

How To Beat Chronic Pain

.....and learn tightfisted proven strategies that reduce or even stop your pain enabling you to be happier, be much more involved in activities you like to do, and be the important person you expected to be all along.



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"How To Beat Chronic Pain"

“Believe a time is coming when you are pain free.”

“The body achieves what the mind believes!”

By Curt Graham, M.D.

You know how it feels! Chronic pain throwing you to your knees so much of the time you can't think straight, can't enjoy anything, and can't find a reason for your suffering nor a hope for a cure!

You already know how pain has brought you to tears, created a world of depression, and often leaves you without hope of ever finding any permanent relief. You need to know what's happening in the upper echelons of our government and in the medical world in order to understand at least some of the reasons you wind up begging for pain medication refills.

Then you can **focus on methods for real pain relief**, not the promises of medical research coming up with the perfect pain relief formula. The future prospects that our elected representatives of government will feel any urgent need to do anything to remove the barriers to your being treated adequately for your pain.....is absolutely laughable!

You're either reading this because you are in pain right now, or you know someone close who is suffering in pain. Imagine being joined by the estimated 75 million Americans who have to struggle with chronic pain, and marching right up to the White House for a little chit-chat with the president about the withholding of effective medical treatment of pain by the medical professionals. **It's a fact—not a suspicion!**

Chronic pain is a relentless soul-sucking disability. Chronic pain has become a public health issue, as well as an issue of great concern to the business and industrial components of our country. It's big enough of a problem to put a large dent in the economy of our country. The estimated annual cost of management of patients with chronic pain is over a billion dollars.

It has been estimated by various surveys that **2 to 40% of the US citizens are in the treatment phase of chronic pain.** My suspicion is that the wide variation in estimated percentages is directly related to the biases of the surveyors—whether the persons collecting and evaluating the data had a chronic form of pain themselves---or not.

The sad aspect of this is that large numbers of doctors and health care providers actually believe you must be a drug addict and are faking your pain symptoms.

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The **National Chronic Pain Outreach Association** reported 34 million patients suffer chronic pain and lose 50 million work-days a year because of it. In addition, seven million of these patients **get no relief without opioids** (narcotic medications)—and **only 4000 doctors** in this country willing to prescribe them. **Does this bother you? It should!**

Gradually, patients are learning about the carefully camouflaged tactics used by the medical profession to avoid treating patients with chronic pain problems. Those tactics have evolved among health care providers **for survival**—in a professional sense. Now, why would they have to stoop so low in the first place? Read on!

When you finish reading this report, you will have the ammunition to convert your role in your own pain therapy from a "passive" to an "active" role.

Some of the common harmful consequences to patients are:

(because of the avoided obligations of medical professionals to provide effective chronic pain treatment)

- Patients having to rely on OTC (**Over The Counter**—non-prescription) pain medications.
- Dangers of mixing prescription pain medications with OTC pain medications.
- Avoiding the doctors who refuse to treat any patient with chronic pain.
- Developing depression, loss of hope for relief of pain, and social isolation—even suicide.
- Driving patients in desperation to perform criminal acts to get pain relief.
- Living a non-productive life requiring constant attention and support by family members or close friends.
- Overdosing with OTC pain medications leading to severe **body damage**.

It's time to pull the curtain back and take a stiff look at the causes and effects of pain treatment and management. "**Pain treatment**" has a completely different meaning than "**effective pain treatment**." Many doctors and other health care providers who treat pain intentionally treat pain patients just enough to take the edge off your pain, and expect you to handle the left over pain some other way.

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For me, it has become a deeply personal issue. I could hardly believe my ears. I sat there listening to the Rheumatologist counseling my wife about her severe pain from her arthritis. He refused to give her any prescription pain medication—suggesting she use **aspirin or Advil**. His primary approach to her pain was to push her into an exercise program for pain relief.

Everyone knows that the **endorphins** (hormones produced by the brain) produced during exercise act like opiates (narcotics) and reduce pain. I asked the doctor if he thought that **“24 hours a day” exercising** was a good idea in a patient with a heart problem as well. My sarcasm was meant to be noticed—but was ignored.

These endorphins are only present when one is exercising and for a very short period of time after. So what does a patient do for the other hours of the day for pain relief? **What do you think?**

The reality of the problem: (Important for you to know)

It doesn't end here! It's not just in chronic pain issues. Even patients with episodes of temporary severe pain caused by injury or disease are being short-changed by pain therapists. The **fear of prosecution and intimidation** for prescribing strong pain relief medications flows straight down into the treatment of common transient pain.

Anyone who treats any form of severe pain, temporary or chronic, is a hostage of the DEA (**Drug Enforcement Agency**) and the “Governor appointed” State Medical Boards.

Every doctor and professional health care provider who prescribes pain medication for relief of pain is automatically under the scrutiny of the DEA and State Medical Boards.

The unfounded presumption by the regulatory agencies that doctors and other professionals are contributing to the spread of the illicit narcotic drug trade in this country, fuels the fire of fear among all health care providers.

The extent of such an unsupported presumption is summarized by Barry Yeoman in an article written for AARP in 2005. He reported on many cases of the ongoing abuse of the Controlled Substances Monitoring Act passed in 1994 by our elected officials, and by the DEA and State Medical Boards that affect you directly.

Katherine Finkelstein went even further in her article in 1997 presenting the statistics.

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She confirmed that in 1994 that State Medical Boards took action against 434 physicians for prescribing violations, and had the DEA investigate each case. The DEA pursued six cases and ended up **convicting ONE doctor** in Puerto Rico.

Does that tell the real truth about physician prescribing—or not?

The fallout of all this "pressure" against physicians and all health care providers, threats to their professional careers, subtle intimidation carried throughout the medical population, is appropriately phrased by one author. He stated physicians have consequently taken on an attitude of, **"If this is the way I am going to be treated, I'm done prescribing pain medication in chronic pain patients." "I just don't need this."**

One method the DEA uses to monitor the flow of narcotic pain medications is by the use of **special narcotic prescription pads and coded prescription paper** incapable of being copied, which physicians need in order to prescribe those medications. Physicians and providers are required to register with the DEA to obtain these special documents. Guess who knows what providers are prescribing controlled drugs!

Many states require doctors to comply with controlled substance registration even if they don't treat chronic pain patients or prescribe any controlled drugs (medications is a better word than drugs). It leaves these providers on the "suspect" list whether they like it or not.

How do the DEA and Medical Boards find out about suspicious prescribing habits of doctors?

- By requiring pharmacists who notice what they believe is excessive prescribing of narcotics to patients repeatedly by certain doctors, to report the occurrences.
- By arrest of drug traffickers who report doctors or providers as one of their sources of drugs.
- By investigations of borderline doctors and providers who are in trouble repeatedly for various violations.
- By patients caught for using narcotic pain medications for other than pain treatment and reveal the doctor or provider as a source.
- By anyone who reports doctors or any provider for using opiate drugs themselves, or over-prescribing to patients.

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Can any health care provider be fooled?.....Absolutely!

Over the years patients have developed sneaky and successful techniques to fool the doctors into prescribing narcotic pain medications. When doctors are misled by a patient, and believe they are prescribing pain medication for very legitimate reasons, should the doctor be prosecuted for that? **It has happened!** Even the elite Medical Professors from top medical centers are not immune.

Even if the **physician is exonerated of all charges**, many lose their practice because of damage to their reputation in the community. It's because we all have a tendency to assume that if charges were brought against a doctor, there must have been something shady that he was doing to warrant such accusations in the first place.

Trust is lost! And not recoverable!

The problem with perceptions:

Patients with chronic pain are commonly perceived to be manipulators. You tell the doctor you have severe pain. How do you go about proving it to the doctor? **You can't!**

How can doctors prove to themselves that you actually do have severe pain? **They can't!** You take a "gut check," energize your sixth sense, and match symptoms with physical findings that validate the pain. That's how a doctor decides.

Because pain is not something that is open to rapid fire detection, a patient is left to the whim and actions of the doctor.

Pain Intensity:

Then a decision has to be made about the intensity of the pain. Most often than not the severity is based on a "one to ten" scale—10 being the most severe. You say it is an 8 severity, and the doctor is thinking you act and appear like it is a 4 level intensity while you are in the exam room with the provider.

Yes, a provider's decision and judgment about how they are going to treat you is based on **whether they believe what you say** and act like in that 10 minute office visit. Not being able to follow you around for the next day or two to confirm how much the pain is affecting you, any doctor is left with what you say to make a judgment.

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If you are taking 2 pain pills every 6 hours, and the pain is gone, should the doctor prescribe less pain medication? **Is the goal to prevent all pain totally?** Or is the goal to taper your pain medication down to a level that controls your worst pain enough for you to go about your daily chores in a reasonable fashion while tolerating some pain?

The perception of how much pain medication to prescribe for you is a complex issue. Your pain threshold (what level of pain you as a person can tolerate), your family obligations, your response to various pain medications, your attitude towards pain, and your personal willingness to follow the prescribed treatments all contribute to how the doctor treats you.

Talk about juggling invisible oranges! It's like waiting for your cat to bark!

Pain Threshold:

The truth about pain severity is dependent on your pain threshold.

Every person has a different and unique pain threshold. One's tolerance of pain varies with the tide. One day you can tough it out, and the next day the same pain is now intolerable. That same pain in another person may be perceived to be mild and tolerable.

And you think doctors can figure this out and be correct 100% of the time? **Absolutely not!** If there ever was a time when a doctor is the most vulnerable to subjective decision mistakes, this arena of judging the patient and their amount of pain is it.

The solution to treatment is by titrating the dosage of the pain medication to match your pain tolerance (threshold). And that's a tough act to follow. So how is it managed? By a series of doctor office visits where treatment is always being adjusted and re-adjusted to your condition at that day (or that week) in your life.

Barriers To Treatment Of Chronic Pain:

My alarm bells ring loudly when it comes to a smack-down confrontation with all the barriers that hinder every aspect of chronic pain treatment.

To name just a few of the most critical barriers:

- Need for more that 50% of patients to change physicians because of their doctor's unwillingness to treat their pain aggressively.

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- Medical school and residency programs are woefully inadequate in training new doctors in pain management.
- Psycho-social influences on patients warp communications with physicians and incite fear, masking of symptoms, side effects of drugs including addiction, and fatalism (described below).
- The health care system is deficient in making available what the patient with intractable pain must have to obtain even what one might consider "adequate" pain management.
- Non-verbal (you can tell by a doctor's actions and comments) communications have a loud "voice" that only a pain sufferer can hear—and directly interferes with pain treatment.
- Large numbers of doctors think they know how to treat pain—but don't.
- Health care providers lack detailed knowledge of the comparative effectiveness of pain reducing medications, especially opiates, and patients suffer from it.

Now, if these are not enough to make you squirm and learn, nothing can! Each of these barriers require a detailed explanation that will bring them into a cutting edge focus for pain patients who desire better pain management—or should I say, "effective pain treatment."

A. The physician availability barrier:

In every sense of the issue our government (our own elected politicians) has criminalized narcotic pain treatment. When the DBA agents show up like a blitz in the middle of a doctor's office hours unannounced in their black outfits and weapons, it has a tendency to scare doctors (which it does).

This intrusion happens repeatedly across the USA to doctors and other providers who have no idea that they were under investigation for anything—let alone prescribing pain medication.

The agents confiscate all office records, which immediately shuts down the medical practice (or even the dental practice). Their arrival with guns and badges is sure to get the local communities attention. But it never gets into the papers. Wonder why?

Now you know it happens!

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Immediate surrender of the doctor's **narcotic license** followed by serving them with a court summons outlining all charges against them, is surpassed only by a \$25,000 fine. In “one” **30 minute span of time** a doctor's personal and professional life is turned upside down—and usually much worse! All on a beautiful summer day with an office full of patients and without a single clue it was coming.

The DEA undoubtedly does it this way to put the fear of God into every physician and health care provider who prescribes narcotic pain medication. It's such an effective technique that it has **essentially placed the responsibility for pain treatment in the hands of the government and the State Medical Boards.** Think about that for a while!

Physicians never considered that the government's War On Drugs had ramifications that included them as the enemy. The consequences of the entire mandate have resulted in holding physicians and patients hostage.

Doctors have responded to this national threat by pulling out of the race. "**Let other doctors handle the patients with chronic pain, I'm out of it.**" The doctors and health care providers who are willing to take risks in their medical practices are left to do the job. My guess is that the majority of physicians actually do treat chronic pain patients.

When I say the majority of physicians do treat patients who must live with chronic pain, I include the middle group of physicians who **filter the patients they do treat very carefully.**

If you walk into a doctor's office as a new patient asking for pain treatment, you may be disappointed. Those who have been patients of their doctor for years usually will receive pain treatment—but not always.

Some doctors avoid these patients and problems by **never obtaining a narcotic license** in the first place. Patients in these medical practices are treated with the milder pain medications. Fortunately, non-narcotic pain medications are available by prescription. If you have severe or chronic pain, you have to be referred to another doctor who can prescribe the Schedule II stronger and effective pain medications.

Darvon Compounds and anti-inflammatory drugs like Celebrex are a couple of those milder prescription pain medications. Rarely do these non-narcotic pain medications help patients with chronic or severe pain.

You have just learned what 95% of people never will discover.

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A hypothetical example.....if you ever had to have major surgery performed by your own doctor who had no controlled drug license, another doctor would have to prescribe the narcotics needed for your post-operative pain. That is, if you weren't a real tuffie who could live through the pain without narcotics? Surgeons are smart. They all have a narcotic license with rare exceptions.

Doctors without a controlled drug license sacrifice an important aspect of their practice in exchange for avoiding this one area of risk. The irony of this is that medical practice is so full of risks every day. Some even more serious than being accused of narcotic prescribing violations. One wonders why that doctor would want to practice medicine anyway.

B. The inadequacy of training in pain management barrier:

Myra Glajchen's article on chronic pain clearly defines the extent of the lack of pain management training among physicians who treat chronic pain. If these experts are quick to admit how poorly they were trained in pain management, what do you think the other physicians would say about it?

Even more troubling is the thought of how many patients in this country are **under-treated** for any pain they may have as a result of their physician's lack of knowledge—without ever mentioning the DEA risks.

The challenge for physicians is to learn everything they can about present day pain management from any source they can find. Medical schools must force this into the minds of every medical student one way or another.

The ultimate aim of any such pain management teaching program is to enable physicians to sharpen their skills for assessment of the quality of pain in a patient so that appropriate levels of pain medication can be used.

When 88% of physicians reported that their medical education in pain treatment was poor, and 76% of an Oncology group admitted their own low competence in pain assessment, it should be a wakeup call for improving the medical care (pain treatment) of patients suffering daily and tolerating the less than adequate pain treatment.

The truth about it is that most physicians learn what they know about the effectiveness of the various pain medications by trial and error during their practice career.

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The problem with having a standard protocol for pain therapy is that there are too many varieties of pain to write a protocol on. Also, every patient has such a variable pain threshold from day to day, and different from others with the same type pain, it is impossible to structure a protocol that fits every patient every time.

What are you learning here? You're learning significant differences exist among doctors who treat chronic pain patients. Differences in training, experience, and knowledge vary to such an extent that you must make your own judgment about whether the provider you are being treated by is of the caliber you need.

Searching for the bottom line in pain management and treatment continues. So little is known about the causes and origin of pain on a cellular level, that doctors must rely on what is known. For most physicians it simply means **using opiate medications** to relieve pain effectively.

Another important aspect of pain management being included in the education of doctors now is what's called **"alternative medicine."** **Pain relief does occur** with the use of many of the forms of alternative medicine. They can be added to the standard scientific treatment of pain, or be used separately. Alternative forms of treatment include such methods as acupuncture, physical therapy, hypnosis, message, herbal medicine, and homeopathic medications, to name a few.

C. The psycho-social problem barriers:

Probably these problems create more insurmountable barriers to chronic pain treatment than all the rest combined. Psychological factors are always present in patients with chronic pain.

When you are looking at the possibility of having pain for the rest of your life, your mind is forced to compensate for the constant disruption of a normal life. When things seem hopeless, depression is the result. Constant pain increases anxiety, insomnia, and isolation.

Dr. Cluett describes the unique and indisputable end result of constant pain. The patient is grabbed by the neck and dragged into taking on the **"sick role."** He explains it as a patient who becomes a victim of their own pain symptoms. It involves need for constant attention, sympathy, and persistent reassurance. **It's a trap.**

For a while it works well. But then it wears on the family members and friends so much that they fade from view eventually. This leaves the patient alone and depressed.

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Finally, the feelings of worthlessness and hopelessness lead to suicidal thoughts. At this stage many consult with PAS (patient assisted suicide) doctors.

Communication problems also exist. Some chronic pain patients are drawn into a codependent status as a result. Such patients **mask their symptoms** so as to please their doctor by making doctors think that they are doing a great job with their treatment. It insures the patient of continuing treatment. **It's called Fatalism.**

Pain assessment is unreliable when you consider that a patient's anxiety, depression, anger, frustration, and dementia can alter the patient's perception of severity of pain, as well as the patient's perception of the effectiveness of the pain medications. **Oh, Oh.....another glitch.**

A **patient's attitude** towards the medications and treatment directly affects the results. **Fear of addiction** to the narcotic pain medications makes some patients avoid strong pain medications. They make it clear to their doctor that they are doing quite well on the lower dose of mild pain medications—when they really are miserable. The **fear of side effects** of strong pain medications is another part of it.

Just the **thought that worsening pain might be caused by the narcotics** leads some patients away from adequate pain treatment. In addition, patients may begin to believe that no medication can make them comfortable enough to resume a relatively normal life. So why take the strong pain meds.

Unless the doctor is aware of all these possibilities, and intentionally makes an effort to clear up all the wrong ideas a patient has, the patient will continue to suffer.

D. The health care system barrier:

You said it! Our health care system is not just a barrier for chronic pain sufferers; it is more like the China Wall in width and the Philippine Trench in depth. **Does that give you a visual picture?** The "system" is a problem for all medical patients as well.

Those of you who have a pardonable disposition towards our health care system should skip the rest of this section and go on to the next. It's not that it happens to be the best in the world, but that it could be miles ahead of where it stands now in more ways than one.

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In about 5 seconds I am going to make you extremely angry! Answer these questions for me:

- a. Why is it that millions of patients needing pain relief for chronic pain are continuously being under-treated for pain by doctors and other providers?
- b. Why is it that the War Against Drugs takes precedent over the health care and pain treatment of millions of patients?
- c. Why is it that hundreds of excellent physicians are being punished each year for suspected narcotic prescribing violations when in fact they are innocent?
- d. Why is it that the DEA and state Medical Boards are permitted to force doctors and other pain therapists into becoming violators of the Hippocratic Oath and the instigators of continued suffering from pain?
- e. Why is it that patients with chronic pain (even that in terminal cancer patients) are "expected" to, and "told to," learn to live with the pain—and try to live a normal miserable life? Anybody who says that to you----smack 'em!
- f. Why is this national disgrace permitted to continue, and why hasn't there been a tsunami of voters who step up and do something about it?

RED ALERT! Our health care system is structured by law. Laws are created by politicians. Politicians composing the legislatures of our state and national governments have caused this problem and are responsible for the consequences. Am I telling you something you don't already know? **I hope not.**

Since legislative bodies are composed primarily of lawyers, and legislative bodies pass the health laws that directly cause problems resulting in inadequate treatment of chronic pain, then logically lawyers are primarily responsible for the outcome. They don't ever apologize to you. Otherwise they would be forced to uncloak their personal motivations for what they have done.

Doesn't, "We're doing what's best for everyone" sound hollow and manipulative?

If these questions don't set your brain on fire, then nothing will change. And when you reach that stage of intractable pain which is not helped by "the maximum allowable doses of pain medication," you may remember who's to blame—**and it's not the doctors!**

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Now let's get into the minor health care system obstructions to pain treatment.

The "ifs" that affect all patients with chronic pain:

- If there were more pain treatment centers, patients would have better access, travel less, and cost less for the patient to get there.
- If there were more pain treatment specialists, patients would get better care.
- If the opiate laws were physician friendly, chronic pain patients would be properly treated.
- If the insurance co-pay rises, how will patients afford care?
- If there continues to be a lack of home health care workers, patients will suffer.
- If pain medication costs increase, who will help?
- If health plans continue to limit the number of prescriptions per month patients need, patients will need to pay out of pocket.
- If pharmacists continue refusing to fill narcotic prescriptions, as some do, because they think the doctor is overdosing them, finding a pharmacist that will fill them is a problem.

E. The "It's not your fault" barriers:

Studies show:

- Minority pain patients are more likely to have inadequate pain relief. (Bernabei et al)
- Minority pain patients near death are least likely to receive pain medication. (ML Martin)
- Pain threshold varies with gender of patient to a small degree. (Cleeland et al)

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- Aged pain patients are more difficult to treat because of dementia, inattention, limited attention span, hearing difficulty, and easily distracted. (Andersen et al)
- Some narcotics are more effective than others in certain types of chronic pain. (Simpson et al)
- Abuse and addiction to pain medication is less in patients who have no history of substance abuse. (Portenoy et al)
- Physical dependence on pain medications is quite different than true drug addiction. (Public Health Service-1994)

Quality of Life Issues:

You can't touch it! You can't see it! But you sure know what I'm talking about. When chronic pain is the issue, one has to distinguish between the chronic pain of malignancy (cancer) and non-malignancy.

I believe that everyone has compassion for the patient who is in pain and about to die. So it's not difficult to side with physicians who go overboard to make the dying patient as comfortable as possible in those last weeks or days of life.

The duration of pain related to malignancy has a definite end point. Non-malignant causes of pain have no definite end point and often are a companion for life. Pain management goals, medications, and treatment strategies of each are quite different. Justifying much heavier dosages of pain medication for pain relief in a terminally ill patient is unnecessary.

Treating chronic pain that is not a result of life threatening disease but yet threatens life in another way brings the quality of life issue to the forefront. The unrivaled purpose of pain management is to improve the quality of life for that patient over a prolonged period of time.

Physicians, who willingly run the gauntlet between effective treatment of chronic pain and risk of prosecution for over-prescribing controlled drugs, deserve the highest respect. It takes guts to do it, but doing the right thing for patients offers the doctor himself a better quality of professionalism as well.

Don't you think the physicians who do everything to avoid treating patients with chronic pain, have guilt feelings about it, and even regrets? **I do!** It runs parallel with doctor's decisions about doing abortions—pro and con.

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The primary concern of every patient with ongoing pain is to obtain enough pain relief to carry on most of their normal life activities. Any relief counts! They hardly ever expect to have their pain totally cured, even though it does happen at times.

Narcotic Addiction Issues:

Drug addiction is thrown at patients with chronic pain repeatedly to justify prescribing lower doses of narcotic pain medications. It's hard to believe that any patient living with chronic pain wouldn't trade addiction any day of the week for putting up with a miserable life.

You need to understand that there are **two kinds of addiction—physiologic and psychologic.**

Patients on continuous narcotic pain medications may develop a **physiologic** addiction. When the time comes to stop the narcotics, the dose is slowly reduced over a few weeks, and the person is back to normal.

Psychological addiction is a physical dependency on narcotics and their effects which is mentally driven in order to cover up life problems that they are unable to handle any other way. When they reduce or stop the narcotic drugs, all the hidden frustrations surface again. Thus, forcing them to continue the drugs forever. And all this is a process that has nothing to do with pain treatment.

Yes, **patients can have both** pain therapy and a real psychological addiction that is already present or they are predisposed to when they begin pain treatment. When a person reports that they started on narcotic pain medication for a serious injury (for example) for chronic pain, and became **psychologically** addicted, it's a crutch.

The "high" feeling and pleasant side effects of narcotics is what they are addicted to—and that is a voluntary choice or compulsion, not caused by the drug. The underlying cause is mental dysfunction, which most addicts vigorously deny.

Contrary to popular belief over the counter medications are **far more harmful to any patient than narcotics.** One study reported from the **American Society for Action on Pain** revealed that 19,000 pain patients a year die as a result of OTC non-prescription pain medications.

This is separate from the 130,000 hospitalizations caused by OTC pain medications each year.

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Tylenol in large doses will destroy the liver. Aspirin and Ibuprofen compounds cause ulcers and gastrointestinal bleeding. Kidney failure is another bad effect caused by these medications. Dr. Brian Goldman, a University of Toronto researcher is an expert in this field.

Realize what risks you accept, or I should say, "**are forced into**" because your doctor either refuses to treat your pain, or continues to treat you with mild pain medications that won't get him into trouble with the DEA or Medical Board.

Patients will not put up with that—ever! Would you? Find another doctor that will treat you effectively. Is this a quality of life issue—or what?

The hypocrisy of it all:

Let me set the record straight! A quick historical analysis of government invasion of medical care with a focus on treatment of patients with chronic pain quickly exposes the **rat**.

Our government has lost the war on illegal drugs. It's a fact that they won't admit. By criminalizing the actions of doctors in treating pain patients, they have provided themselves a platform to gain back public support—"getting rid of bad doctors." It's printed on their virtual battle flag.

Check this out:

- 1970 Controlled Substances Act created. DEA categorized controlled drugs into Five different "Schedules." Schedule II drugs are those most commonly prescribed for pain.
- 1973 ODC (Office of Diversion Control) was created. **Assignment:** To insure that pharmaceutical drugs were available and prevent them from illegal sale and use.
- 1984 ODC given power to revoke a doctor's DEA registration and license to prescribe controlled drugs. Previously, the registration could only be taken away for 3 reasons:
 1. Falsifying a prescription.
 2. Doctor convicted of a felony relating to controlled drugs.
 3. Medical license suspended, denied, or revoked.

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- Since 1984--ODC has reinterpreted the law to mean they can revoke doctor's registration anytime they determine that there is a "**threat to public interest.**"
- 1990 Physicians Manual states, "narcotic analgesics have a legitimate clinical use and the physician should not hesitate to prescribe, dispense, or administer them when they are indicated for a legitimate medical purpose."

The DEA agrees on paper, but has its own interpretation of what this last statement means.

In the early 1990's **State Medical Boards decided to start their own purge.** That effort fell flat on its face judging by the results that the Federation of State Medical Boards published. This attack by the Medical Boards not only petrified every doctor who prescribes controlled drugs, but also alienated all doctors.

The spin off from the actions of the State Medical Boards goes far beyond controlled drugs. Suddenly the medical licensure requirements stiffened. Doctor applications were rejected in numbers far above those reported in previous averages—and for reasons that a few appointed doctors and state officials (Medical Board) considered contrary to state statutes.

The suspicion is that they believed that by rejecting large numbers of the less qualified doctors they would be eliminating the majority of the doctors who would be narcotic prescription violators. I wonder if it worked?

If you really want to know how shamefully the DEA and Medical Boards have performed their functions relative to these issues and to our health care system, I invite you to take a reading tour of the references at the end of this report. Focus on the details of the cases against doctors that have been researched by these authors and organizations. Don't take my word for what is happening—**decide for yourself.**

A point needs to be made of just a few cases that validate the incredible hypocrisy and appalling antics of these enforcement groups who make their own rules and believe they are "above the law" in what they do.

Stan Milner, a Jackson, Mississippi based attorney defending doctors uncovered the blatant conflicts of interest displayed in the state's Medical Board actions in the McFadden case.

**Do you believe State Medical Boards make decisions free of any political agenda?
Do you think State Medical Boards are composed of only arrogant individuals who believe their judgments and decisions should never be questioned?**

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Milner summarized it in these terms:

- Those that collected the evidence were on the payroll of the Board.
- Those that judged and prosecuted the case were on the board's payroll.
- The judges are the investigators and they hire the prosecutor.
- The judges sit as the jury, plus referee the match.
- No proof was presented that patients had complained.
- No evidence that McFadden had harmed any patient.
- The Board and their expert witness never introduced the fact that the doctor was a lousy record keeper—a factor in favor of the doctor.
- The Board counsel bragged that they were number one in the country for bringing disciplinary actions against physicians. Do you think that fact brought every doctor in the state to a personal wake-up call.....wondering who's next?
- The pharmacist who filled McFadden's patient's prescriptions called it a "witch hunt."

It became very clear that it was probably easier for a drug addict to buy black-market narcotic prescriptions on a street corner than it was for a patient to obtain a legal prescription for Vicodin.

The associate director of clinical services (National Institute on Drug Abuse, research division) explained that no research data was available at that time to indicate that the diversion (doctor prescriptions to patients are transferred on to street trafficking in controlled drugs) process starts primarily in doctor's offices.

Also, he stated that no one knows the nature and extent of diversion from doctor's offices, thefts, forgeries, and smuggling—or any other sources. It's easy to pick on vulnerable medical professionals (my comment) and sick patients.

Have you noticed that this stuff really fries my oysters!

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How many patients do you think out of desperation and hopelessness consulted with Dr. Jack Kevorkian in Detroit? I don't know. **You know who he is—right?**

The depressing and insulting aspect of all this is that any patient in chronic pain should never have to resort to such extremes in our "moral and civilized" (a little sarcasm I just couldn't hold back) society.

In 1995 the Tennessee Board of Medical Examiners (the name of the State Medical Board—and same naming tactic used in many other states) determined that McNeil had violated several provisions of the State Medical Practice Act. The Board labeled him "impaired."

He was forced to give up his narcotic license and join a codependent support group. His attorney's advise; **Put your head in the guillotine and let them drop the blade.**

On appeal, the state appeals court threw it all out and stated that the conclusions of the Medical Board were without needed validation and evidence. I liked what Finkelstein wrote in 1997, "McNeil succeeded in blowing up the board's **opiophobic** (I just love that term) logic that when it comes to drugs, no proof is required: We would not accuse you if you were not guilty."

In 1994 Dr. Katherine Hoover was charged with over-prescribing controlled substances by the West Virginia Board of Medicine. She was prescribing much more than her peers. She was the **only doctor treating chronic pain patients** in the area. So what doctors would we consider to be her "peers?" None! Doctors are usually judged by their peers (those on equal status).

Doctors always have to practice according to the standard of those who are doing the exact same thing in medical practice—those are the peers.

Her successful \$10 million suit against the State Dept. of Health and Human Resources and the State Medical Board charged them with extortion, conspiracy to defraud, and discrimination. Many doctors are now considering doing the same thing, or have already done it.

In April 2005 Dr. Hurwitz was sentenced to 25 years in prison for "**drug trafficking**" after prescribing large doses of painkillers such as OxyContin, morphine, and methadone to his patients. One of his patients overdosed and died.

He was way ahead of his time!

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His patients testified that he was the only doctor that had ever provided them effective relief of their debilitating pain.

There's an ever-growing list of highly respected physicians and university medical department heads who have been charged with violations of narcotic prescription drug over-prescribing. The attack is not limited to the little small town doctors.

Some helpful and positive changes that have occurred in pain management in the last 30 years:

- **1980**--doctors who used opiates to treat pain considered Morphine to be too potent and dangerous to use even in terminal cancer patients in excruciating pain. The lack of knowledge about narcotic pain medications even such a short time ago is unbelievable.
- **1986**--Dr. Portenoy's article reporting the successful use of narcotics in terminally ill patients created outrage from colleagues. What doctor in his right mind would believe that one should be more concerned about drug addiction and fogging their brains than a terminal cancer patient screaming in pain?
- **1989**--ten states passed intractable-pain treatment acts supporting the use of narcotics in treatment to pain.
- **1990**--Oregon passed the Compassionate Care Act sponsored by Senator Bill Kenemer as a result of his own wife with terminal breast cancer in severe pain being unable to find a doctor willing to prescribe enough opiates to relieve her pain.
- **1996**—two leading medical professional groups declared opioids an essential part of pain management.
- **2001**—DEA and 21 health organizations agreed that opioids are often the most effective way to treat pain, and often the only treatment option that provides significant relief of pain.

The "expectations" problem and barriers:

Because no elected official wants to be known as being "soft on drugs," relaxing of the punitive efforts of the DEA and Medical Boards won't happen for a considerable length of time.

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Doctors will continue to run for cover from the swarming opiophobic enforcement storm troopers.

Patients will continue to be held hostage by this unholy alliance between the DEA and Medical Boards until we vote them out of office.

The general public will not continue to tolerate such demeaning treatment. Since patients now are obtaining medications from outside our own country and from illegal sources, it's no wonder we are accused of expanding the DEA's war on drugs.

It seems logical that pharmaceutical companies will be spending considerably more research funds on developing more effective OTC pain medications and non-addicting prescription pain medications.

Without a doubt the smart illegal drug traffickers are already planning ways to supply chronic pain patients with narcotic medications. Chronic pain patients are now and will continue to look for any source of pain relief they can find. **Is this a wake up call—or what?**

Don't consider me an expert in the fields of narcotic treatment of pain, pain management, or illegal drug trafficking forecasting. But, if I can think up possibilities, so can everyone else. My medical career **does paint me** as a narcotic pain treatment advocate.

I'm very comfortable telling you that my surgical patients were made "comfortable" post-op, were up and about before other doctor's patients were even allowed to eat, and rarely needed to call me back during their recovery period to ask for more pain medication.

The pain management problem:

Doctors who limit their practices to pain management have not only brought the effective treatment of pain to the attention of everyone, but also have reinforced the value of pain treatment for those patients who are forced to live with pain.

It's especially important when you consider quality of life issues for millions of patients. Pain assessment techniques have evolved slowly, but have a long way to go. Being able to evaluate the effectiveness of each pain medication in each patient is one thing, but having to quantify the amount and severity of pain a patient has is another thing.

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Even though technology has made huge breakthroughs in medical care, it has fallen short of being helpful in the evaluation of pain.

Pain management is a system that is based on a few anatomical and physiological principles, but reaches its real function based on subjective evidence.

Doctors have to accept your word for how bad the pain is, where you feel the pain, and how well the pain medication is working for you. This leaves it wide open to errors, misleading communications, manipulation, and the biases of doctor and patient. It leaves it closed to scientific evaluation and accurate testing procedures.

Pain is like the wind. You feel it and can't see it. You know it's there but can't prove it. You see the results of it but don't know where it came from. You see the misery it causes but can't make it go away and stay away.

Several strategies used to manage pain:

- **Cover up the symptoms** of pain with drugs.
- **Increase the pain threshold** of the patient by certain techniques.
- **Transfer the patient's focus** away from the pain.
- **Remove the cause** of the pain if known.
- **Disrupt the transfer** of pain messages to the brain.
- Allow pain to be there, but **learn to control it**.

OK! I haven't listed them all, but at the moment these are the most beneficial. Please disregard any reference to the 45 caliber treatment. Some of these treatment methods are better than others. And the problem with that is doctors have no acceptable way to know which method will eventually work best with you.

Cover Up Pain:

The easiest method and probably the most popular is to cover up the pain symptoms with narcotics. They do the job quite well if given in enough dosage. Titrating the dosage to a level where you can perform normal everyday functions and yet are not zonked with intolerable side effects is the quest.

Increasing the patient's pain threshold or tolerance to pain is not easy. Most doctors seem to think that insisting that the patient "**learn to live with the pain**" is a way of doing that. It doesn't work! But it certainly does anger the patient. Maybe that's the trick. If you get them angry enough they'll forget the pain. Briefly, it does work.....maybe for 48 seconds.

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Trouble is that you can't stay mad for the next 20 years, at least not continuously.

Distraction Factor:

Enabling a patient to **get their mind off the pain**, even for just a part of the day does **two things**. It proves to the patient that distractions result in loss of pain, or at least a reduction of it.

The best example of this is found with contact sports. You rarely notice injuries while you run around the field, rink, or gym looking for someone to clobber. Only after the game you notice that someone stepped on your toes way too hard, crunched you arm enough to cause a large bruise, and twisted every tendon in your neck.

Athletes experience the remarkable nature of how the body and mind are able to hide the pain of injury from our conscious minds at the time the trauma occurs. Soldiers who are wounded in combat also remember a span of time when, "the wound didn't hurt."

The **second thing** it does is teach you that there are techniques other than taking a lot of narcotics that can help you decrease your pain. Encouraging patients to do strenuous exercise, play sports, keep moving, and engage in hobbies that require physical activity, offer patients with chronic pain an option to try along with other techniques. Combining several techniques is very effective as well.

Remove The Cause:

Remove the cause of the pain seems simple enough. If you have chronic pain in one leg as a result of a bad fracture of the lower leg (as an example), and it didn't heal well, amputation is an option, or even removing the bone and replacing it with a prosthetic borrowed material.

My daughter has exactly that same medical problem. A truck crossed the midline, crushed her car, and crushed her leg below the knee. First consideration was amputation, but the orthopedic surgeon had just learned some new techniques for repair of bone and saved her leg. Over the last several years she has had repeat surgery and suffers with continual leg pain.

Prevent Transmission Of Pain Messages:

If you have abdominal pain, you can't remove the abdomen---except at autopsy. Did I just say that? **It's crude, but not rude.**

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Many chronic pain patients benefit from trans-section (cutting or dividing) of the nerve bundle transmitting the pain message up to the brain where pain is recognized. Occasionally, trans-section (cut in two) of the spinal cord is needed to stop lower body pain in extreme conditions.

Epidural anesthesia given at intervals, or even by a continuous pump, will chemically block the nerve transmission of pain. Injection through the needle is for short term relief (few hours). The needle is removed immediately after the injection of the anesthetic into the spinal fluid.

Long term use of an indwelling catheter is very effective for some kinds of chronic pain. In case that is something new to you.....A large hollow needle enables sliding a narrower soft hollow plastic tubing into the spinal fluid canal. The anesthetic (nerve deadening drug) is injected through the tubing.

The tubing can be left in place for extended periods of time. The outside end of the tubing is hooked up to a small (2 to 3 inch diameter) battery operated pump you wear on a belt or tape to the skin. The small pump draws the anesthetic fluid from a connected reservoir at pre-set times or manually on demand and pumps it into the spinal canal.

The pain message must reach the brain to be "felt" or perceived by the patient. But you knew that all along—right?

Alternative Medicine Treatment:

Control Pain Without Medication:

Mental control of pain is possible. **Biofeedback** techniques have been used for years to accomplish such things as lower blood pressure, stop migraine headaches, and change the pain threshold. Only a certain group of chronic pain patients can learn to use this well.

Hypnosis and **acupuncture** have worked wonders in certain susceptible patients.

These latter two methods are not usually covered by health insurance and tend to be expensive in the long run because it involves repeated treatments for prolonged periods of time.

If “The body believes what the brain perceives” is a fact, then belief is a great starting place.

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You may have noticed that I have been careful not to poke my nose into the areas of herbal medicine, homeopathic treatment, and the vitamin/food culture. It's because I've never studied them to any degree and know little about how they are used in the field of chronic pain treatment. Just because I haven't spent the time to research the world data concerning their applications to medical treatment doesn't mean I consider them useless.

What I find most interesting about alternative medicine treatment advocates is their response to direct confrontation. Seems like they are not only defensive about what they believe, but also very hesitant to reveal supportive information.

When I have contacted people or experts in one of those areas of knowledge over the years to learn more about their ideas, I rarely get an answer back. Those who do respond usually refer me to published literature on the topic—avoiding personal interaction.

Outsiders often perceive those responses as being a scam!

Dr. Frank's "Instant pain relief" by simply sniffing a nasal spray formula sounded great. So I attempted to obtain their "expensive" product to see what it does. Every phone call I made to get information was unproductive. Ordering the medication over the Internet website was a whole new experience.

It was necessary to listen to 20 minutes of product by product information advertisements before payment could be made. I gave up. I just wanted to know what the active pain relief chemical was. Never able to find out.

Another **medical doctor** (similar training that I had) with an alternative medicine website and newsletter repeatedly reports dramatic and unbelievable cures of patients medical problems that other medical doctors were unable to cure using scientific standard medical treatments. Using his magic method of food manipulation and various herbal products to cure them one by one is a miracle.

My email to him requesting detailed information was dead-ended. He mentioned several medical studies that supported his treatment results but never revealed a reference where others could read them. Either he is the world's greatest BS'er, or he should be a candidate for the Nobel Prize in Medicine.

Since alternative medicine results are so extremely difficult to support by using the scientific standards of proof, maybe we should treat it all **like the Bible**.

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Until the time when all things are proven and understood, perhaps we should accept the results of alternative medicine treatment on **faith alone**. If the treatment works, great. If you feel better and the pain is relieved, fantastic. What do you think?

My general impression is that they do have some usefulness for treatment of pain, but I shy away from things that cannot be proven scientifically. Why? Because it's impossible to distinguish between "placebo" effects and "effective" results—unless it's proven to be of lasting value over time using established scientific methods of research.

Having 200 people saying that a certain herbal medicine reduced or cured their pain doesn't mean that it is safe, or that the herbal medicine was the cause of the pain relief. In my E-book "**Healthcare Secrets Revealed—Finally!**" I tell a true and tragic story of my patient who had a curable cancer and decided to rely only on herbal medicine to cure it....it didn't.

However, history has shown us repeated examples of ideas and principles which were discarded as useless and later were documented to be true. Everyone should keep an open mind about the truth or effectiveness of herbal and other alternative medicine treatments until we have ways to be sure of their value and safety.

After all, the medications we now use and know their value commonly are derived from plants.

Anything that results in pain reduction for you at any time, whether it is temporary or permanent, whether it is scientifically supported or not, and whether or not anyone knows how or why it's working-----USE IT as long as it continues to work for you and there are no body-ripping side effects.

Comments and Advice:

This report is not meant to be a substitute for advice from your own doctor. It is not provided as medical advice nor should it be interpreted as such. The information is a thought provoking strategy and idea generator to help patients with chronic pain. Anyone with chronic pain knows what all this is about because they have already faced many of these treatment barriers and problems.

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My epiphany:

During my medical school training at the University of Pennsylvania in 1962 some babies were being delivered under maternal hypnosis. About 20 years later I took a course in hypnosis to test my beliefs about hypnosis. Not only did I quickly learn to believe it works, but that I could use it for many patient problems in my practice—and did!

In the 1970's acupuncture was considered by most in the medical profession to be useless. So after my epiphany with hypnosis I had another with acupuncture. When my patients came back from the acupuncture therapist (I referred them only to medical doctors trained in acupuncture) treatments cured or at least with considerably improved symptoms, I then believed what the Chinese have been telling us for centuries.

That's why I remain open-minded!

Hopefully, this information will be of great value to patients suffering with chronic pain by providing options, ideas, and approaches to pain treatments they are unaware of—or previously had no reason to trust. In the same sense, this information will be of great value to those who do not have chronic pain themselves, but someone they care about does.

Knowledge, information, and options about pain management are crucial to chronic pain patients, no matter what the source is. Information concerning the names and uses of all the controlled pain medications, and how they are used can be found detailed in many excellent articles on WebMD.com, MedicineNet.com, and many others on the Internet.

My suggestion is to use the Internet as your primary source of information. There are **Forums, Chats, and Bulletin boards** on pain and hundreds of other topics. Type "**pain relief forums**" into the search line and you will see and hear what other patients with chronic pain are doing about it. Reach out to them and reap the benefits.

Remember, if you are not good with a computer or the Internet, libraries have all the information you need.

I might caution you that much of the public medical literature published today is subject to whitewashing, culture filtering, truth masking, and editorial sorting. In other words--lacks credibility to a degree. As you continue reading you will begin to understand that there always is a consensus of legitimate opinions among the experts. That's when you can grab the truth as it should be believed. Eventually, all the garbage is trimmed away.

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When you visit my main website <http://www.healthcare-toolbox.com> you will discover medical truths as I see it, in depth medical and healthcare information not found anywhere else, and a “no BS”, experienced, medical doctor who can make your life better.

“One cannot get through life without pain....What we can do is choose how to use the pain life presents to us.”

Bernie S. Siegel, M.D.

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The references listed below are among the best, with the most reliable information on the topic of chronic pain.

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*"Treat pain and rage as **visitors.**"*

Ben Hecht

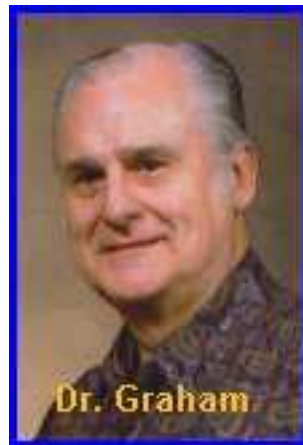
The author, **Curt Graham**, is a retired medical doctor who has written extensively on many topics over his 35 plus years in active medical practice as a specialist in OB-GYN. He has been published in Modern Physician, and is credited as a "Platinum Expert Author" by EzineArticles.com Internet Directory.

If you have a need for more specific information on chronic pain or are looking for a medical website where direct contact between you and a real medical doctor is possible---**Go Here Now!**

<http://www.HealthCare-Toolbox.com>

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**Things unsaid are never dead.....but are left to be uncovered at
the right time.**