioid medications are effective for my particular case and this study will demonstrate their utility | “I strongly believe in being on my opiate pain medication. When I was on it gave me the most normalcy to life. I was able to function, do daily activities, take care of my son, and be able to gain weight because my pain was all under control.” |
|                                                                      | “I have tried alternative methods of pain reduction but also need pain meds. The other methods help but can’t replace my (hydrocodone/acetaminophen)” |
|                                                                      | “It sounds unnecessarily cruel and I don’t think it will tell much. The group having their medication lowered are going to be in more pain why do you need a study to know that.” |
| Opioid medications have been ineffective in treating pain or cause significant side effects | “I am concerned about using opioids as I age. I know that these drugs contribute to my foggy brain and that has gotten worse over the last year or so.” |
|                                                                      | “I hate what the medicine does to me.”                                                                                                             |
|                                                                      | “For me, I have Adhesive Arachnoiditis, pain is so bad. Opiates do not last long, become immune, dependent physically.” |
| Providers have labeled or judged patients based on their opioid use   | “I’m not on any opiate medication because of the Crackdown but I do have chronic pain and I’m being treated like a criminal after back surgery a year-and-a-half ago.” |
|                                                                      | “I am not concerned about dependency on opioid. Believe it or not I can go off my medication without withdrawal. I am angry that because I take pain medication I am not taken seriously about the problems I am having.” |
|                                                                      | “I feel that people with chronic pain that have well tested and documented medical conditions causing the pain, are treated like addicted people and have high levels of pain daily that isn’t treated properly. Sometimes opioids may be the only way to ease the terrible pain.” |
| Alternative, non-opioid methods of pain control should be more widely studied | “Those of us who have chronic pain, including myself, would just like some solutions for the pain. The study still needs to provide for pain management.” |
|                                                                      | “I suffer from CRPS. If you are going to ask patients to give up their opioids, I hope you have something better. I don’t think any real patients enjoy the way they feel on opioids. But pain relief means everything. You’ve got to have something better.” |
|                                                                      | “Those of us who have chronic pain, including myself, would just like some solutions for the pain. The study still needs to provide for pain management.” |
| Regulators and providers have unfairly discontinued medications without other options for managing pain | “Considering newly instituted statewide regulations, how fair is it to have pain meds like opioids eliminated for older adults in chronic disability conditions.” |
|                                                                      | “To understand my theory that legitimate chronic, life-long pain sufferers are being pushed off the only currently available, effective treatment with these medications.” |
|                                                                      | “Chronic pain is real. I hope this helps government understand that interference with treatment that doctors determine are best for their patients.” |

**Figure 3.** Quotations from survey responses representing each of the themes identified by thematic analysis.
Conclusion

Given the information gathered with this survey, there appears to be patient support for future research into the effects of tapering opioid medications. Any future study could expect adequate community and patient participation while addressing the patient concerns outlined in the narrative survey results.

Appendix

Dear Patient,

Family Medicine physicians at Mayo Clinic Rochester and the Mayo Clinic Health System propose to conduct a study with people who are currently on chronic opioid therapy for non-cancer pain. (Opioids are strong pain medications such as OxyContin, Vicodin, morphine, Tramadol, etc) Before we recruit participants to the study, we want to know what you think of our study proposal. We invite you to take part in this anonymous survey to help us define and develop the study to make it meaningful for people managing pain.

By completing this survey, you are not agreeing to participate in the study

Proposed Study Design

Study participants would be assigned randomly to one of two groups: the first group would slowly decrease their medication dose by very small amounts each month and the second group would continue their regular dose throughout the 1-year study. Only the research pharmacists would know who was in each group.

Study participants would be required to visit with a study coordinator in person once at the beginning of the study and again at the end of the study. Telephone consultations will be done every 3 months for 1 year. The first and last visits would take 45 to 60 minutes and occur at your home clinic. Telephone consultations every 3 months would take 20 to 30 minutes. Each time, participants will complete questionnaires about pain, daily life functions, and quality of life. At any time, participants can withdraw from the study and return to their primary care provider (PCP) for continued management of their opioid therapy. During the study, participants would still receive care from their primary care provider. The study would provide free medications and send them to the participant’s home at no cost. We would provide compensation up to $200 for full participation. There is a risk that participants could experience an increase in their pain and a small risk that they could experience symptoms related to withdrawal from the medication. It is worth noting that the risk for withdrawal is very small due to the slow reduction in dose every month.

How You Can Help

Complete the short survey on the following page to guide us in developing this study. Your participation is voluntary and your responses are confidential and anonymous. By completing this survey, you are not agreeing to participate in the proposed study just described above; you are only agreeing to provide input to help us design and develop a future study.

We realize that you have a choice in medical care and we appreciate you putting your trust in us. Thank you in advance for your assistance in improving our care.

Acknowledgments

We wish to thank Julie Maxson, CCRP, for her endless support and facilitation for the duration of the study as well as nursing staff at all collection locations for their efforts in conducting the study. We also wish to thank Colleen Young, Community Director for Mayo Clinic Connect and Marquita Davis, Mayo Office of Patient Experience for their assistance in the development and distribution of the surveys on Mayo Clinic Connect. Finally, a special thanks to all the survey participants who took the time to complete this survey. Without their participation, this study would not have been possible.

Author Contributions

All the authors participated in the study concept and design, analysis and interpretation of data, drafting and revising the paper, and have seen and approved the final version of the manuscript. JJ, BL, and TW conceived of the study concept and participated in design; provided administrative, technical, and material support; had full oversight of the study conduct during data collection; had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis; participated in review and interpretation of study results; and also drafted the manuscript and participated in critical revision of the manuscript for important intellectual content.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This study was supported by our institution.

Ethical Approval

In accordance with the Declaration of Helsinki, this study was reviewed and determined to be exempt (ID 19-004703) by the Mayo Clinic Institutional Review Board (IRB). The IRB-approved passive consent was obtained for all study participants prior to study participation. This study was reviewed by expedited process and determined to be minimal risk research for Institutional Review Board Approval under 45 CFR 46.109f, item 1. The oral
contact cover letter (which served as the passive consent) and the survey were both reviewed by the IRB and noted. Passive consent was obtained from all study participants prior to study initiation.

ORCID iDs
Jared James https://orcid.org/0000-0003-4916-3575
Terrence Witt https://orcid.org/0000-0002-2534-3363

References
1. Daubresse M, Chang HY, Yu Y, et al. Ambulatory diagnosis and treatment of nonmalignant pain in the United States, 2000-2010. Med Care. 2013;51:870-878.
2. Centers for Disease Control and Prevention. 2018 Annual Surveillance Report of Drug-Related Risks and Outcomes—United States. https://www.cdc.gov/drugoverdose/pdf/pubs/2018-cdc-drug-surveillance-report.pdf. Accessed November 11, 2019.
3. Levy B, Paulozzi L, Mack KA, Jones CM. Trends in opioid analgesic-prescribing rates by specialty, US, 2007-2012. Am J Prev Med. 2015;49:409-413.
4. International Narcotics Control Board. Narcotic drugs estimated world requirement for 2019—statistics for 2017. https://www.incb.org/documents/Narcotic-Drugs/Technical-Publications/2018/INCB-Narcotics_Drugs_Technical_Publication_2018.pdf. Accessed November 11, 2019.
5. Busse JW, Wang L, Kamaleldin M, et al. Opioids for chronic noncancer pain: a systematic review and meta-analysis. JAMA. 2018;320:2448-2460.
6. Chou R, Turner JA, Devine EB, et al. The effectiveness and risks of long-term opioid therapy for chronic pain: a systematic review for a National Institutes of Health Pathways to Prevention Workshop. Ann Intern Med. 2015;162:276-286.
7. Frank JW, Lovejoy TI, Becker WC, et al. Patient outcomes in dose reduction or discontinuation of long-term opioid therapy: a systematic review. Ann Intern Med. 2017;167:181-191.
8. Noble M, Treadwell JR, Tregear SJ, et al. Long-term opioid management for chronic noncancer pain. Cochrane Database Syst Rev. 2010;(1):CD006605.
9. Hundley L, Spradley S, Donelenko S. Assessment of outcomes following high-dose opioid tapering in a Veterans Healthcare System. J Opioid Manag. 2018;14:89-101.
10. Krebs EE, Gravely A, Nugent S, et al. Effect of opioid vs nonopioid medications on pain-related function in patients with chronic back pain or hip or knee osteoarthritis pain: the SPACE randomized clinical trial. JAMA. 2018;319:872-882.
11. Kurita GP, Hojsted J, Sjogren P. Tapering off long-term opioid therapy in chronic non-cancer pain patients: a randomized clinical trial [published online May 13, 2018]. Eur J Pain. doi:10.1002/ejp.1241
12. Berna C, Kulich RJ, Rathmell JP. Tapering long-term opioid therapy in chronic noncancer pain: evidence and recommendations for everyday practice. Mayo Clin Proc. 2015;90:828-842.
13. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain—United States, 2016. JAMA. 2016;315:1624-1645.
14. Sacristán JA, Aguarón A, Avendaño-Solá C, et al. Patient involvement in clinical research: why, when, and how. Patient Prefer Adherence. 2016;10:631-640.
15. Chalmers I, Glasziou P. Avoidable waste in the production and reporting of research evidence. Lancet. 2009;374:86-89.
16. Elwyn G, Crowe S, Fenton M, et al. Identifying and prioritizing uncertainties: patient and clinician engagement in the identification of research questions. J Eval Clin Pract. 2010;16:627-631.