

A Tale of Two Treatments



By *Iris Erlingsdóttir* — February 9, 2019



Image: Advanced Pain Care [1]

Under the influence of the CDC Opioid Foolaid, at least a dozen U.S. cities are toying with the idea of opening “supervised” or “safe injection sites” (SIF), where drug addicts can shoot up illicit drugs watched over by medical professionals. The American Medical Association (AMA) voted in 2017 to support pilot SIFs. Patrice A. Harris, M.D., chair of the AMA Board of Trustees and the AMA Task Force on Opioid Abuse said such facilities will “help inform U.S. policymakers on the feasibility, effectiveness and legal aspects of supervised injection facilities in reducing harms and health care costs associated with injection drug use.” Preventing heroin and illicit fentanyl overdose deaths by babysitting drug addicts courtesy of taxpayers is certainly a noble proposition but hardly a viable one.

Since one of the medical establishment’s many excuses for refusing pain patients licit opioid pain medications is their alleged clear and ever- present danger to our “function” (I can confirm that 24/7 unrelieved, chronic pain will screw with one’s “function” in a meaningful manner), I must wonder: How “functional” is a person when high night and day on heroin or illicit fentanyl? Do drug addicts come to the “injection sites” on their lunch breaks? On their way to and from work?

Drug addicts visit the centers, sometimes multiple times per day, consume their drug and wander back into the street. How does this affect their safety and that of the general public? According to the Massachusetts Medical Society Report of the Task Force on Opioid Therapy and Physician Communication, the SIFs (and your tax dollars at work) will provide: “Health services including education, distribution, and disposal of drug using equipment; a variety of medical, nursing, and social work services; access to medical care and emergency services in case of overdose; hygiene services including laundry, showers, and bathrooms; drug treatment referrals, including drug substitution treatment such as methadone maintenance therapy, detoxification, and

rehabilitation safe injection sites.”

They won't supply you with drugs, but they will test your poison though, to make sure it's "safe." "SIFs are in keeping with the MMS Code of Ethics whereby physicians are obligated to provide compassionate and respectful medical care to all people while respecting individual human dignity and rights," the Report states. I must admit I'm astounded at the medical establishment's TLC and extraordinary efforts on behalf of drug addicts, since, as a chronic pain patient, the attitude I've come to expect from the medical profession is one of contempt and cruelty.

If the views of Dr. Nelson Hendler, former assistant professor of neurosurgery at Johns Hopkins University School of Medicine, are any indication, compassion and respect are in somewhat short supply among those who specialize in treating pain patients: "In a typical clinical setting, a physician has several major considerations when evaluating a patient with chronic pain. The first ... is to determine if a patient is exaggerating his complaint of pain, for secondary gain, be it financial or psychological, or if he is using the totally [sic] subjective nature of pain to obtain narcotic medication, by totally [sic] fabricating his symptoms. This latter case is real [as opposed to "unreal"?] malingering which is defined as a conscious attempt to deceive for personal gain." (1) You'd think a physician's first consideration would be trying to determine the cause of the chronic pain, but you'd be wrong. The first order of business is to catch that pill-popping, doc-shopping, drug-seeking criminal in the exam room.

Dr. Hendler is one of a group of John Hopkins University School of Medicine researchers who developed "The Pain Validity Test," an online test that the inventors say "can predict with 85% to 100% accuracy...who are faking their pain and exaggerating it." I didn't want to fork over the \$300 test cost (in 2016) for the 15 min., 33 question test, so I can't opine on its quality (or lack thereof), but Dr. Hendler's statement: "To combat the current opioid crisis ... the Pain Validity Test ... can predict with 95% accuracy who will have abnormalities on medical testing (a valid complaint of pain)" indicates that he doesn't understand that no amount of questioning of pain patients can possibly "combat the current opioid crisis" which is caused by illicit fentanyl and heroin. Curiously, while John Hopkins is eager to keep the drug-seeking pain patients in line, they want to ensure that no drug addict goes without her heroin.

A 2017 article in John Hopkins magazine describes a visit to the Canadian SIF Insite, a "building with a boutique-store facade. Once inside, they ... are politely escorted to a mirrored, light-filled booth where music gently plays. There, they can inject heroin...Hundreds visit the facility daily, some more than once, to safely inject illegal drugs such as heroin, cocaine, and morphine at one of 13 booths. Clients are provided sterile supplies to use their own drugs under the watchful eye of trained medical staff, without fear of prosecution. This is a no-judgment zone." Of course. Judgment has been reserved for pain patients.

If I seem unsympathetic to the cause of drug addicts, it's because the same medical establishment that wants my tax dollars to give drug addicts a life has determined I don't deserve one. The NarcoNazi era "opioid crisis" policies have destroyed my health and life as I knew it and left me with a view of the medical profession that is beyond repair. I was "fired" by my doctor of over a decade—ostensibly for "missing appointments"—the "termination" announced to me by the clinic director five minutes before an appointment I'd been waiting for two weeks (to be seen for a

serious systemic inflammation, not pain medication, not that it should have mattered). I was taken aback and hurt that my doctor of many years, someone I knew better than most people in our town, couldn't behave like a professional adult and tell me this to my face.

It's not like I wouldn't have understood that I wasn't the most desirable patient in these times of CDC NarcoNazism run riot. However, that could be dealt with later. I needed to see my doctor, I told the clinic director—any doctor, and I had an appointment. But at the Northfield (Minnesota) Hospital Family Clinic bureaucratic personnel are allowed to make medical decisions that affect patients' lives and health, and I was shown the door—from a hospital and clinic full of medical professionals—four days before Christmas, not the optimal time to seek medical care under any circumstances and got to spend the holidays with a festering inflammation. The Northfield Clinic did not refer me to another doctor or make arrangements for continuing care. It took me a few weeks to get an appointment with a pain doctor—who refused to refill my pain medication prescriptions, saying the clinic was more of an “injection clinic”! (Injections being so much more profitable than writing prescriptions).

A friend advised me to go to the Mayo Clinic; they'd surely be able to help someone with my complicated condition. I contacted Mayo, and a series of tests and appointments with doctors in various specialties were lined up for me, including with a rheumatologist, who was able to give me what I'd been looking for twenty years: a diagnosis. As depressing as it was, I was happy to have a diagnosis of a disease that could even be “seen” on plain old-fashioned X-rays, instead of suggestions of conditions running the gamut from fibro, CFS, it's-all-in-your-head, and drug-seeking. “This is an extremely painful disease,” she said. That was no news to me, and I asked her to make an appointment for me in Mayo's Pain Medicine Dept. I wanted to discuss pain management of this “extremely rare genetic arthritic condition characterized by the buildup of crystals causing chronic joint pain and acute pain episodes, as well as stiffness and swelling. The buildup of crystals causes progressive damage to the joints, and the pain can be severe and very disabling. There is no known cure...” But every time I called Mayo no Pain Medicine Dept. appointment had been made for me.

My rheumatologist found a notation in my file saying the only pain management option deemed—by unknown gatekeepers in Mayo's Pain Medicine Dept.—suitable for me was in the Mayo “Pain Rehabilitation Center.” And that despite the fact that my rheumatologist did not, because of the nature of my condition, consider me a candidate for the “Rehab,” nor did she believe it wise to take me off my pain medications, because I had been “doing very well on them” for years; the disease was “very painful” as well as incurable and untreatable, except insofar it was possible to treat its most significant and worst symptom—pain. I was getting worried because I was almost out of my pain meds, and if no one was going to prescribe them for me, at least I'd have to be tapered off them. “What is going on in this place?” I asked my rheumatologist after having received a letter from “Mayo Patient Care” saying that the Mayo had sent me a list with names of “pain clinics in the region.” Is finding pain relief my problem, I asked her. I am a patient of the Mayo Clinic, and it's their responsibility—not that of some unspecified other “Pain Clinics in the region”—to ensure that I receive the care I need. Does the Mayo list “a few regional” heart surgeon “recommendations” on computer printouts to give to its patients needing heart surgery?

The Pain Medicine Dept. Gatekeepers may have missed the class on long-term opioid pain medicine therapy, which teaches that following discontinuation of opioid pain medication therapy comes withdrawal, “which can be dangerous, with severe symptoms” and can last for “weeks or even months,” but someone at the Mayo Clinic has knowledge of this aspect of opioid medication therapy. Mayo strongly advises patients: A “scholarly” version on this subject is a 2015 Mayo Foundation paper, which discusses how “the risks involved in a taper.” The paper noted that the Mayo Clinic [taper] program used “gradual, structured taper...with rates of completion that can be above 90%.” And here I thought the Mayo didn’t have a “Program” to taper patients off opioid pain medications. Not a single Mayo Clinic physician would prescribe me opioid medication sufficient to “safely reduce [my] dose and get off [the] medication.” And I didn’t just “ask for help” to do that to do that—I begged. Many times.

When my last Fentanyl patch was used up, I got to do, courtesy of the Mayo Clinic, a DIY at-home opioid withdrawal (complete with Gatorade, popsicles, ice-packs, vomit bags, and used fentanyl patches I’d saved for this purpose). If Mayo medical staff believe this is a suspenseful experience—“will I live through this, sans stroke or heart attack, or just feel like a drowning rat for weeks?”—that no pain patient (and one with high BP, like yours truly) should miss, they are mistaken. The withdrawal symptoms, plus the unrelieved pain of the condition that was the reason for my needing opioid medication to begin with (in addition to months of stress and worry over losing my way of life as I knew it) undoubtedly shaved a few years off my life.

It was months later that I had the wherewithal to try to discover more about the Pain Medicine Dept. Gatekeepers who’d kept me from consulting with a pain doctor. I found out that despite never having laid eyes on me, a nurse and a physician’s assistant were able to determine, I had “exhausted ...appropriate pain management treatments...and therefore we are denying the request” to be seen in the Pain Medicine Dept. The only “appropriate” pain management for me according to these two “experts” who didn’t know me from Eve was of the \$45,000 variety on offer in Mayo Clinic’s 15-day “Pain Rehabilitation Center.”

What shocked me the most, however, was discovering that the months of consults and tests I underwent at Mayo were a travesty of my trust in medicine and all I believed it stood for. My “treatment” was determined long before any doctor even examined me. According to the two Pain Dept. Gatekeepers, referring me to “our Pain Rehabilitation colleagues” would “best serve her [me].” (These \$45,000 Pain Rehab spots don’t fill themselves). They wrote this one week before I met with another of their colleague, the expert on the subject of my chief complaint, my rheumatologist. Whatever my rheumatologist would conclude—her diagnosis, her advice—never mattered. There was never any intent to consult with her or to consider the medical information—which would be produced over the following months at great cost in terms of time, money, and effort.

It would have saved me a great deal of time, stress, money, and driving (and my health insurance a lot of money) had I known that my treatment protocol at the Mayo Clinic was determined within less than a week of my first appointment there, and that the only treatment I’d be offered, regardless of the outcome of any tests or consultations, was the back of a Mayo Clinic door if I would not or could not participate in their \$45,000 “Pain Rehab.” That I was a chronic pain patient

who had been on opioid pain medication therapy for years and would need to taper off the medication if I would no longer get it prescribed was of no concern to the Mayo Pain Medicine Department gatekeepers. Neither was the fact that my health insurance did not pay for the Mayo “Pain Rehab,” and what I’d do for “chronic pain management” if I didn’t have \$45,000 and a willingness to fork it over to the “Pain Rehab” for a “treatment” that, according to Mayo’s own expert, I wasn’t even a candidate for.

If this charade is the best the self-described “trusted leader in healthcare worldwide” can offer, I’ll settle for a drug store counter in Podunkville. It should be within the moral, ethical, and clinical capabilities of the Mayo Clinic—which is always happy to take me and my health insurance’s money for any other treatments, tests, and fishing expeditions—to provide passable pain care. Failure to treat patients adequately for pain—let alone those suffering pain from untreatable, incurable diseases—is not just negligence. It is a form of “torture...cruel, inhuman and degrading treatment” that will be to the everlasting shame of the medical establishment and the Mayo Clinic, which would have us believe its “primary value” is: “The needs of the patient come first.” Dr. William Mayo must be spinning in his grave.

NOTE:

(1) Evaluating Chronic Pain Patients Using Methods from Johns Hopkins Hospital Physicians, *Journal of Pain and Relief* (Sept. 2016).

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