Opioids In Chronic Pain Management – A Guide For Patients

J. Kimber Rotchford, M.D., M.P.H.

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Introduction

This manual is directed toward patients who are asking themselves whether the use of opioids is appropriate or not for their pain management. The Greeks said a long time ago that one man's food is another's poison. While evidence based medicine based on the study of populations or groups of patients is often helpful, the best of medical care is individualized.

When one considers using pharmaceuticals or other potent prescriptions, it is best to seek advice from someone properly trained and who is prepared to provide impartial prescriptions. While physicians are historically the experts in prescribing opioids, their prescribing authority has been significantly compromised. The explanations for this are multifactorial and likely to be longly debated.

For whatever the reasons, regulators and third parties are now the default authorities regarding the proper use of opioids. Regulators determine appropriate diagnoses, limit certain opioids to specific contexts and prescribers. They determine the nature of care, oversight, doses, access, etc.. Third party payers emboldened by the regulators regularly determine which opioid and how much of an opioid is appropriate. More to the point third parties(insurers) determine what is paid for. Some third parties, despite apparent concerns about conflicts of interest, have been emboldened to determine what constitutes safe prescribing.

Rules and regulations regarding potentially life-threatening substances are of course appropriate but as with opioids themselves, too much or too little, depends on the clinical context. It is the author's opinion that rules and regulations in context of opioid and other "controlled substances" are excessive and contribute to the justifiable concerns about opioid use and misuse. For a combination of reasons, physicians now

have limited authority in their prescribing of opioids. Physicians understandably are afraid of regulators and even the Attorney General of the United States has overtly threatened prescribers with serious legal consequences for the inappropriate prescribing of opioids. The assumption being that the regulators know what constitutes appropriate prescribing. Perhaps their opinion is justified for it has become more a matter of law than the practice of medicine.

Even when a physician has a clear intent to help a patient and their prescriptions are consistent with the best of medical knowledge and evidence, they can be held liable. This is can be the case even when their care results in a good outcome. Even the most well-trained, well-intentioned experts in the field can come under serious attack with serious repercussions to their careers and the patients they care for. It is arguably no longer prudent for a physician outside the protection of a large institutional setting to provide medical care to patients who benefit from long term opioids. While I still continue to prescribe opioids when indicated, I do not fault colleagues who chooses not to prescribe opioids for chronic conditions, even when a patient might clearly benefit from an opioid prescription.

Most physicians are well trained and capable to prescribe opioids in the context of acute pain, pain which lasts less than a month or so. When it comes to treating chronic pain or opioid use disorders, ignorance is widespread even among capable and seasoned physicians. The majority of physicians still rarely establish a diagnosis of an opioid use disorder, despite evidence that 20-25% of patients on chronic opioid agonist therapy (COAT) for pain meet the criteria for the disease. Furthermore, when dealing with chronic complex pain, physicians continue to commonly explain the pain through diagnoses associated with nociception. Nociception is just the medical term for describing pain coming from input that originates from tissue injury. This is typically the case in acute pain.

Western science has confirmed that the central nervous system(CNS) is involved and is dysfunctional in most cases of chronic complex pain. This implies that help for the CNS is often needed for optimal outcomes in patients with chronic pain. While ongoing nociception is stressful and interferes with healthy CNS functioning, limiting nociception is often not enough, particularly in complex cases. In these complex cases it is as if the CNS has adapted to the nociception and the corresponding neuro-adaptations have now become part of the problem, if not the problem. Furthermore, sleep deprivation, mood disorders, and other stressors to brain health, even in those patients without any apparent source of nociception, are associated with serious and sometimes widespread pain.

When effectively used, opioids influence the CNS in beneficial ways and primarily reduce pain through limiting excitatory circuits and facilitating inhibitory circuits. Opioids potently reduce anxiety and have been used as mood enhancers throughout modern times.

With this briefest of introductions, I now intend to empower patients or their advocates to better obtain proper care for pain, whether with or without opioids. I will do this first by providing some of the considerations and discussions I commonly provide at the time of a new patient consultation.

Chapter One

New Patient Consultation for Opioids in Chronic Pain Management

In my specialized practice there are typically 5 components of a new patient consultation for pain management regarding opioids. These components typically benefit from follow up visits to assure adequate assessment and benefit from recommendations made.

1. **Assess current pain levels and function**
2. **Cronic Pain vs. Acute Pain** **Introduce patients to the notion that chronic pain is different than acute pain. It feels the same and may similarly or not limit function.**
3. **Help assess whether opioids are part of the solution or the problem**
4. **Assess other interventions or support**, **other than opioids, which might improve CNS function and consequently help better manage pain.**
5. **Establish an initial plan for clinical progress.**

1. Assess Current Pain Levels and Function

There are many questionnaires and other means to assess pain and disability associated with same. Some are designed to assess pain and disability related to specific types of pain such as back pain. Most physicians have access to these instruments and they can be helpful not only to assess current pain and function but also to monitor progress. In my specialized pain practice I use a customized version of

the Wisconsin Brief Pain Inventory. The maximum amount of possible pain and associated dysfunction during the past week is 100. While the numbers one provides to the different questions are subjective and one's 5 might be another's 7 or eight or vice versa, it does give us a chance to compare one's score with others and to observe changes over time.

Pain like blood pressure and other physiological processes varies over time. So one set of scores has limited value. What is most important clinically are the changes observed over time.

The following is a link to both my Global Pain Questionnaire and Brief Follow Up Inventory. The Brief Follow Up Inventory assesses in more general ways overall Brain Health & well-being. Poorly managed chronic pain implies a brain that is not working well. I was looking for a series of questions that could help me monitor same, particularly in patients with comorbid substance use disorders and other mental health concerns. While this particularly inventory has never been formally validated to assure validity and reliability, clinically I have found it helpful and worthwhile. At the very least it gives patients another opportunity to assess their progress or lack thereof.

2. Chronic Pain vs Acute Pain

When we experience acute pain that is relatively new pain, it is most often associated with some amount of tissue damage. This is the pain which as children growing up we all experienced. We scraped our knees, bruised our noggins, cut ourselves, etc. Hence, as adults we assume that when we experience pain it is related to "tissue damage" and best managed appropriately. A hug from mom, a dressing, a suture, or at least a bandaid. Perhaps we were given an aspirin or Tylenol for the pain so we assume that a pain pill is the way to address all forms of pain. For more severe forms of pain, whether from serious injuries or procedures, we may have been even provided opioids. It is

understandable that we as adults when we experience pain we are looking for similar explanations and remedies that have worked in the past.

The problem is that with chronic pain most often the level of pain experienced does not correlate well with tissue damage. It is challenging based on x-rays or even more refined imaging techniques to assess the likely amount of pain a patient is experiencing when the dealing with chronic sources of possible pain such as degenerative arthritis. Some patients will have minor or no pain with serious x-ray findings and others with horrible pain will have only limited changes in their joints or other structures. While levels of inflammation and other local factors not readily appreciated by standard imaging techniques can and do play a role, when dealing with chronic complex pain inevitably one is dealing with serious dysfunction within the CNS in addition to structural problems apparent on standard imaging techniques.

There is a plethora of references online and elsewhere that review the nature of chronic pain and how it is different than acute pain. Below are just a few, some of them written by me. The syllabus was written over a decade ago and was part of a college course I taught. It remains a fairly comprehensive source of basic information on pain while some of the material is outdated. More and more we are considering chronic pain as a disease, in and of itself, associated with significant findings in the brain and elsewhere in the CNS.

3. Opioids are they part of the solution or the problem?

This is perhaps the most common “charged” part of my new patient consultations. Most patients referred to me by colleagues or who seek out my specialized care independently, are concerned about not having access to opioids for their painful conditions. Surprisingly, for many of my colleagues, the opioids are part of a solution. The most common reason is that patients have developed an opioid use disorder as a

result of chronic opioid agonist therapy (COAT) or did so independently from opioid abuse in the past.

In simple terms this means their brains have been changed, most often permanently as a result of being exposed to opioids. In my paper on COAT(reference) I estimate that about 20% of patients develop a significant opioid use disorder. Recently, I have seen estimates from the CDC as high as 25% of patients on COAT develop an opioid use disorder. In my references and in my COAT article I provide the criteria for an opioid use disorder, or opiate dependence as it was formerly called. The criteria represent the best minds and the best research regarding who has or has not the disease. Note that none of the criteria have anything to do with moral or even legal concerns. The criteria are such that it is readily easy to establish the diagnosis or exclude it. The problem is that there are no established biomarkers as in diabetes or other chronic relapsing diseases. While there is quite a bit of ignorance, even amongst physicians, as to the criteria, they are the best we have even though they are often entirely dependent on an accurate and thorough patient history.

It is important to appreciate that the 20-25% of patients who develop an opioid use disorder(addiction) have risk factors for same. Genetics plays a large role, but there are other important factors such as the age when first exposed to significant amounts of opioids (the earlier the age the greater the risk and exposure prior to brain maturity is particularly risky). We also know that significant trauma in the past whether physical, sexual, psychological, or even spiritual greatly increases risks. Comorbid substance use disorders, whether licit or not such as to alcohol, tobacco, are major risk factors. Other co-morbid mental health problems increase the risks as well.

Based on the patient's history, familiarity with the formal criteria, as well as the risk factors I am aware of I make a diagnosis of an opioid use disorder or sometimes I will

assume a patient has an opioid use disorder until proven otherwise, particularly when risk factors are high.

Bottomline, if a patient has an opioid use disorder, particularly if moderate or severe, their prognosis is poor without ongoing agonist(opioid) therapy. The literature and expert consensus confirming this is quite significant compared to most indications for medical care. (references) The prognosis is particularly poor in my experience if they have comorbid serious pain or other mental health disorders.

There are about 30% of patients on COAT, who will likely do better if tapered off of opioids. These patients have been “neuro sensitized” to opioids and as a result of long term use of opioids their pain thresholds become quite low. While their pain might seem to be better as the result of taking a pill, the fact is that the continued use of opioids is making the pain worse! The problem is trying to sort out which patients fit into this category. There are some possible clinical indicators based on history and findings but generally the only way to know is to taper a patient off of opioids off and see how they are doing.

How about the other 50% of patients who are on COAT? Are the opioids part of the solution or the problem? Sometimes the clinical history is obvious. If a patient has taken opioids for years, perhaps is elderly, and has done well with opioids with little or no side effects and are apparently otherwise healthy and doing well, I think that supports ongoing judicious use of opioids. I do not want to take the risks of putting an elderly patient through withdrawal or unmitigated pain unnecessarily. In other words, as of now clinical contextual variables need to be judiciously reviewed to best assess who is to be tapered and if so how quickly. Some patients in the “grey” area come in and want to be tapered. Understandably so, for who wants to have to take a medication to remain functional, especially a medication with all of social concerns and taboos associated with its use. When I am unable to make the diagnosis of a significant opioid use

disorder and/or there is a lack of serious or multiple risk factors, of course I will do what I can to taper them off of the opioids and do my best to assure their pain is well managed. Again, as already stated routine and regular follow up is indicated to assure progress with pain and overall health.

There is much to be written on the subject of whether the opioids are part of the problem or the solution. I haven't even entertained the social and community risks associated with prescribing opioids. In keeping the focus here primarily on patient well-being, I often assure patients who are on COAT use long acting forms of opioids. The brain is designed to benefit from staying in a state of homeostasis. This simply means that the brain doesn't like its internal environment to change much. Short acting opiates as appropriate as the are for acute pain, I find have little or no role in managing chronic complex pain. There may be a role for shorter acting opiates in acute flares of an underlying disease such as rheumatoid arthritis or gout, but in general my clinical bias is toward long acting stabilizing opioids for I am not only intending to treat pain but more directly my intention is to help the brain function better and be as healthy as possible.

4. What other interventions might best improve CNS function and help with pain management?

There are a plethora of interventions available other than opioids to help manage pain. The problems are associated with access and effectiveness for a given patient. When it comes to helping the brain function better there are a myriad of approaches and issues to explore. I have written more extensively on the subject in my handout Brain Health 101.

In patients on opioids or with pain management needs I generally want to assure sleep is good. I generally need to assure there is no sleep apnea. Opioids commonly can

induce or aggravate sleep apnea. We want to assure hormone levels are adequate; vitamin D and other basic nutrients are adequate; and, that there are no other major medical problems or substances being used that could interfere with brain function.

Brains work best when they are feeling safe and in a state of homeostasis. Situational as well as internal stresses interfere with proper brain functioning so over time I do my best to eliminate them or help people limit the stress and anxiety in their lives.

Comorbid mental health conditions are common. Depression is well known to contribute to pain and can even be the primary cause. Since Anxiety and Post Traumatic Stress Disorders are quite common I often refer patients to my handouts on same. (references below)

On my website at OPAS.us I alert patients to the myriad of ways patients have effectively better managed pain. One of the biggest clinical challenges in this work is tailoring an effective program. Generally, it is not simply one intervention or change but a combination that works best.

5. Establish an initial plan for progress

Patients should always have a plan after each office visit. As already mentioned, in general a combination of approaches works best. I often refer patients to my Plan Handout. The most important part of the plan is a return visit to assure there is progress in meeting goals for better pain management and overall well-being.

Another important part of the initial plan is to assure that a patient has an adequate health care team. No one physician can do it all particularly in caring for many of the more complex pain patients. I require the majority of my patients to have a primary care provider to work with. Often other specialists are needed as effective members of the

team. Unfortunately, in my practice, putting together this “care team” is one of the biggest challenges as to the initial plan.

Chapter 2 - Is the plan Working?

Follow up visits initially are at least monthly and most often more frequent than that. The brain often takes 3-6 months to make long term changes. It is unreasonable though to wait 3-6 months to see if the plan is working or not. The reality is that no physician or patient can ever be entirely sure what is going to work or not when it comes to helping patients manage their chronic pain. Most often it becomes a bit of trial and error. In some complex patients it can take 6 months or even more to establish a plan that is working, relatively safe, and is sustainable.

Patients are commonly told that there is nothing more that can be done for their pain. I strongly disagree. There are patients, whom, for a host of reasons, I am unable to help further. That’s different than concluding there is nothing more than can be done to better manage their pain. The brain and CNS are very adaptable and I think are capable of change and learning until the brain has deteriorated irreversibly. Some patients will benefit from more intense therapy that even I as a pain and addiction medicine specialist can provide. Some will have limited access to further help for a host of reasons.

We need to have appropriate expectation in pain management. Using the above mentioned pain scale, if a patient’s pain levels are in the twenties or below I consider this to be successful pain management. Of course it can one day be zero but I cannot expect that. Treating chronic pain is similar to treating most chronic and relapsing diseases. If one seeks perfection in treating diabetics one is likely to fail but with general progress and reasonable blood sugars the outcomes are generally quite good. It is similar in chronic pain management.

We need to continue to evaluate our patient plans. If they do not seem to be working as expected, adjustments are in order. There is not a recipe that works for everyone. That is why I commonly refer patients to my website and encourage them to read my handouts and links related to pain management. I tell them it is like a menu at a restaurant. Choose from the myriad of options and see what might work for you. If they want help or suggestions in prioritizing what they want to try next, of course I provide my opinions. Sometimes overtime and in getting to know a patient I become quite confident that one option will work better than another. It is a humbling process though for both patients and I are often mistaken about what will work. Given the uncertainties, it makes sense to start with the safest remedies and proceed from there. During this process of coming up with an effective plan, I like some of the slogans in 12-step recovery programs: it takes time, progress not perfection, easy does it, keep coming back, it works if you work it, it's a "we" thing, take what's of use and leave the rest, these are but suggestions.

Chapter 3 - What are your options if the plan is not working or your physician/caregiver is not offering viable alternatives?

The first step is generally to make a visit with your primary care provider

How to help your doctor properly prescribe pain medications to you.

10-Step "To Do" List to Help Your Doctor Help You

A. Make An Appointment

B. Your First Visit

C. What You Want

D. Work With Your Doctor

E. Ask Questions

F. Be Willing

G. Educate Yourself

H. Be Knowledgeable

I. Ask for Referral

J. Minimize Stress

Regrettably, patients and caregivers are needing to spend valuable time and effort to get the services that are medically indicated, despite adequate medical coverage. I estimate that well over 50% of my clinical time is spent in debriefing patients regarding third party and regulatory issues. Another common concern is the lack of access to indicated medical care. This latter concern is particularly pertinent for patients who benefit from COAT for their Chronic Complex Pain concerns. I see no quick resolution in pain management for the waste of time and resources which is burdening the

cost-effectiveness of medical care. Clearly the waste increases costs and further limits access to services. Access to COAT in my relative rural area in the State of Washington I find has been aggravated by recent legislation that has specified rules and regulations regarding the prescribing of opioids. Physicians often poorly understand the rules and there is little legal precedent as to how they will be interpreted and reinforced.

This liability alone has prompted even large practices to announce they will not provide opioids for chronic non-cancerous pain. The liabilities are coupled with other factors that help explain limited access to care: chronic pain management is relatively poorly reimbursed; many physicians are not prepared to safely and effectively manage chronic complex pain with or without opioids; complex pain is complicated by other medical concerns, substance use disorders, and other significant mental health conditions which warrant a team and collaborative approach to care. So what's the first step?

When confronting significant "system" problems which we have little control over, I suggest we focus on solutions and come back to what we can do to better assure access to needed medical services.

The following are a list of some of the suggestions that I have provided to patients over the years:

The first step is generally to make a visit with your primary care provider

I suggest the first thing is to see what can be done by talking with your primary care provider. They are traditionally the practitioners who are responsible to assure patients get the specialized care indicated. The following are some suggestions regarding your dialogue with them:

When a medical professional suggests a change in your medical regimen, ask on what basis the change will be judged. What is the time frame? How frequently will you be seen to assure progress? What assurance do they give if other therapies are not working, or there are complications, what can or will be tried to at least provide you with similar relief to your current regimen. I suggest formally documenting the conversation content.

If you have been diagnosed with an Opioid Use Disorder, be sure to discuss that for even the Washington State pain rules (reference) note the importance of agonist therapy. To not assure adequate agonist therapy, provides a patient redress under the pain rules and formal professional standards. When harm can be demonstrated by either failure to make an appropriate diagnosis or not assure appropriate care, malpractice laws may apply but this is the last resort because ultimately the process does not prevent a patient's suffering or undue disability or mortality and is very stressful to boot. This is not a prescription for well-being.

Any physician at times must make recommendations that a patient doesn't like or is reticent about, whether it concerns medication, surgery, hospitalization, behavioral therapy, diagnostic testing, stopping smoking, etc. It is the physician's responsibility, however, to assure that long term health improves as a result of referrals and other recommendations made and carried out. It is my opinion that recommendations are best when based on individual assessments in addition to available population/group based studies.

It is not enough for a primary care or other physicians to say they can't help you. It is the responsibility of all licensed practitioners to advocate for and help their patients obtain the best medical care. There are limits as already discussed as to what any medical professional is able to provide and I suggest to limit energy spent in being being critical

or blaming. Focus on the possible solutions first for you or a loved one and then for the greater community.

The Washington State's Medical Quality Assurance Commission assures that patients receive professional care from licensed practitioners. They can be contacted online and the office has a handout (reference) on seeking advocacy/accountability through them.

Once we've assured care for ourselves or loved one, we all must wonder what we can do politically and socially to address the social concerns about access to necessary pain management care and the proper use of opioids. Clearly, the over reliance on opioids for pain management has contributed to the current opioid abuse epidemic. I just find the causes much more complex and the reader can review my thoughts and opinions on this subject in small book I wrote entitled "Opidemice" (reference). In addition, I have written a paper yet to be published on the cultural influences regarding how we address substance abuse issues.(reference)

In 2013, I wrote down the following suggestions for patients who were being challenged in finding appropriate medical care. Some of the suggestions are most pertinent for patients residing in the State of Washington. Some of the suggestions clearly duplicate what has already been said. Of course, they are but suggestions. I suggest we accept that often nothing seems to work. Facts, reason, or even disciplinary consequences may not sway an individual with a rigid belief system. This seems to be particularly true for most people when their beliefs are reinforced by those in authority, or relate to established laws and regulations.

How to help your doctor properly prescribe pain medications to you.

Audience: This is for patients, in the North Olympic Area, who struggle to find a physician who will prescribe them pain medications or agonist therapy for opiate

addiction. It is to be used in conjunction with our List of Providers and the Letter to Colleagues. Other pertinent handouts are available online at www.opas.us.

Note: There is no recommendation that would help every patient with every doctor. As the best of medical care is always individualized, the same holds as how best to approach one's physician.

There are a host of reasons physicians may not feel comfortable prescribing controlled substances to patients. Your job is not to convince your physician to feel differently or to convince them of anything. Rather, I suggest you attempt to understand the reasons they have for making their recommendations. In medicine there have always been different opinions about what constitutes the best care for a given patient and unfortunately decisions are sometimes based on "cultural" factors more than scientific evidence or knowledge. Nonetheless, as best you can attempt to understand the medical reasons for their recommendations. Try not to focus just on what you think is indicated. Nonetheless, I do advise you to simply express your desire to receive the best of medical care.

10-Step "To Do" List to Help Your Doctor Help You

A. Make An Appointment. In general, it is best to make an appointment at a primary care office where you have been seen sometime during the previous three years. You are then by definition "an established patient." Make an initial appointment for a general checkup. If your appointment is with a primary care provider they are generally most interested in your general medical care rather than just addressing pain or addiction problems. So best to focus on general medical care to start with.

B. Your First Visit. Once with the doctor and after customary introductions you may acknowledge that you are anxious. As a result, you might then ask the doctor if you may

record the conversation to help better process what you are told. Another option is to bring a friend with you who will help you record what is said and likely allay some of your anxiety. People do not function at their best when overly anxious.

I also suggest you bring in old medical records that document who prescribed what and for what reasons. At the very least, bring in your old prescription bottles. It is even better to bring in all the medications you are currently being prescribed. Understand, that most doctors now have access online to your list of currently prescribed controlled substances.

C. What You Want. As much as possible be direct as you can in letting the doctor know what you want. “Doctor, I would feel less anxious if I could have my prescriptions filled at their current level. My experience is that this works best. If we can find other better options I will be thankful. Of course, I am not happy about being dependent on these medications.” or “Doctor, I am very anxious about going through withdrawal and having worse pain, what are you recommending I do to help me avoid withdrawal symptoms and to more effectively manage my pain?

If you haven’t been formally evaluated for being opiate addicted, and there is a question about that, ask for such an evaluation. The criteria for opiate dependence are listed online at OPAS.us Handouts. Look for the paper on Agonist therapy for opiate addiction. If you are opiate addicted inform your doctor of such. Let them also know, that whenever possible, you intend to follow through as best you can with their recommendations.

D. Work With Your Doctor. If the doctor indicates a need for more records or more diagnostic tests before he or she can feel comfortable prescribing you opiates, acknowledge the request and your willingness to comply. Do not hesitate though to request further clarifications: “Doctor, my understanding is that complex chronic pain

can not be readily measured by standard diagnostic tests but these tests generally only provide clues as to why I might be in pain." "How are the diagnostic tests you are ordering going to determine how much pain I am in or how much pain medications I require?" "Doctor, I am happy to complete any formal pain questionnaire for I understand they are helpful to you and for me to know my progress. How do you suggest we are able to go forward with my pain management? If you think it would be helpful, I am willing to see a pain specialist to have my pain levels validated."

Sometimes a doctor simply intends to confirm your prescriptions to assure you are not getting multiple prescriptions from multiple providers. This is reasonable. Fortunately, they can now check that out while you are in the office with the Washington State prescription monitoring program.

When appropriate thank him or her for helping you find other options besides pain pills to get some relief but meanwhile, request that your pain be effectively addressed and remind them you want help to avoid any symptoms of withdrawal. Let them know that you are prepared to come back as often as they find necessary to help assure that the medications are being used properly and are part of a solution rather than a problem.

E. Ask Questions. If they recommend lowering your dosage ask them why. Ask them what they will do if the pain gets worse or you develop classic symptoms of withdrawal or you suffer from other stress related disorders. If they do not offer effective care for withdrawal, ask them why not?

F. Be Willing. Remember that our current payment system does not reward physicians for spending much time with a patient. Be willing to come back frequently to have your questioned answered or to express your concerns. Let them know you are willing to attempt behavioral and other interventions if they are practically available, possibly safer, and they are as likely to help with your pain management. ***Indeed, there is a***

***subgroup of pain patients who will actually do much better when they are off of all opioids*.**

G. Educate Yourself. If they bring up the new Washington State law as the reason they cannot prescribe, inform them that you have read it. (reference) Share with the doctor that you do not see where the law prohibits them from maintaining patients on their current levels of opiates. If they request a formal pain management consultation agree to have one as soon as they can arrange it. Meanwhile, request that they prescribe adequate opioids for pain management and to avoid any unnecessary withdrawal symptoms.

H. Be Knowledgeable. If they say that clinic or hospital policies do not allow them to prescribe you opioids or higher doses of opioids, then ask for a copy of those policies. While confrontational, you might also ask whether those policies protect them from the legal and professional mandate to provide proper medical care. If they say you need treatment for addiction ask them where you might get that help and ask for a formal referral. If they recommend a state licensed facility, other than a methadone clinic, remind them that agonist therapy is not available through state facilities and that our state licensed facilities rarely provide medical care and clearly are ill prepared to address chronic complex pain. Agonist therapy is often required for proper brain function in patients who are opiate addicted. If this seems to be news to them provide them with references from the “Agonist” paper available online at OPAS.us Handouts. (Reference)

I. Ask for Referral. If the doctor acknowledges feeling unqualified to manage your pain or addiction needs, thank them for being forthright. Ask then for a timely referral and if possible ask them, on account of your anxiety, to have the consultation set up before you leave. Another option is for you to ask them, as noted above, if they are willing to work with a specialist to assure you get the medical care required.

As your primary care provider they are arguably responsible to help you find the best medical care, especially when the care could be life saving. If they do not know who to call for help or where to send you, acknowledge the lack of expertise or access to same in the area. Offer to go out of the area if needed.

Lastly, you might ask whether they feel comfortable stabilizing you medically until more specialized care is available. If they do not think it is medically indicated to limit symptoms of withdrawal or to adequately treat pain then I suggest you establish medical care elsewhere.

J. One last clinical reminder: Minimize Stress. Any change to care, particularly care perceived to be helping and part of a longterm approach is stressful for a patient. I advise all patients struggling to get proper medical care to seek out professional and other support in dealing with the anxiety that arises. Anxiety does not help pain or the brain function better. Anxiety is often a strong trigger for pain to flare or even to abuse substances, whether licit substances or not.

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Diagnostic Criteria For Opioid Use Disorder

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