A TALE OF TWO PATIENTS

Summer, 2017

‘ Medicine encourages physicians to favor the simplest explanation for the symptoms presented to them and to adhere to the most tried-and-true methods of treatment. There’s little reward for speculative thinking and a lot of risk.’

True enough…and for professionals in other arenas as well.

That is no excuse, however, for failure to act to correct a known set of medical conditions which cause horrible, long term and dangerous symptoms. I speak generally of the ‘opioid crisis’ and specifically of a general and continuing unwillingness or simple ignorance by medical professionals to some very specific and very important facts.

Primun non nocere. First do no harm—a noble and admirable axiom to be sure. And one which ought to encourage enough compassion and dignity to allow for professional, corrigible accountability. But what follows represents a betrayal of the spirit and letter of this axiom, for harm was most certainly done, and this letter is testimony in fact.

This is the reporting of Patient A and Patient B, two long standing members of the Curry County community whose chronic pain medical conditions had been successfully treated by the same General Practitioner for sixteen years. These two patients were among many chronic pain patients referred to the Pain Management Group, Curry Health Network, Brookings, Oregon, when their physician suddenly retired, leaving them in limbo regarding access to badly needed pain medication.

Let us begin by examining some pertinent issues in the form of some questions. How many Md’s, or other trained medical professionals might agree with this statement---- A patient who has been prescribed and who has taken opioids for chronic pain relief for, say, at least three months, should never be immediately taken off those same medications--- Right? Is it safe to assume that statement might be considered common knowledge in the medical profession?

And can we further assume by the acceptance of the statement that tapering the patient off the medications is the best medical practice here? If this is yes, a patient who was prescribed 180 mg. of morphine daily, and who had been safely and effectively taking this dosage for fifteen years would qualify for such a regimen? And the same consideration given to a patient who was taking 30 mg. daily of Diazapam for fifteen years? Although not an opioid, any benzodiazepine carries with it an even greater risk to one’s health if tapering is not observed, worse than Heroin.

Three minutes inside the Google machine reveals that a ‘cold turkey’ approach with benzodiazapines might result in death due to seizures, not to speak of the awful

horrors associated with the withdrawal process. And an equal amount of research time indicates that approximately twenty percent of chronic pain patients using opioids who were not given the benefit of proper titration now suffer from Protracted Withdrawal Syndrome, a most unpleasant and serious medical condition. Witnessing it one time makes one determined not to witness it again.

These two examples are but a small sampling of chronic pain patients in Curry County, Oregon, who have had their pain medications immediately taken away, or reduced through an accelerated process driven by the actions of the largest and dominant medical provider group, The Curry Health Network. Perhaps upward of one hundred chronic pain patients were forced to accept continued services by the Pain Management Group located in Brookings, Oregon.

Under the auspices of this Network is the medical practice of Dr. Christopher Amsden, head of the only Pain Management Group in Curry County. Under his tutelage is Kim Hanks, PAC. Between the time of April 2015 and July of 2017, all chronic pain patients in the county were forced to see Dr. Amsden as there was no other choice available. Of the two physicians who treated these 'chronics' prior to April 2015, one had to retire due to medical reasons, the other forced to retire by claims of 'over prescribing' opiates.

Immediately upon first visit to the Pain Management Group, all patients were told that their pain medications were being reduced by 25%, regardless of individual symptomology. From there, the Group's idea was to eliminate the opioids altogether, replaced with a combination of three or four other medications which were claimed to 'work together' to effectively reduce serious chronic pain. An anti-seizure and an anti-depressant were included in this mix. Several compounding pharmacists and many nationwide drug counselors called this plan of action 'reckless' and 'absolutely wrong.'

From our two above examples, patient A---the opioid patient---was on a high dosage due to numerous physical traumas compounded by severe rheumatoid arthritis. For over a decade, this regimen was continued which allowed the patient the ability to work year after year, at least ten hours per day. His first two visits with Kim Hanks resulted in the 'cold turkey' of Dilauded, TID. Then a rapid reduction within two weeks from 180 mg. Morphine ER to 15 mg. Then, a sudden increase back to 180 mg. then another rapid reduction back to 'no further prescriptions' for these two pain relief medications, and 'no reason to see you again.' Patient A's resulting Protracted Withdrawal Syndrome has rendered him practically helpless, and in a sickened condition quite seriously resembling those devastated by the effects of abuse and malnutrition. Of the past 24 months, he has experienced intractable diarrhea for 20 of these months, the explosive type perhaps six to ten times per day. And after 18 months, continued severe body muscle cramps, at times pinning his legs back over his head in his sleep, but in his case as a double amputee, his 'stubbies' pinned to his

chest, the ends only inches from his face. And only the passage of several hours allow his legs to return to normal. Also, there have been several times this patient has been violently thrown from his wheelchair from the effects of severe body spasms. All this a result of a continued assault of the Central Nervous System upon the body. And all this because of widespread ignorance and negligence on the part of medical practitioners in the Curry Health Network.

This symptomology and other pertinent data may be found by simply Googling Dr. Heather Ashton. Ashton is the world's foremost expert on pharmacological interactions, with years of experience owning several drug intervention clinics in Great Britain. She has written extensively about drug interactions and withdrawals, and has lead research efforts toward continued professional publication.

Only now, well over two years from the initial symptoms, has patient A been able to secure possible help, well beyond the borders of the Curry Health Network. He will have to undergo a 'detox' process, even though being without medication for this length of time, and will likely involve a reintroduction of former medication which addresses the need to stabilize the Central Nervous System, then an intensive program with Suboxone, a synthetic opioid antagonist and agonist, to try and return to some level of normalcy, including a degree of pain relief. One wonders why he was so soundly rejected by so many medical providers within the Curry Health Network? Where is the program to address this issue?

Just for a minute, try to imagine these pain management practitioners dispensing a specific medication which actually *caused* widespread symptoms of diarrhea, dry heaves, severe stomach and body cramps, tinnitus, insomnia, severe gastric distress and general malaise. Imagine the uproar and demands for help which would spread through the county! Now imagine these symptoms occurring month after month. What doctor would allow this?

Despite repeated attempts to get help for this apparent never-ending horrible condition, Patient A was rebuffed at every turn. 'This can't possibly be happening.' This sentiment was the essence of our medical community's assessment of his condition. 'You can't possibly be in this much pain.' What were they thinking? His pain medication was taken away. Did they not expect a return to serious pain levels?

But really, the crux of the matter is that these medical providers were largely ignorant of the real dangers associated with the use and administration of opioids and benzodiazepines. Most of them protested loudly that withdrawal symptoms 'cannot and do not last more than two months…just a mild discomfort.'

All this until they read the literature. All this until they take just a few minutes to follow up on the facts.

Turning to other physicians within the Curry Health Network was of no avail. Not only was his story met with disbelief but some practitioners said they could not override the decisions made by the Pain Management Group. Apparently, Dr. Amsden sets the rules with the guidance and direction of the policy makers within the organization.

It is noteworthy and certainly tragic that such a high percentage of medical professionals offered little or no knowledge of this rather serious condition. Kim Hanks said that unpleasant symptoms would last 'for only a few days.' a direct contradiction when faced with empirical evidence and a plethora of valid research readily available from the Internet. If aware of the seriousness and severity of her decisions, she might have acted accordingly. But her unwillingness to listen or believe Patient A persisted. Please imagine this gastric suffering, month after month. This is torture defined.

PATIENT B

There was one physician who did follow through with Patient B, however, Dr. Craig Reed, a psychiatrist working with a small medical/drug counseling group in Curry County, Curry Community Health.

As Valium is primarily considered a 'mental health' drug, Patient B had to participate in a three-month drug counseling program with CCH before allowing him access to the psychiatrist, the one source of possible help to get a prescription and foster a halt to his withdrawal symptoms, already seven months in full swing. Dr. Reed was initially quite put off with Patient B and his insistence that his symptoms were real. Patient B aptly passed a rigorous and lengthy mental health exam, and was promised that his research recommendations would be pursued and followed up with a report.

Patient B pointed the psychiatrist to Dr. Heather Ashton, one of the world's foremost expert in psychopharmacology. She and several other medical researchers have written extensively about opioid and benzodiazepine Protracted Withdrawal Syndrome. In his final report, Dr. Reed admitted the existence of Protracted Withdrawal Syndrome, its medical seriousness, and its valid and reliable research conducted during the past thirty years. He recommended a clinic in Medford, but the clinic did not accept Medicare/Medicaid. No further help was offered by any other medical provider.

Dr. Reed left his practice with Curry Community Health shortly after his findings.

Patient B had been prescribed 20-30 mg. Valium for fifteen years to combat the effects of a severe muscle cramp in his lower right leg, a cramp caused by a sensory/motor neurological disorder which was a result of a case of Industrial Toxic Neuropathy. Additionally, this patient was prescribed morphine and hydrocodone for associated chronic nerve pain.

Both Dr. Amsden and PAC Hanks simply refused to refill the Valium prescription, saying only that they would not be involved because of potential negative drug interactions. Certainly, there are dangers associated with a benzo/opioid combination, but not one moment was devoted to discussing this long-term regimen with the patient or why it was necessary to change medications when they were working well. Or, what kind of effects would occur by taking Valium completely out of the picture. This patient had been able to work during these years, generally felt

good, with all medical tests within normal limits. No excesses, no respiratory problems in fifteen years.

The first week passed without the benefits of the Diazepam. Patient B's world began to fall apart. He experienced the worst case of stomach flu in his life. The debilitating kind. The kind where the stomach cramps are so bad that they bend you over in your chair, daring you to move, combined with mostly dry heaving and explosive diarrhea. And a minimum of eighteen hours. And awful muscle cramps. Difficulty swallowing began and the starting of tinnitus, expanding to a loud hiss, relapsing and remitting, yet always present. To this day, two full years since the beginning withdrawal symptoms, the hissing and squealing of this auditory disorder continue, as intense as ever.

Then, two weeks later, the 'flu' came back, as bad as the first time. Barely recovered, patient B struggled to re-gain his strength. Seventeen days later, he was struck down yet again. His primary care at the time was PAC Jennifer Dengler. She was baffled by these symptoms until she read several accounts of Protracted Benzodiazepine Withdrawal, then realized what was happening. Until this time, she had little knowledge of this condition. She stated there was nothing she could do as Dr. Amsden's treatment program could not be changed without his permission. In one year's time, patient B experienced this 'flu' fifteen times, every time with 18-24 hours of unrelenting diarrhea, dry heaves, and terrible stomach cramps. He remembers feeling like death was upon him, and wishing it would come to end the pain and suffering.

To add to patient B's ordeal, PAC Hanks set up a schedule to reduce his opioid dosage from 120 mg. daily to 60 mg. on the first visit, then to 30, then to 7.5 within a 60-day period. Then, nothing. There was also some stipulation that those patients who were legitimately participating in the Medical Marijuana Program had to choose between receiving even a bare minimum of pain medication and their 'medicine' from the Oregon Marijuana Program. One could not have both. Any Cannabis in the system meant no pain medication.

Fortunately for patient B, he found a pain management M.D. in another part of the State who realized the benefits of his current pain medications, and re-instated most of them. However, still no prescription for Diazepam, and a reduction of morphine by 50%. Patient B found a way to live with this, and avoided an unwanted encounter with another bout of Protracted withdrawal. He does not believe he would survive another similar experience. During this two-year period, Patient B also reports he was unable to complete contract work and needed to postpone badly needed hip surgery due to a serious decline in overall health.

This testimony and account of both Patient A and Patient B is easily verified by pharmacy records and journals kept. It is intended for the view and dissemination by the public, and is hereby released to the interests of all, allowing for unobstructed publication from and by existing Internet platforms.

So, as surely as justice for the poor is contrived and as surely as redress and recompense against those responsible for this horrible situation would be denied, efforts toward some level of restitution will likely rest on the abilities and efforts of several experts on Internet Publishing using successful marketing platforms; established networks reaching and linking to over two million independent news and events websites and social media. This issue has obvious local implications, and apparently is being repeated in other communities nationwide, demanding and deserving a full measure of attention.

Fortunately for the aggrieved individual, information is power, and community interests are high in the light of the current 'opioid crisis.' And massive distribution of information is inexpensive, allowing for widespread scrutiny and accelerating public awareness, both locally and nationally. Already, one major Oregon newspaper has expressed an interest in developing a story, awaiting the possible outcomes of Patient A's further treatments.

All comments will be read, and all questions answered within reason. With apologies to none, I remain,

Patient B,

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