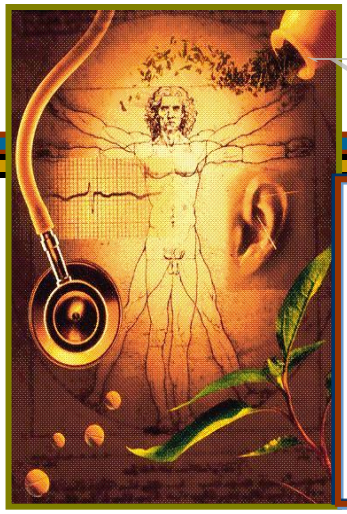

THE P.A.I.N. INSTITUTE

Pain & Addiction Integrated Network, Inc

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CURRICULUM VITAE, PERSONAL THOUGHTS, & PHILOSOPHY

In 2000 I was appointed Associate Medical director of Ambulatory Services for Health Care Partners Medical Group, SouthBay Division (250,000 patients) when the IPA I cofounded was purchased by HCP. Subsequent to this occurrence, HCP was purchased by DAVITA Corp. for 3.4 billion dollars.

After a 2 year stint with HCP, I presented the concept for THE PAIN INSTITUTE at Little Company of Mary Medical Center (see copy of brochure). Since 2003, my focus of practice has been in the specialties of Pain Medicine & the clinical treatment of Addiction and physiologic dependence on "doctor prescribed opiates and other controlled medications." These two areas of medicine are commonly inter-related because of the use of doctor prescribed opioid medications in the treatment of moderate to severe acute & chronic pain. Prior to 2002, from 1982 thru 2002, I practiced both inpatient and outpatient Family Medicine, but I also served a stint as the Medical Director of the San Pedro & Peninsula Hospital Chronic Pain Center for 5 years, Co-founded a large primary care medical group-Coastal Physicians Medical Group that grew to 14 physicians and 3 offices, Co-created the Alliance IPA which was sold to HealthCare Partners, and as I stated, as a result of that acquisition I was appointed Associate Medical Director for Ambulatory Care Services for Region III (250,000 patients) at Health Care Partners Medical Group from 2000 to 2003. I was responsible for reviewing and authorizing specialty requests for authorization to do invasive therapeutic and diagnostic interventions and surgeries by specialists in interventional pain medicine, orthopedics, podiatry, rheumatology, neurosurgery, plastic surgery regarding breast reduction surgery, gastric bypass for obesity, and the ordering of all diagnostic radiology for these services.

My experience at this position allowed me to fully assess how genuinely dysfunctional our approach to the treatment of chronic pain had become. My experience at HCP was frustrating because I saw how archaic chronic pain disorders were treated in the 21st century, and it was shocking to me to see how poorly patients in chronic pain were treated and evaluated. As a result of my observations at Health Care Partners Medical Group, I studied the state of pain medicine and came to believe that chronic pain management is really a primary care responsibility and that unless primary care physicians take on a broader base of responsibility in taking care of chronic pain, and addiction, our system will never change and will perpetuate the poor outcomes. I also believed that addiction diagnosis & treatment goes hand in glove with the medical management of chronic pain. In fact, our countries dismal record in the areas of addiction treatment caused me to look carefully as to how both of these interrelated medical problems could be better served. It was because of my direct experience as Director of Health Care Partners Ambulatory Care Services that I began to develop and formulate how best to bring this service to our community. I left Health Care Partners in 2003

and founded, and created a new concept & model of how primary care physicians could become better trained in pain medicine and addiction medicine and, I established "The Pain Institute at Little Company of Mary" from 2002-2005, but due to budget cuts and hospital priorities like the now defunct "Spine Institute at Little Company of Mary", I was told that I could continue The PAIN INSTITUTE under the auspices of the hospital but I would have to support the entity myself, or I was also given the option to take the program private at my own expense. I chose the latter to maintain my independence.

My conceptualization regarding the approach to this very complicated and challenging area of clinical medicine initially was to create a "Pain Program" that would be comprehensive in scope because I recognized that there were major deficiencies in the current diagnostic & therapeutic approaches to the treatment of pain and addictive disorders in the U.S. today and, that Pain disorders are present across the entire spectrum of medicine, crossing virtually every single specialty of medicine except pathology. The concept of a primary care based approach to pain medicine allows for a broad approach to the diagnosis and treatment of pain and avoids the limited and narrow approaches offered by specialties in orthopedics and anesthesiology. Unfortunately, pain is one of the most difficult areas of medicine to investigate. Anesthesia based interventional pain management often leads to misdiagnosis primarily because of the tendency to narrow treatment focus towards "injection" therapy. Orthopedic based pain medicine tends to treat pain by offering surgical and injection therapy alone.

One of my goals in creating "The P.A.I.N. Institute" was to create an environment in which typical "knee jerk" and "shot-gun" medical approaches to diagnosis and treatment of pain disorders were avoided. Quite, pain physicians, orthopedic surgeons, and other specialists automatically order tests and therapies based on their narrow specialty field and, as a result they do not complete a thorough and, clinically focused history & physical examination. As a result by not carefully listening to the patient recount their concerns the specialty physician may fail to match the history, the objective physical & clinical findings, diagnostic & radiologic studies, and previous specialty evaluations and misdiagnose the likely pain generators. Diagnosing pain requires an open mind and an ability to view the patients problems in a global perspective, which means understanding the "whole" human being across many physiologic systems. Putting the pieces of the puzzle together is not easy. This is why interventional pain medicine only plays a minor role in the evaluation and treatment of chronic pain.

Unfortunately, as a result of failing to institute the "art & science of medicine" when evaluating the complex issues and medical co-morbidities often associated with the equally important psychological and emotional problems inherent in the diagnosis of chronic pain, patients feel as though no one is listening to their complaints. As a result I often see patients inflicted with medical and surgical approaches that are aggressive, invasive, and potentially harmful. As a result, often the naïve and trusting pain patient ends up getting unnecessary injections like epidurals, or major surgeries like spinal fusion and joint replacement, or undergoing unnecessary diagnostic radiologic procedures like MRI's and epidurograms, resulting in inaccurate and misdirected diagnosis and treatment. As astounding as it sounds, many Americans are undergoing unnecessary surgeries such as total joint replacements, cervical and lumbar spine fusions, arthroscopy, epidural and facet injections, sinus surgery, spinal cord stimulator implantation trials, and many other more risky and potentially dangerous procedures unknowingly and in my opinion unnecessarily. Primary care physicians are better trained to keep the evaluation and treatment process safer and simpler during patient evaluation. Most chronic pain problems are misdiagnosed and therefore, often mistreated. This occurs because the interventional pain physician or surgical specialist often approaches the pain problem from a narrow field of focus. As hard as it is to believe, I have prevented major spinal surgeries and fusions, joint replacement, implantation of spinal cord stimulators and morphine pumps, epidurals, and therapies like RFTC procedures many times over the last decade and continue to do so. The patients often just require better pain control, therapies like viscous joint

lubrication, and better directed joint injections. When we compare the U.S. with the rest of the" first world" the rate of invasive and surgical pain intervention is 2 to 3 times higher in our country, the morbidity and mortality associated with these interventions is equally as high, yet the outcomes are poorer. Why? Because we don't listen to our patients and we do not match complaints with objective findings. All too often I see patients who were not examined by the specialty physician, but when the orthopedic surgeon looked at the MRI and saw degeneration, immediately told the patient that the MRI clearly showed the source of pain, when the patient's clinical history did not match the MRI findings. No wonder that post-surgery the patient still complains of pain.

As an example, just this month, I had a patient who was told by a prominent local orthopedic surgeon that he needed a partial knee replacement based on 5 weeks of pain and an MRI that showed "bone on bone" joint space. But in my office, within 15 minutes I had diagnosed and treated his condition with a simple targeted cortisone injection for what was obvious tendonitis, and as a result, my patient was saved from an unnecessary surgery. Just because the MRI shows joint narrowing doesn't mean that it is the source of pain. On clinical exam the patient had good range of motion without crepitations or stiffness. The patient also stated that the orthopedist injected a different area, nowhere near the painful region. Needless to say, my patient is still ambulating without difficulty.

Another patient of mine went to see an Ear, Nose, & Throat specialist in Beverly Hills and was told that he needed sinus surgery for obstructive polyps that were diagnosed in the office without any radiologic studies. Before he was out of the office he was set up with a surgery date at the local Surgi-center. Luckily for him, I bumped into him at the store and heard the story. I treated him for allergic rhinitis and laryngitis, and I diagnosed that he suffered with chronic vocal cord irritation due to reflux and allergic rhinitis. I sent him to a trusted colleague in Otolaryngology for a second opinion who disagreed, and thank God, the patient did not undergo surgery. Incredibly, that Beverly Hills surgeon still calls him asking why he hasn't re-scheduled his surgery. Unfortunately, these stories are not isolated incidents, but are becoming more common events and increasingly prevalent in areas where excess numbers of certain specialties have set up shop.

A 3rd example patient went to see a local orthopedic spine surgeon and based on an MRI, was told that he needed an immediate spinal fusion and laminectomy of the cervical spine. He came into THE P.A.I.N. INSTITUTE for a 2nd opinion and I told him that he 1st needed to get off of his opiate analgesics with a drug called BUPRENORPHINE and that in my experience, chronic opioid use for pain diminishes the brains capacity to fight pain because of the opiate causing reduction of endorphin production which results in opioid induced hyperalgesia. We successfully got him off of all pain meds and his spine pain became minimal, to the point that he no longer needed to have surgery. The orthopedic physician was operating on the basis of what "a picture or MRI looked like" rather than assessing the clinical state and history provided by the patient. All too often in the U.S. we operate because an MRI looks bad and we ignore the fact that the patient actually can improve on his or her own over time. Unfortunately, I have seen too many major post-operative complications because the surgeons were too quick to operate. Too many physicians intervene based on a "picture" rather than taking a thorough history, matching the clinical findings, and objectifying the data so that findings on adequately explain the patho-physiology

I created "The P.A.I.N. Institute" partly because of my negative experiences with inappropriate therapies and procedures ordered by well-meaning interventional pain anesthesiologists and other specialists who do not understand that a "band-aid therapy" like an epidural for most chronic degenerative conditions is useless, ineffectual, costly, & inappropriate when dealing with incurable chronic unrelenting pain for which such interventions may be temporary at best, and generally a waste of time and money. In my view, more than 80% of epidural injections are unnecessary for chronic back pain.

In addition, despite newer approaches to the treatment of addiction, current rehabilitation treatment is stuck in 1950's and 1960's AA mentality and, as a result, our ability to prevent addiction & relapse is dismal because of these archaic attitudes. Not only that, the U.S. is the only major industrialized 1st world nation where 80% of all opioid medications, illicit drugs like heroin and cocaine, and drugs created world-wide, supply just 4% of the world's population as represented by our populace in the United States. It is simply appalling, yet we continue to espouse to the world that we have the best medical care in the world! We don't really fight a war on drugs. How can we? When more Americans are addicted today than ever before? Addiction can be treated aggressively, but we have to stop allowing money and greed control how treatment is offered. We just fought a war in AFGANISTAN, and now the U.S. is flooded with cheap heroin. That is something to ponder.
AA was developed in the 1930's to treat alcoholism and it still is a godsend to many addicts worldwide, however addiction to opiates, cocaine, methamphetamine, nicotine, sedatives, etc. is a "brain biochemical & neurotransmitter" disorder and AA has been a failure in this group. Naturally, if a person has gotten clean and is happy and functional as a result of AA, then more power to them. But if relapse is the outcome, then 21st century treatment is required to target the brain receptors reinforcing the drug addiction. Relying on the AA rehab model is how we have gotten to the current epidemic of addiction and dysfunction.

Marijuana is being legalized to treat medical conditions in many states, yet there is no evidence that it is effective against anything but a handful of chronic conditions. Rational Public policy is absent and what should be scientifically based treatment is controlled by money, greed, and ignorance. An estimated 10% of high school students use Marijuana daily in the U.S. How can this be happening? I am a Hispanic-American, and addiction & alcoholism is rampant not only in the community where I grew up, but in many African-American communities, Native-American communities, and the uninsured and poor communities of America in general. Incredibly, drug policy in the U.S. does not include input from professionals of color like myself. Why? It is a perplexing, deplorable, and frustrating situation that eats away at my soul because I can only treat one person at a time, and as a result it has become very disillusioning because I recognize the need to help other physicians to take on the challenge.

This discussion is not meant to create controversy or paint myself as a "rabble rouser," but rather to raise appropriate questions and understanding about where my passions for the practice of medicine arise and why I am so concerned about the current epidemic of both addiction and chronic pain (1/3-1/4 of Americans) in our country today. I believe that constructive non-aggressive consensus building is the only approach to solving the many difficult issues that I bring up for discussion here, however, it is important to me that people understand what made me leave a thriving family medical practice after 20 years, to build a new practice in new specialties with so much enthusiasm and fervor.

As the Assistant Medical Director for Ambulatory Care Services at Health Care Partners Medical Group for the South Bay, Region III, I was given the responsibility to oversee medical decisions affecting the 250,000 patients of Region III and, in my capacity overseeing utilization review requests for procedures I saw so many inappropriate requests for procedures for non-indicated reasons from contracted physicians who specialized in Interventional Pain Management, Spine Surgery (orthopedic & neurosurgery), Podiatry, Medical & Surgical pain therapies, Routine Orthopedics such as joint replacements, spinal procedures such as discograms, nucleoplasty, spinal cord stimulators & morphine pump trials and permanent implantation, ENT procedures, Acupuncture, and Chiropractic care. In addition, I was responsible for developing and implementing a Nurse Practitioner / M.D. home visitation program to monitor and care for frequently hospitalized (so-called "frequent flyers") patients with the effort and goal being to cut down unnecessary & preventable re-hospitlaizations. My directorship at Health Care Partners came about because during the decade prior, I had co-founded an IPA, Alliance of South Bay Physicians with Bob Lewis, M.D., leader of I.D. Med in 1992. We grew rapidly, and by 1999 Health Care Partners Medical Group (HCP) acquired our

fledgling IPA and as part of that acquisition, I was asked to take on the position of Assistant Director of Ambulatory Medical Services for Region III as part of the agreement. As an aside, in December 2012, Alliance IPA, still a small subsidiary of Health Care Partners Medical Group was sold, along with the parent company HealthCare Partners to Davita Corp for 3.4 billion dollars in cash and stock. I am proud to have been the co-founder with Bob Lewis, M.D. of an entity that continues to grow and provide a choice of excellent private IPA healthcare today.

As the Assistant Medical Director of Ambulatory Care Services at Health Care Partners, I found myself increasingly taking on the role of "patient advocate," when I observed abusive practices from specialists willing to do unjustified invasive procedures for profit. I frequently protested to my superiors the irregular and abusive requests by certain pain specialists. I felt a need to protect the community from the many unnecessary requests for Epidural and Facet Injection procedures, nucleoplasties, and implantation of inappropriate devices requested by aggressive Interventional Pain Management providers.

While treating chronic pain suffering patients, I also came to realize that many of these patients were addicted or dependent on their pain medications and were labeled as "addicts." Most had become addicted because no one had addressed their underlying pain condition rationally and many had been abandoned by the very physicians who had first prescribed their opioid pain medications. Most physicians aren't trained in the long-term use of opioid analgesic to treat chronic pain and many do not understand how to treat and prevent addiction. In addition, at San Pedro & Peninsula Hospital Chemical Dependency Center, a Little Company of Mary affiliate partnered with a company that had developed a treatment protocol called the "HYTHIAM HANDS" program which treated addiction to alcohol and cocaine as well as other illicit drugs by infusing a drug used to reverse benzodiazepine overdose called FLUMAZENIL. The hospital charged $10 to $14 thousand dollars for this therapy, however it was merely a sham therapy. I remember meeting with the president of the hospital, and both the medical and administrative directors of the chemical dependency unit and when I raised my concerns about these useless interventions, I was essentially told to shut-up & cease criticizing the program even though they, and I knew that the HYTHIAM HANDS PROGRAM was in my opinion useless in treating addiction and a bogus therapy. This was another learning experience for me, and once again greed and profit were paramount over providing excellent healthcare. Needless to say, I was frustrated, disappointed, and very hurt. I thought, "I must really be naïve and foolish to think that I could expect change just by pointing out treatment abuse?" It was very difficult for me because many leaders of the California Society of Addiction Medicine (CSAM) were essentially supported this sham treatment and knew full well that I was right. It was an eye-opener for me and I still can't believe that my fellow medical colleagues could sell out and actually practice bad medicine.

These experiences are still difficult for me to think about, and I continue to see abuse and malignant behavior. However, I have come to realize that in order to continue practicing family medicine in a career that I love and that I believe I was always meant to do, and not become jaded or negative, I must believe that I can change the world by doing what I believe is right and so, it was ultimately from these experiences that I envisioned and created "the P.A.I.N. Institute." It is a simple and different concept and, as such, it is a new and unique approach to the treatment of pain and "addiction to doctor prescribed opioid analgesic medications" which is addressed and treated from a "HOLISTIC, COMPASSIONATE, and HUMANE" vantage point. I believe that only when we approach pain management from a more global and comprehensive perspective, and allow ourselves as physicians, the opportunity to become the pain sufferer's "personal guide and advocate" can we help the pain sufferer begin their journey into what is a very complex and difficult medical system to traverse when suffering with unrelenting and persistent chronic pain. Remembering that many pain patients have already seen a myriad of specialists and previously undergone numerous diagnostic studies and useless invasive procedures is the driving force for me to continue guiding these individuals towards the right treatment options and therapies. I recognize

that, as physicians, treating pain and addictive disorders are probably addressing the two most difficult problems that we encounter in medicine today. Despite this fact, insufficient time is given to these subjects in medical school and residency training. It is incredible that the symptom and treatment of pain, a problem that crosses every single specialty of medicine except pathology, and is the most common reason for a visit to the emergency room or doctor's office, is so poorly taught to clinicians.

Pain is a universal symptom which is present at some point in a majority of medical maladies, and pain is estimated to now affect well over 100 – 150 million individuals, or an estimated 20 to 25% of all Americans from all walks of life, education levels, and careers. Even though we categorize Pain as a symptom and not a disease, it crosses every single specialty of medicine, from Pediatrics to Geriatrics, Orthopedics to Neurology, Physical medicine to Emergency medicine, Psychiatry to Rheumatology, General Surgery to Ear, Nose, & Throat medicine, Dermatology to Podiatry, and from OBGYN to Hospice Care and, in fact, every specialty in medicine may exhibit pain except for pathology.

Even though "pain" is not a "vital sign" like a pulse, blood pressure, or temperature, PAIN is often referred to as "the 5th Vital Sign" because pain & discomfort of any sort is considered a "universal symptom" and is the primary reason why patients will seek medical care in the U.S. today. So, while pain is not a specific disease or type of illness, every disease and disorder that exists today may exhibit or present as pain or discomfort at some point in the disease pathophysiology and presentation and, often this may occur suddenly and unpredictably. In 2002, as I analyzed this dilemma at Health Care Partners, I recognized that the treatment of chronic pain is really a "primary care" issue and should never have been given to Interventional Anesthesiologists! How did this happen? Well, this occurred because primary care physicians have never really been trained in how to address chronic pain and have always viewed it as a time consuming and challenging dilemma. In addition, when one adds in the issue of potential addiction to "doctor prescribed opioid analgesic medications," naturally many primary care physicians will automatically defer to others because of their perceived issues with having to deal with potentially addicted individuals. However, the fact is that more than 50% of American families have to deal with these two issues at some point in life and, although their family physician is someone who they expect to treat their pain and addictive disorder, unfortunately a busy primary care physician does not often have the time to monitor treatment safely when opiates are indicated. The other issue and problem facing pain treatment today is that Interventional pain doctors, who are really anesthesiologists on the other hand, focus primarily on doing procedures and choose not to talk to or listen to their patients, and let's admit the obvious, anesthesiologists chose their career for this reason in the first place. After all, their primary job is to put people asleep, not talk to them.

Incredibly, our medical system has taken the two most complicated areas of medicine that require a great deal of physician and patient communication and time, and turned the care of these two issues over to the least communicative of specialties, anesthesia, whose main interest is to do the procedure and send the patient back to their primary care physician. This occurrence makes absolutely no sense to me, but the reality of the situation today is, that if we are to solve this epidemic of pain & addiction, primary care doctors will have to become more like oncologists, who deal with very difficult problems like death and dying. By training primary care physicians to treat Pain and Addiction, the medical system will literally save hundreds of billions of dollars in the treatment of these two primary care conditions, and prevent countless unnecessary procedures and surgeries, and the complications associated with those therapies. Family Medicine Residencies should take this challenge and take the responsibility as soon as possible.

In my opinion, over the last 12 years, the P.A.I.N. Institute has functioned in this capacity quite successfully and I believe that pain, misery, and accidental drug overdose deaths have been prevented and we have dramatically improved the quality of life for many of my chronic pain and

previously addicted patients. However, the conclusion that I have arrived at is that the forces of change are not about to acknowledge this unique approach. I can only treat so many individuals, so I am looking for opportunities where I can re-create this approach on a larger scale and integrate the concept into the primary care setting. With a shift in medical education, I believe that this concept can be integrated very well into most primary care offices with the right guidance and flexibility. I am hopeful that residency training programs will see the value of training residents in these two sub-specialties.

If primary care providers could first be taught to initially evaluate the pain patient in an approach which determines the underlying "Pain Generators" that are causing the patient's pain disorder(s), and then understand the need to analyze the underlying patho-physiology and disease process(es) affecting the pain patient physiologically, psychologically, and emotionally and, secondly learn how to focus therapy towards realistic treatment option(s) and solution(s), the impact on society would be tremendous. In addition, doctors who aggressively address underlying addiction and drug dependence issues such as those associated with "doctor prescribed opioid analgesic medications," as is done at the P.A.I.N. Institute are sorely needed. If this were done in a coordinated and comprehensive manner, a new & innovative pattern of care might be developed to handle the already severe epidemic of chronic pain and drug addiction to doctor prescribed opioid analgesic medications and begin to make a dent in the more than 40,000 pain patients who died in 2012 from accidental drug overdose, many of which where iatrogenic.

As we move into the beginning of the 21st century, the "Baby Boomer Generation" is entering into the geriatric stage of life and the numbers of well-trained physicians who are able to address the added burdens of the "epidemic of pain" and over-whelming issues related to drug addiction have already begun to dramatically strain and challenge our health care system. It is already taxing our limited healthcare resources and if new physicians are inadequately trained on how to approach the evaluation, assessment, and treatment of the escalating burden of pain and addiction, it will become a public health nightmare. It is just not possible to afford inpatient addiction treatment & management programs in facilities like PROMISES in MALIBU or The Betty Ford Center in Rancho Mirage, besides the relapse and failure rate of even so-called "gold standard care" that these programs offer is still a dismal record. We need new solutions and new approaches to treat the ever growing numbers of addicted individuals, especially those that we can get out of our burgeoning prisons for drug related incidents. Our schools also would be helped immensely with new ways of treating addiction in the outpatient realm. It's sad really, because we have so many new medicines to treat addiction, yet old attitudes, some perpetuated by the lay public and AA / NA erroneously interfere with newer treatment options. New physicians taught with enthusiasm in the latest medication therapies and treatment techniques can be part of the changes that are needed in the future.

In many ways, pain management and addiction treatment are really primary care issues, and those family physicians and internists who become adept at handling pain and addiction related disorders and feel comfortable with the pharmacotherapy of chronic pain, and learn how to properly deal with doctor prescribed opiate pain medication & drug dependence issues will have added credentials that few doctors currently possess.

Convincing family medicine residency programs of this major deficiency in physician training is important. Most communities, regardless of socio-economic status, are faced with problems related to chronic pain and addiction. Teaching new physicians and medical students about how best to care for patients who suffer with chronic pain and, not just opioid pain medication addiction, but all other addictions -alcohol, heroin, methamphetamine, marijuana, cocaine, stimulants, tobacco, & benzodiazepines/sedatives is a real challenge. Unfortunately, attitudes and pre-conceived notions about these disorders often interfere with the healing effect of the therapeutic doctor / patient relationship and changing these attitudes cannot be learned from a text book.

As a consultant to the medical board of California and the DEA, I have written many reports and analysis on more than 70 physicians to date regarding their approach and therapy of pain and common disorders that family physicians routinely treat. Most physicians are placed on suspended probation, asked to take courses on record keeping, and medical education based on my analysis of their professionalism but, unfortunately a few of these physicians were sent to prison, one for 25 years, another for 12 years, and most recently a physician from Orange county known as the "Starbuck's" doctor, who was sentenced earlier this week (10/17/13) to 11 years in prison despite the deputy attorney general's prior plea bargain of 8 to 10 years. It saddens me to think that many of the communities that these physicians potentially could have served will now lose a physician. As a result of my experiences in this area of administrative & legal medicine I have pondered greatly over consequences of physician behavior in the care and treatment of their patients. Why didn't these physicians get proper training in medical ethics and why didn't they value their responsibilities and positions in the communities that they served? I have concluded that, while we cannot provide the basic foundation that a sound family structure in which children are raised to be honest, truthful, caring, considerate, helpful, decent, thoughtful, kind, non-judgmental, sincere, optimistic, unselfish, loving, responsible, and "you get the picture," as medical educators we must instill basic medical ethics and encourage courageous behavior in young physicians so that they will always try to do the right thing, for the right reasons.

I know this may sound contrite but, I have to say that over the last few years I have increasingly seen some incredible medical decisions made by supposedly well-trained physicians that were totally unjustified. Spine surgeons who have operated on patients without justification resulting in patients ending up having to live with permanent bowel and bladder incontinence, epidurals being done repeatedly and unnecessarily, and spinal cord stimulators implanted without good reason obviously for monetary gain. Incredibly, and I do not exaggerate, these types of procedures are being done thousands of times weekly in the United States. It is certainly not for lack of knowledge or ignorance, because mistakes are usually not repeated, continuous abuse of the physician's professional status for personal gain is the only conclusion that I have been able to come up with in my analysis of the situation.

The fact that over 720 individuals contracted fungal meningitis last summer due to contaminated compounded steroids last summer in Massachusetts and more than 150 of these individuals died, pointed the finger at the pharmacy that produced this contaminated steroid product, but I know, based on what I see every day in the pain management community, more than half if not 75% of these individuals likely did not need or were inappropriately given epidural injections for unjustified reasons. Teaching doctors to base their decisions on proven medical evidence and guidelines needs to be instilled in training, and part of the education must expose young physicians to acknowledge the consequences of inappropriate decision making and the impact that unsound medical practice choices ultimately has on families and the communities that they live in. Another example was the "1-800-get thin" surgical program that resulted in a number of deaths and disfigurement. All medical education programs should institute medical education which emphasizes discussion of these issues and the implementation of the highest ethical standards.

The P.A.I.N. Institute was created as a "virtual clinic without walls" providing the South Bay communities access to a patient focused program able to coordinate the evaluation, diagnosis, and treatment of chronic pain and co-existing medication dependency & addiction disorders in a thoroughly "Holistic," "individual," and "Compassionate" manner. I am Board Certified by the American Boards of Addiction Medicine and the American Board of Pain medicine, and the American Board of Family Medicine, and my training in pain medicine occurred when, in 1987, I was appointed temporary medical director of the San Pedro & Peninsula Hospital Inpatient Chronic Pain Program when the then medical director, rheumatologist Kenneth Nies, M.D. resigned, and I was asked to step in temporarily while the search for a director began. However my on the job

experience continued and became permanent when I stayed on as medical director for a total of 5 years through 1992, including a 1 year transition period when it was moved to Bay Harbor Hospital in 1991-1992.. In addition, I was one of the admitting physicians at San Pedro Peninsula Hospital Inpatient chemical dependency unit for 2 years but when the hospital entered into a unethical arrangement with a exploitative, useless, and expensive treatment approach, "HYTHIAM HANDS PROTOCOL," I discontinued admitting patients to that program in disgust. Currently, my experience with my current office program, initially with Little Company of Mary Hospital for 2 years from 2002-2004, followed by transitioning to the private entity that it is today, the P.A.I.N. INSTITUTE (Pain & Addiction Integrated Network, Inc.) in which I have been treating patients as outpatients for the most part I believe very successfully, but I continue to do inpatient consultations as well since 2004.

After the first 2 years as medical director of the hospital pain program at Little Company of Mary Hospital Pain Institute, I saw that the political will and support was not going to happen. Little Company was going to let the pain program continue, but I would be financially responsible for its' day to day operations, and for all aspects of program support. I concluded that the program would function better as a private entity so that I could also work with Torrance Memorial Medical Center personnel, since many of the patient referrals were also coming from Torrance Memorial physicians and the hospital emergency room. So, as a result, I decided to broaden the community of patients and physician service area and I became an independent entity so that I could include Torrance Memorial Medical Center.

We are already seeing increases in disorders like arthritis, diverticulitis, accidental trauma due to falls of the "infirm and aged," spinal degenerative disorders, and osteoporosis induced fractures, as well as many more conditions associated with an aging population. Add to this the expected 40 to 50 million uninsured Americans who will enter our current stretched healthcare system, many for the first time in their lives, and the estimated 20 million undocumented individuals who reside in our country today, it will literally inundate and test our already fragile health care system. In addition, when we add the 20 to 30 million Americans who suffer with addictive illnesses, many of whom are dependent on "doctor prescribed opioid analgesic medications because of chronic pain disorders," our dire situation becomes overwhelmingly more urgent and critical. Today, physicians who are even minimally trained in both pain and addiction medicine are already in acute short supply and the burden of balancing appropriate pain therapy with recognizing the issues of "doctor prescribed opioid medication addiction & dependency as a result of chronic pain treatment" are straining our health care system at a critical time as we usher in healthcare reform.

Managing chronic pain appropriately is very time consuming and stressful for most physicians, and fewer and fewer doctors are choosing to treat chronic pain and addiction disorders because of the demanding level of clinical care necessary to safely treat patients who suffer with chronic pain. As a result, we are seeing this epidemic of pain and opioid dependence & addiction being treated in a costly and irrational manner. Unfortunately, much of the public, and many physicians for that matter, are unaware that 80% of "pain specialty physicians" who are labeled "pain doctors" are really trained in "Anesthesia based Interventional Pain Medicine." Pain physicians whose original specialties were in anesthesia based pain medicine do not usually see pain and addictive medical problems as chronic and primary care focused areas of medicine, and, unfortunately opioid and other controlled medication addiction and medical issues are not necessarily something that anesthesiologists feel comfortable dealing with over the long term, and yet, the majority of pain patients, perhaps 80 to 90% of chronic pain sufferers, require conservative medication management, and not invasive and expensive procedures such as spinal injections like epidurals & facet blocks, ganglion sympathetic blocks, morphine pumps, or spinal cord stimulator implants. Any one of us could be stricken with chronic pain tomorrow without warning. Do we really want access to pain medications to be difficult for ourselves and our families?

In the U.S. today, the majority of board certified anesthesia trained pain specialists (about 7000-8000) are "interventionalists" who have little training in long-term and primary care pain and addiction medicine. There are only about 3000 specialists, board certified by the American Board of Pain Medicine, like myself, who are trained in non-interventional medical management of pain disorders. Unfortunately, since the majority of patients do not need or require Interventional Pain treatment using interventional therapies, we may actually have an over-abundance of physicians in this category of pain medicine who are experts in using these invasive procedures, sometime without justification or in excess. Of course, when appropriate, these interventions can be "godsends," however, and unfortunately, most interventional procedures are "rarely" needed in the treatment of chronic pain. Since pain is not a "curable" disorder and usually it is a more sinister chronic disorder, more like a chronic disease entity such as Diabetes, Hypertension, Hyperlipidemia, Cancer, Diverticulosis, Rheumatoid Arthritis, Renal insufficiency, to name a few disorders, and most pain patients rely on medication management or alternative methods such as acupuncture, physical therapy, stress reduction, nutritional treatment, chiropractic, and massage. With only 3000 Board Certified Non-Interventional Pain physicians, it is clear that more primary care family physicians, and internists will have to step up to the plate and be trained, along with hopefully some of the "interventionalists," in order to provide Americans with quality pain medical management.

With 30 years of clinical expertise I have always tried to first ensure that the most accurate working diagnosis is considered and that a differential diagnosis is determined and understood so that the pain condition can be appropriately worked up in order to understand and address the underlying pain disorder and focus treatment aggressively against the identified "Pain Generators." Secondly, as an expert in the field of addiction medicine I always assess the patient's existing dependence on "doctor prescribed opioid analgesic medications," and maximize the individual patient's therapeutic options so that the pain sufferer, who has been stricken with the misfortune of unrelenting, constant, & severe pain may improve physically, psychologically, emotionally, and spiritually by compassionately treating their addictive disorder. There is no place in the world today addressing these issues as an outpatient approach whereby the pain patient is not labeled "an addict." Yes, there are too many accidental overdose deaths so what is the answer? Instead of restricting access to treatment because of fear of developing an addiction problem or because of irrational political pressure, we must train new doctors on how to best utilize pain medications and monitor patients using "Universal Precautions." Family Medicine Residencies must initiate this training process if we are to effectively change the current situation facing our medical system.

The key to combating chronic pain is to approach it from a multidisciplinary and scientific perspective whereby we can analyze and guide the patient through the necessary tests and specialty consultations required to make an accurate diagnosis and identification of the pain generators of concern. Once therapy has been decided upon, the perspective should change to a more "Holistic" long term team approach whereby the pain physician becomes the patient's advocate and insists on quality and conscientious medical care thereby helping the chronic pain patient cope with the overwhelming pain and discomfort of the chronic disorder with the ultimate goal of "creating the best quality of life, with as little pain and suffering as possible."

My primary concern when beginning a patient 's pain management evaluation is to focus on maintaining their "Quality of Life and work to enhance their ability to live free of pain along with promoting effective therapies with minimal side effects and complications as the primary goals of therapy. Most patients, and many physicians, do not realize that in more than 50% of cases of patients already on opioid therapy for chronic pain, the individual actually may be on the wrong treatment and no longer require the use of opiates to control their pain. Having said that, the other 50% of patients do require opiates to be part of the solution and therefore, the pain sufferer cannot be expected to regain a life free of pain without opioid therapy and unless the proper management is not instituted and monitored carefully the patient there is no hope for restoration of the pain patient's quality of life. Having the skill and wisdom to treat patients with opiate therapy when

indicated, as well as the ability to safely detox and withdraw pain medicines and other controlled drugs are two very important management approaches to the treatment of pain that have not been taught to the new generations of physicians very well, and this must be reversed if we are to develop well rounded and trained family physicians.

Essentially, the concept for The P.A.I.N. Institute was to create a model approach to addressing the current problems related to the inadequate assessment, evaluation, management, and treatment of chronic pain disorders in family medicine and primary care offices in the U.S. today. It was designed to be established with minimal disruption to a primary care facility. Any family practice, especially a group of family physicians, can designate one of the partner physicians who has an interest in treating and managing chronic pain, or the group may desire to add another physician who has an inclination or desire to provide new specialty services on behalf of the family practice.

Essentially, I envisioned The P.A.I.N. INSTITUTE as the HUB of a "Virtual wheel" in which the spokes represent ALL specialties involved in treating chronic pain radiating outward into a network of some of the South Bay's and Los Angeles's finest and renowned medical specialists in all fields of medicine, including Little Company of Mary's Director of Interventional Radiology, John Jordan, M.D., and Torrance Memorial Medical Center's Director of Interventional Radiology, George So, M.D., along with the Orthopedic and Spine Surgeons of both of these renowned institutions. As the "hub" of the "Virtual Wheel," my role and responsibility is to evaluate and treat all pain patient's referred to the P.A.I.N. Institute for chronic pain and opioid and other drug addiction issues, much like a primary care specialist might do, but with the added experience of my now 30 years of clinical practice, and 3 Board Certifications in Pain, Addiction Medicine, and Family Medicine. In California, Pain and Addiction specialty boards are considered ABMS equivalent by the Medical Board of California and it is this unique approach to the treatment of pain that guides and reassures patients and those who may have become addicted to "doctor prescribed opiate analgesic medications" to have confidence in the medical care that they receive as they travel along their difficult journey towards the road to recovery and disease management.

-script to my story. Due to the changes brought on by the Affordable Care Act, it is not likely that pain medicine as a medical specialty can survive as a highly specialized endeavor. So it is ironic that I have come full circle on this issue and now am creating a primary care office in family medicine with the focus on what I call the "DEVIL's TRIANGLE" of 3 disorders that touch virtually 95% of all medical conditions in terms of etiology for the majority of clinical disorders in the U.S. today and they are OBESITY, CHRONIC PAIN, and ADDICTIVE DISORDERS (alcohol, tobacco, opiates, stimulants, food, marijuana, sex, cocaine, and many others), and I am now implementing programs to address these 3 primary and interrelated disorders. Just aggressively addressing OBESITY can alter many disorders like hypertension, joint and spine pain, lipids, etc. Addressing PAIN increases mobility, improves quality of life, diminishes depression, etc. And addressing addictive disorders affects CAD, COPD, CANCER, HTN, etc. Focusing on these three areas can dramatically change the patient's health status and each.improved area will have demonstrate measurable outcomes. This concept is very important one because soon physicians and hospital reimbursement rates will be based on improvement and positive outcomes in patient healthcare.

Primary care physicians are the best equipped to handle these areas of medicine, and the primary care office experience will have to become creative if it is going to become the driving force for change in healthcare.

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