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Honorable Senator Gustavo Rivera

Dear Honorable Senator Gustavo Rivera:

My deepest apologies, I was hoping to testify before your excellent hearing in reference to some issues as a neurologist who has practiced in the Bronx uninterrupted from 1977 who has treated many patients with chronic pain syndrome since I am a neurologist. I have numerous patients who have chronic pain syndrome who deservedly deserved pain treatment. I want to give a historical background and explain a word in medicine that mostly you may know, but I want to explain the word "iatrogenic". Iatrogenic means caused by the physician basically and we are causing iatrogenic epidemic, not through our fault. We were implored through evidence-based medicine to give without considering experience-based medicine. Let me explain this to another degree to you. There were countless papers produced in the 1980s that showed that OxyContin was safe under evidence-based medicine. I questioned that possibility because I knew the physiology of addiction. It is a disease in which the neurons gets super sensitized to the narcotic and they produce more receptors on it, and therefore, they require more medication in order to keep quiet and that is how addiction is created. Now, some people get addicted because they experimented with it or are committing a crime. However, what we created were people who had severe pain either due to herniated discs in the neck or lower back. We were required to take care of the fifth vital sign. A vital sign before was defined as blood pressure, pulse, temperature, respiration, and then through these evidence-based medicine studies, they said there is a fifth one and that is pain and the doctor has obligation to take care of pain. In fact, the OPMC, the office of professional misconduct, had accused doctors of not taking care of pain. Pain was defined as trying narcotics to take care of the severe pain the patient has, and so, numerous patients of mine from 1986 on were placed on Vicodin. The reason I did not place them on Percocet was Percocet did not have refills, and therefore, I did not place them on Percocet, I put on Vicodin and so, numerous patients of mine got addicted to Vicodin. When Vicodin was just as addicted as Percocet when Vicodin was required by state law to not have refills, I switched to Percocet since it was a slightly better medication to be used, and so, most of my patients ended up on Percocet. Senator Savino is quite concerned about the patients of this sort. So, what can we do for the patients who are addicted who really have pain. They are not just addicted, and therefore, you can take away the addiction by some other modality, but they really have a pain syndrome. They have large herniated discs in the cervical and lumbar spine. So, I feel that there has to be a grandfather clause for these patients that I have, that there should not be the same obligation of verifying the patients need for medication to a degree of the patients first, to the medication. I will state that I have not started the patient on any narcotics since it has become well known that the evidence-based medicine that was produced was faulty at best; however, I do have a number of patients who are presently on medication. Now, one of the two problems that I see here is if you can trust the patient who is in chronic pain, they should be able to get a three-month supply of the medication. Right now, they have to come back every single month in order to get their medication, which puts a great strain on our system. Patients do not have to be seen every month. Their problem is a chronic problem and they do not have to be seen every month. I would hope that if a doctor documents that it is safe to give a patient a three-month supply, they should be given a three-month supply. The insurance companies should approve when physician documents chronic long term pain. Also, the doctor is responsible for the I-STOP.

I would like the pharmacist also to check I-STOP. Another factor is that because of the privacy laws, they were first created with methadone, the I-STOP does not show the patients on methadone. So, the doctor only finds out the patient is on methadone after the fact when he does a urine approximately one month later. Patients do not always aver to methadone and it would be nice to be able to coordinate that factor. Another issue that has come up now is that one of the hallmarks of medications that we use instead of narcotics is gabapentin and now there has been a groundswell from the evidence-based medicine group that the gabapentin can cause addiction. I have been practicing with gabapentin since 1994. I find it is an excellent synergistic with narcotics and prevents people from getting addicted. I have never had a patient get addicted to have to require more than 3200 of gabapentin. It is a relatively safe medication and I do not want that stigmatized in any way. Third of all, a number of pharmacy benefit management companies are misinterpreting the law, especially when it comes to a patient on chronic medication. There are pharmacies that have refused to give patients who they have given for years of medication and because they say they do not have it in stock. I think that is not so and I think that there should be some sort of way to supervise these pharmacies that if they do make that statement that they have to be penalized in some way because one of my patients for example went to Walgreens, which is a national company, and they told her they are out of stock on Percocet, even though she has been filling her prescription with Percocet for years at that pharmacy. If we are going to give patients medical marijuana, then we should somehow figure out a way to inform insurance companies that they have to be responsible to pay for the medical marijuana. What good is it to give a person in South Bronx, a prescription for marijuana when they have to pay $180 or so to pay for the marijuana. They are not able to afford it, and so obviously, once they realize they cannot afford it, they are going to the street for it, and therefore, there should be some way to let the insurance industry know that we at the State of New York have approved medical marijuana and therefore you are obligated to pay for the product.

Thank you for considering my written testimony and my apologies again for not presenting it beforehand, but I would like that you please incorporate that and particularly Senator Savino should be seeing this because I saw her concerns. I understand her concerns and not that in any way, I have any problems with patients, people who have been addicted not because of pain, but because of social pressures or other sorts, but we have to have a special niche for those patients who really have pain. If you are going to withdraw your patient slowly on whatever method you have for addiction and not secondary to pain that is one layer, but if you are going to withdraw your patient because they have severe pain and the medication helps their pain and they are addicted that is the second layer and it makes it much more difficult obviously in the treatment of the patient.

Thank you.

Respectfully submitted,

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