**Chris Johnson**

**Narrator**

**Amy Sullivan**

**Interviewer**

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**At the Home of Amy Sullivan**

**Minneapolis, Minnesota**

Chris Johnson -**CJ**

Amy Sullivan -**AS**

**CJ:** I'm not an addiction specialist but you can't be involved in this problem as much as I have without learning something about it. The typical model of putting someone in someplace for however long and you take away their job.

**AS:** Thirty days, sixty days.

**CJ:** Yes, they feel better. Then, "Well that works then. Look they're feeling better." It's sort of like, I liken it to someone who treats compulsive hoarding by just cleaning out their house and saying, "Oh look isn't it nice to have a pretty house now." Without dealing with the underlying compulsion. Why with that pretty house did this person feel like keeping every newspaper? Why did they attach emotional significance to having every *﻿City Pages* ﻿even with coffee and other stains on it?

**AS:** We're just going to clean you up and get the drugs out of your system.

**CJ:** Without dealing with the underlying, what sort of mental anguish were they escaping from. That also explains why certain people are unique. You look at their history and say, "That was going to happen." Severe physical or sexual abuse. A person with that little self-worth, every minute is an anguish. That person is looking to escape that constantly. Some people do get better with intensive therapy. They get into a new situation where they can find an answer and they don't feel that. Sometimes you can't. Sometimes that person tragically—let's say they were eight years old when all this happened or just high school, these experiences where you're trying to develop a sense of worth and trust in the world and you permanently destroyed it. A person like that, a high percentage much higher than the average population, that person is a higher risk for developing chemical dependency. The stress, the anguish they're escaping is just them every day.

I think the traditional treatment community doesn't get it. I think they do what's typical, what they can build for. When it doesn't work they come back and build some more. It's in their interest to have people relapse because that just fills their beds again. I'd like to say that medicine would have higher ideals but my experience has been not really.

**AS:** That medicine would?

**CJ:** That medicine looks out for what's their long term health.

**AS:** You would hope that that would be the case.

**CJ:** My experience has been I've found that that has been compromised. Have you seen my talks?

**AS:** I saw you at the Saving Lives.

**CJ:** When was that?

**AS:** In September. That's when I met you and a lot of people came up to you at the Convention Center in September, Downtown Minneapolis. It was put on by Hazelden and the DEA.

**CJ:** I just did a panel, was I just sitting up there with a bunch of people or did I have a whole hour?

**AS:** I honestly don't remember but I remember being impressed with what you said. Why don't you just say some of those things but if you've already got the text or video of things that you would want to share with me you don't have to repeat them right now.

**CJ:** They recorded it. If they send me a recording I can forward a link to you. I sent you my articles right?

**AS:** No.

**CJ:** Really?

**AS:** No.

**CJ:** You saw my CNN article right?

**AS:** No.

**CJ:** I'm sorry.

**AS:** It's fine Chris. We're just meeting each other. It doesn't matter right now.

**CJ:** People request me to talk, I'm like here's some of my stuff.

**AS:** We didn't. This was just going to be an interview. I'm going to pause this for a second. People say their best things in the first couple of minutes.

[pause recording]

**CJ:** If you're not familiar with some of my opinions on this my guess is you just saw me as a panelist.

**AS:** I saw you apologize on behalf of all doctors. You talked about quite a lot.

**CJ:** Did you see slides?

**AS:** I don't think so.

**CJ:** I don't think you did. I think you got me as a panelist. If there's no slides and it was the convention center, are you sure it was the convention center?

**AS:** Yeah.

**CJ:** Then I did not speak with my slides. It was put on by the law enforcement. I was one of a group of seven.

**AS:** Law enforcement and Hazelden.

**CJ:** There were seven people up there.

**AS:** You were one of them.

**CJ:** I got a ten-minute spiel.

**AS:** I can tell you why I'm interested in this and how this all came about. Oral history is my area. I looked at the 1970s, a tragedy at a Girl Scout camp in the 1970s where three girls were murdered and had been sexually assaulted, three little girls. I went back and interviewed survivors because I was at that camp that night as a survivor myself and grew up with no knowledge with what PTSD was or anything like that. When I did finally learn that and work through all those things as a women's history student I had an epiphany one night that this was what I needed to write my master's and my dissertation about. I went and I found women who were now, some of them, were willing to talk. I learned a lot about trauma and how things change.

Of course historians look at how things change over time. I saw a parallel to what's happening with heroin and opioids with a shift in thinking about it and a little bit of a decrease in stigma in some respects and a demographic shift from who were the main users and how are they being treated differently from previous users. I wanted to just document people who are active in this world right now for an oral history collection of interviews. Then I was approached by an editor at the University of Minnesota Press who asked if I was interested in talking to him because he saw I was doing this project. We started talking and he said, "Well why don't you think about it as a book and let's talk about it." That's kind of how this has come about with chapters that look at different sectors of what's happened since 1980. I'm not sure exactly what year I'm going to start with but up to the present. I'm interviewing doctors as well as treatment specialists. I'm very interested in looking at what places like Hazelden are doing with this. I have a historian's eye on it and understand the history of why the Minnesota Model came to be. I understand that but I think with the opioid epidemic and meth I'm not sure it's helping everybody in the way that it could be.

**CJ:** You understand that the Cochran Club Organization looked at twelve-step recovery and found no evidence that it did anything. They did that in 2006. No evidence. Honestly it shouldn't surprise you. It's a religious based program.

**AS:** I'm very interested in your childhood, where you grew up.

**CJ:** I'll go off on that. Tell me how you want me to start.

**AS:** I want you to start by saying your name and that you give me permission to record this interview.

**CJ:** My name is Chris Johnson, I'm an emerging medicine physician working at urgent care with Allina Health. I give you permission to record this interview.

**AS:** Thank you. Now we can kind of start. What was your childhood like, where did you grow up? I'm also as a writer, not just as a historian, I'm more of a narrative driven person. I would really love to hear some basics about your childhood and how you got into medicine.

**CJ:** My childhood, there was some significant family dysfunction in my childhood. My parents were and are, one of them is not alive anymore, they're both very bright. Both my parents went to Harvard. My mother was an economist, majored in Econ at Harvard and my father was English. That's where they met.

**AS:** He was an English major?

**CJ:** He was an English major. He did not have a very functional career. He was a bit disorganized, very disorganized. He couldn't decide what he wanted to do after Harvard. He apparently got into Columbia Law but stopped Columbia Law after two years then got into the PhD program at Tufts University for English, never finished that either. Things started off looking well then lost interest. Ultimately ended up being an opera singer. He was a good singer, he was in the Harvard Glee Club, that was always one of his passions to sing.

My mother, she didn't have the traditional female skill set. It was maybe reversed. She was math, she was about the mathematics. She will say she is a failed mathematician in the sense that she couldn't do math like the real Harvard math people. She could do pretty well. She went to the PhD program at MIT for Econ, the best Econ program in the country. After that got a job teaching at Stanford, Economics. I don't remember things much before California. My early memories of life are Palo Alto. My mother was there as a Stanford Econ professor. My father was singing in the San Francisco Opera.

**AS:** How old were you by that point?

**CJ:** Do you even remember things at age four?

**AS:** Four is when you moved?

**CJ:** I think I moved when I was like three. I don't remember. My earliest school memories are in Palo Alto, California. I remember saying goodbye to my dad every day, he had rehearsal which I guess was in the evenings or something like that. I'd see him the next day. I realized later the marriage was kind of breaking up at that point. Part of the going away in the evening wasn't just for rehearsal. In any case, that family life that at least my brother and I. I have one younger brother, he's one year younger than me. The last time we were together as a family would have been 1979 in California in Palo Alto.

My mother did not get granted tenure at Stanford which is not all that unusual as an Associate. You go there to begin and then you go off and hopefully you become famous and publish. Then if you can come back when you're famous. She did not get tenure and she was snatched up by the Federal Reserve in Washington D.C. to be an economist there. That's when my family moved to Washington D.C. My mother, my brother, and I moved to northern Virginia right outside of Washington D.C. A town called Falls Church, Virginia. At that point it was single mom. My mother worked as an economist for the Fed. We lived in a small single family home. My brother and I went to regular old public school in Fairfax County Public Schools. Eventually it became clear, the story initially was my father was going to rejoin the family, he was going to get more and more important opera parts and then maybe try out for The Met in New York. There's lots of banks in New York. She could be an economist at a bank in New York. That was the vision. It turned out later it wasn't going to happen. I won't go into that, that's not for the book. In any case, I grew up with my younger brother in Falls Church.

**AS:** How old were you when you moved?

**CJ:** Nine and he was eight.

**AS:** You were born in 1970?

**CJ:** I was born in '70. From that point on it was just going to finish elementary then junior then high school. Then I went to college at the University of Virginia in Charlottesville. Neither my brother nor myself were as smart as they were. I applied to Yale, I went to public school. It worked out. Now I'm actually very proud that I haven't gone to a single private school in my education ever. Public school the whole way. People will say, "Oh yeah. UVA, so tough. The mean streets of Charlottesville, Virginia with Monticello and Jefferson. It's a tough environment. Dodging bullets on your way to art history class." At UVA I was actually a government major. It wasn't medicine. I sort of had this kind of a social justice part of me that was always kind of there. I thought maybe policy or law was a way to manage big problems. I'll admit I wasn't a great student. I wasn't the best student. I did things that didn't make a lot of sense. I was government/foreign affairs; it was more foreign affairs. Wouldn't it be great if people could just get along on a national level? I concentrated on the Soviet Union. I was so stupid; I didn't take Russian. What do you plan on doing with your great theories about improving relations if the nation you're studying and their government structure, which was the Soviet Union with a central committee, but I didn't speak any Russian. While I was there then the whole thing fell apart. That's when the revolution happened again and the Communist Party went away. Now technically it's back in a different form. The same sort of centrist is back. I won't say that I had a great deal of direction in how I proceeded with my academic career at UVA.

When I graduated I considered with a degree in government you choose academics or you choose law. I paralegalled for a little while. I mean like a year. In the Washington D.C. area. That was a pretty serious recession at that time. That was when Clinton got elected. Jobs were tough to come by. It was not a very happy time of my life. You graduate college in 1992, I think I just got out of a break up. It was bad. On top of all that there's no jobs. Especially for young, undergraduate degree in D.C. Paralegal work was all I could get not even full-time paralegal work but temp paralegal work. It was enough for me to learn about the law. I realized very quickly even though I was not doing law type work, I learned about the process of law. Some jobs I got to interact with lawyers quite a bit and learned about what was it that made them interested. You realize that it's just the process of filing this and being sort of a champion, usually it's one company suing another company. Your contract said this, you owe us this. It's the company defending themselves against the Department of Justice. You violated this anti-trust whatever. If you didn't really enjoy the process of it and that sort of confrontational, it wasn't for you. It wasn't for me.

The whole idea of fixing big problems on a national scale, a bit naive. I thought well maybe if I can't do national level problem solving maybe I can do it on individual levels. I did like science. If I was a physician, I could fix problems on a patient by patient level. I'd only taken some introductory science at UVA, I didn't do well. I was a goof off. I was one of my high school valedictorians, I was at the very top with the 4.0 plus something. I used that as a reason to goof off for first semester in college. I had the 2.2 GPA to prove it. It was that time I took Chemistry and it was impenetrable to me. When you only study one day a week lots of things were going to be impenetrable. The poly exclusion principle of up and down arrows for the electron orbitals. I thought, "Who can understand these orbitals and quantum theory and stuff." Then you realize later on when you took it again, one goes up one goes down. You just count. You don't have to figure it out. They figured it out you just have to do your little exercise. In any case, the idea came to me that maybe that science wouldn't be as bad if I actually studied.

I went back to school. I did part time work. I actually worked retail, I worked at Circuit City. Circuit City existed at that time. I worked at Circuit City as a sales associate. I took the science classes part time at a nearby university that was just a commuter. George Mason is not well known outside the D.C. area; George Mason University is in northern Virginia. It has a fairly large student body because a great many of George Mason students are commuters. They're getting more education while they live and work. I took the Chemistry, the Organic Chemistry, the Physics, some math, Biology. I did all that there. I did very well because when you sort of get this idea when you studied, "Oh, it isn't that hard." When you've got purpose.

**AS:** You're doing it for something.

**CJ:** You're doing it for something. I treated it like a job. I had a leg up over the eighteen or nineteen year olds who were kind of goofing off like I was years earlier.

**AS:** By this point you're twenty-four?

**CJ:** I'm twenty-two, twenty-three. It took a couple years to get it done. You can't take Organic Chemistry until you take Biology and regular Chemistry. That set you back. It took like two and a half years to get that done. I studied for the medical college admission test. I aced that. I found out I had aptitude for science so I did it. I applied to medical school and got in.

**AS:** Where did you go?

**CJ:** I went to the Medical College of Virginia which is in Richmond, Virginia which is the home of Phillip Morris Tobacco and former capitol of the Confederacy. They really never got over that. They still haven't gotten over that. It's not Martin Luther King Jr. Day there it is Lee Jackson King Day. As in Robert E. Lee, Stonewall Jackson, and the civil rights guy. Civil War, Civil War, Civil Rights. It's actually not called the Medical College of Virginia anymore; it's called the Virginia Commonwealth School of Medicine. There was always a relationship between those two but they just made it more explicit. What I'm saying is if you go looking for the Medical College of Virginia you're going to get redirected to VCU. I went to MCV from 1996 to 2000.

After 2000, in that last year, I decided I wanted to do emergency medicine. Hennepin County Medical Center was at the top of my list of places to go. Hennepin County Medical Center was one of the top five, certainly top ten training programs for emergency medicine in the country. I was a good medical student. I wasn't top ten percent but I was top quarter. On the board exams I was top ten percent in the board exams. I knew my stuff. I was lucky enough to match at Hennepin. That's what brought me to Minneapolis and I haven't left. I did my emergency medicine residency in Hennepin County, graduated 2003. Then practiced full time emergency medicine at St. Louis Park Methodist Hospital. That's sort of the arc of how I got here.

**AS:** How did you get into this work around addiction or opioids?

**CJ:** How did I get into work with opioids?

**AS:** How did you get into that?

**CJ**: It began at Hennepin County in the sense that we saw a lot of chemical dependency there.

**AS:** In the ER?

**CJ:** In the ER. They had sort of a program where you keep a look out for known people that are suspicious for this or that behavior. But you kind of blow it off a bit in the sense that it’s a county hospital with a county population. You’ve got lots of minorities. Not just minorities but people from terrible family backgrounds, absent fathers, prison fathers, single moms, mothers are gone, grandmothers are raising the kids. Lots of pathologic family structures that lead to dysfunctional behavior.

I saw a lot of abuse of drugs like heroin. Also drugs like oxycodone, OxyContin, Vicodin, all that stuff. Coming and looking for pain pills. I was like, this is so absurd, “When I get out of here then I’ll get back to doing what I’m supposed to be doing.” Then I went to Methodist Hospital in St. Louis Park. They’re the patients from St. Louis Park, from Minnetonka, and Edina. You realize, “Oh. Suburban people are looking for oxycodone, OxyContin, Vicodin, Dilauded. It isn’t just the inner city. It is the suburbs, it’s everywhere.”

**AS:** Was it pretty soon before you realized that?

**CJ:** It was within the first year. You couldn’t go a shift without seeing it. Someone who had a “chronic pain exacerbation.” They’d have a diagnosis of chronic pain. You’d look at their chart they’re on oxycodone plus OxyContin plus oxycodone for breakthrough. They would come and say they were helping a friend move and helping a friend move is apparently the most dangerous thing you can do because apparently the friend will drop the other end of the couch, you’ll pull your back out and now you’ve got a pain exacerbation.

**AS:** They might have on their record chronic pain as a diagnosis?

**CJ:** Yes.

**AS:** Then they come in for pain exacerbation.

**CJ:** Right.

**AS:** Which means they’re just looking for more meds.

**CJ:** Something flared up their...something stronger, something to temporarily boost them up now. Something flared it. Chronic pain exacerbation became the bane of my existence. It was the bane of everyone’s existence. It got to the point where you couldn’t go a shift without it. Usually you’d see more than one. It was almost comical how often it was helping a friend move. You can see where if you’re trying to generate sympathy. They’re just being a good friend. “I was trying to help my friend. I didn’t want this. I would otherwise be stable and fine. I was just trying to be a good friend.” Granted you can’t disprove whether than actually happened or not. It was a story that could generate sympathy.

**AS:** The fact that it got passed around and repeated.

**CJ:** It was repeated so frequently by that population. It was suspicious. It was certainly suspicious. What happened is maybe a year, two years of this, you’d see the same patients back again with another exacerbation for something. This time maybe they were in a car accident, someone rear ended them, it wasn’t their fault then either. “I didn’t ask them to rear end me.” They don’t have an accident report. “No we didn’t call the cops.” Whatever incident was immune to disconfirmation. They were there for flare up. At that time the flare ups are treated, we were being told that pain is a disease, pain is the fifth vital sign, opiates aren’t really that addictive. They were getting multiple doses of Dilaudid in the emergency department. They would be there for about three or four hours. After about three doses you’d ask them, “Hey can you go home now?” Maybe you got an x-ray if they looked like something really serious might have happened. Usually you didn’t have to. They get two or three doses of Dilaudid. Either they’d say they could go home or they’d get admitted. They’d go home with another prescription or they get admitted, they’d stay for three days and then they’d go home with another prescription. Then they’d be back.

You would see that this was, the patients weren’t getting better. They keep cycling through. It was frustrating for us as doctors because they’re often very demanding patients. They require a lot of nursing staff to keep going in there. You’ve got other people to see. You’ve got the heart failure patients, you’ve got the COPD patients, you’ve got the septic patients, you’ve got febrile seizures. You’ve got other things to do. The patients weren’t getting off their meds, they were staying on them and they were coming in with more flare ups. What clinical progress are we seeing with them? It was frustrating for the doctors. This is not interesting medicine. It’s making my job harder to deal with this other stuff. Invariably they can be very demanding patients that are difficult to get along with but you must be nice to them so they give you a good performance review. They became very stressful; you want to get customer satisfaction surveys to go very well. The hospital wants to make sure you make everyone happy and they pay their bill on time and pay their bill in full. It wasn’t good for the hospital in the sense that when these people get admitted they wouldn’t be compensated for the second or third day. They might be compensated for one day. The hospital’s losing money with these prolonged admissions of people who won’t leave but they won’t take the step of just kicking them out the door. No one’s benefiting. The patients aren’t getting better, the doctors are frustrated, the hospital is losing money.

I decided, I think it was 2005, I’m going to do something about it. At that point I decided to contact the pain clinics in the area. I spoke to the Britton Center, I went to MAPS in Edina, I went to United Hospital and spoke to Dr. Hesse. I spoke to Dr. Belgrade. I spoke Dr. Matthew Monsein. I independently set up interviews with all these medical directors on my own and started talking to them.

**AS:** On your own time?

**CJ:** Just on my own time and did it. I found out later it was weird. Most people don’t do that. What’s this thirty-five-year-old doctor doing investigating pain clinics and figuring out what the hell are we doing wrong? This doesn’t make any sense.

**AS:** But they talked to you.

**CJ:** They talked to me. They were happy to talk to me. No other ER doctor, no one else asked them. I told them what we’re seeing here. They said, “You need to have some sort of a policy, some sort of universal way of approaching these patients.” That’s when I went to Methodist Hospital which was Park Nicollet, now it’s Health Partners. It was Park Nicollet at that time. I contacted risk management and said, “Hey look. Everyone’s seeing this problem. The hospitals are furious. It’s in everyone’s interest to get a committee together.” We put together this chronic pain committee at Park Nicollet. Then I spent the next four years from 2005 to 2009 meeting every few months. I was a pain in the ass to them. There’s no money to be made.

**AS:** You’re just asking them to come before work or after work.

**CJ:** Or in the middle of work to meet and talk about this and what should we do and put together this. It’s not making them money. It’s not going to make Park Nicollet money.

**AS:** Who were the people who were on this committee?

**CJ:** Risk management was there; the director of the hospital service was often there.

**AS:** You pulled those people together from the hospital.

**CJ:** From the hospital, the clinic system.

**AS:** You were trying to work within the hospital setting that you were in to make a change.

**CJ:** To make a change, to have a universal policy that we could all abide by. The pain doctors said, “This is entirely appropriate.” I brought that to them. It took four years. A few months go by and nobody does anything and then you see another chronic pain patient. Then I fire off another angry email, “Oh hey. Just checking on how we’re doing. Just saw a patient. Could have used this policy.” After four years we eventually did come up with this policy about opiates and how we use them for chronic pain and how we would not do IV opiates for chronic pain exacerbations unless we found an objective new injury.

**AS:** That’s the Dilaudid that you’re speaking about?

**CJ:** The IV Dilaudid I was talking about.

**AS:** You stay there.

**CJ:** If you have chronic back pain you came with a back pain flare. Usually we just did IV Dilaudid but we’re not doing that anymore unless there’s a new kidney stone, okay. You’re back flared up again, no. You’re going to get two tablets of whatever it is you normally take. Two Vicodin or two Percocet. That’s it. You’re not going to be admitted for pain medicine. If you feel you couldn’t go home safely, like “Oh I can’t walk.” You’ll be admitted. You’re still only going to get two more tablets, whatever your scheduled dose is. You’re not going to get hooked up to the IV, here you go. If you want to stay because you feel unsafe we’ll keep you because you’re unsafe. You’d be amazed at how few people wanted to stay in the hospital when that was the policy. They left. They got up in a huff and stormed out of the ER with amazing speed for someone with that critical amount of back pain they were in. That dramatically changed how the hospital functioned, having that policy. It didn’t change how difficult it was in the ER because the patients would still come in looking for this. It helped the hospitals because they wouldn’t be admitted.

**AS:** You were still on the front lines dealing with people and having them be mad.

**CJ:** The hospital would never put out signs in the waiting room saying, “This is how we treat chronic pain.” They never did that. They want you to register. Once they register you they generate a bill. Once they generate a bill they get money. They didn’t want to turn away any customers. They didn’t want anything that would dissuade them from registering. That’s not their reasoning. “We don’t want to miss anything.”

**AS:** Something else could be wrong.

**CJ:** What happened is admissions for chronic pain went down to almost zero. These patients weren’t interested in coming in for what they could do at home.

**AS:** Can you describe who these patients are? What’s their kind of demographic?

**CJ:** They’re middle aged, they’re in their forties. Thirties to fifties. Twenties is more like, it’s hard to have a chronic pain diagnosis at twenty. Late thirties to early fifties would be it.

**AS:** Men, women?

**CJ:** More women than men even.

**AS:** Middle class?

**CJ:** Middle class people.

**AS:** Mostly white in St. Louis Park?

**CJ:** Yes. You’d still get minorities. It was never Hispanic. Hispanics hardly every have chronic pain. You have African Americans, but I don’t any more than just their normal percentage of the population.

**AS:** I’ve read something about this, I can’t remember what it is.

**CJ:** African American doesn’t mean you don’t have the chronic pain and all that stuff. You’d see very few Asians, very few Hispanics with the chronic pain diagnosis. It was mostly Caucasians. That was the demographic. Once the pain policy went into effect the admissions went almost to zero. They would still come into the ER. We don’t want to dissuade anyone from registering. It didn’t make the ER jobs easier because you’d still have unpleasant conversations. “Why aren’t you doing this? You used to do that.” The truth is even after that I would see chart of my partners, even with this policy, they didn’t want the argument. They would just be here, IV some more to go.

**AS:** Say that again?

**CJ:** Even some of my partners in the ER.

**AS:** Would choose not to follow the policy?

**CJ:** Would just ignore the policy and would do what was easy.

**AS:** They didn’t want the conflict.

**CJ:** They don’t want the conflict; they want to make sure they still get a good performance review.

**AS:** They don’t have to follow it.

**CJ:** There’s no teeth behind it. There’s no punishment if you don’t.

**AS:** It’s a recommendation.

**CJ:** If you wanted to show the patient you could show a little letter. There’s nothing forcing you to follow it. There was no punishment if you didn’t. There’s no enforcement, there’s no teeth. It was very much ignorable. I only came across this because patients would come in, I wouldn’t do that, and they’d say, “Hey the last time I was here a month ago I got this.” I go, “Really?” Then I would look it up. Sure enough. That’s exactly what happened.

**AS:** Did you confront your colleagues about this?

**CJ:** That’s a tough thing to do. They’ll say, “This person was in tears. They gave a good mechanism, I thought something was really wrong.” What are you going to say to that?

**AS:** That’s you questioning their decision as a doctor.

**CJ:** You weren’t there. You’re jeopardizing a partnership and a friendship to bring that up.

**AS:** That is intense.

**CJ:** Hold on one second. [pause]. People are reluctant to approach their physician partners and say, “What the hell were you doing?” They also didn’t want to get a negative performance review. They don’t have any exceptions for that. That would still go in your file. There were still incentives to get it done. Make them happy, get them out.

**AS:** Is this about 2009?

**CJ:** Around 2009. Granted some partners were very good about that. They knew what would happen. It gets that conflict over easy but then you’ve incentivized them coming back. At least half, more than half did use the policy. There were certainly handfuls of those who would not do it.

**AS:** How many doctors are we talking about?

**CJ:** The department group that I was in was probably about twenty docs. To staff all the shifts, it was around twenty docs. Most of them were good about it. None of them went through the effort that I went through but they were all frustrated with how things were going. They were frustrated. They were good about it. They would be frustrated with their partners when they wouldn’t do the policy because they knew they could expect to see them back.

**AS:** The repeat behavior ends up proving that the policy might be necessary, it might be a useful thing.

**CJ:** It wasn’t enforced, there were no teeth behind it, it wasn’t universal. It didn’t stop anyone. All it takes is one or two, the patient’s like, “I might get it. Might as well go in and see.” For a patient who is dependent on these medicines. That’s the most important thing they’ve got to do that day. They have nothing they’re going to do. There’s this asymmetry. As a practicing physician you’ve got all these other patients. You’re responsible for them. This person’s going to try to take up all your time, is going to wear you down, is going to make things unpleasant, get the nursing in here to try to make it not worth your while to fight them anymore. That would happen a lot. It would also be especially compelling when they would bring their kids in. When they bring their children in the pain doctors that I met over at the clinics had a word for that. They were called props. When you bring the kids in it sends that added message. “You’re not only making me suffer but how am I going to take of my kid in this pain?” You’re harming them too. That’s extra pressure they bring.

**AS:** You’re in a compassionate field.

**CJ:** Your default is to trust. Your default is to care for and relieve suffering.

**AS:** Do you need to stop?

**CJ:** No. This person forgot that I was doing this. 2009 ongoing there was still that battle. We had support but it wasn’t great support. What I had hoped to see with that policy was the number of chronic pain patients go down to like zero. The word would get out. That policy became my department policy but became department policy for all of EMPA, which is the largest emergency medicine group in the Twin Cities. It’s not large, large but it’s like six hospitals. It became their policy. Then it became the policy for the American Emergency Physicians, Minnesota Chapter. This goes to show you that look, if you have a policy without enforcement who cares? Drunk driving is against the law but what happens? We tell you not to do it again. We penalize your license. You’d have to be caught drunk driving twenty times before anything happened. Who cares that it’s against the law? Behavior doesn’t change. The policy really never changed behavior that much. The only thing that policy did was it helped the hospitalists because these patients wouldn’t be admitted. Even with this policy the patients kept coming in. As you can see, deaths haven’t changed. The curve for opiate use and overdose and admissions, nothing changed really.

**AS:** It wasn’t saving lives.

**CJ:** It was doing some minor thing for hospital function but no real change was happening.

**AS:** Was it your intention to save lives at that point? What that in your awareness?

**CJ:** I had thought there was a multi-pronged benefit to this. The chronic pain patients weren’t getting better so this would help them. The doctors were being extremely frustrated and burned out with all this so it’d help them. The hospitals were losing money so it would help them. I thought all would benefit. It turns out really only the admissions, that’s all that really happened from this. They were still coming in, the doctors were frustrated, the patients weren’t getting any better.

**AS:** They were just finding other ways to get their drugs.

**CJ:** Right. After doing that, it was 2012 they were still having these meetings. “Is there something else we can do?” We’re having occasional talks about the chronic pain committee. But a lot of these chronic pain committees after these policies went into effect was how do we make sure patients are comfortable coming out of anesthesia? Making sure the chronic pain patients have enough pain medication after surgery so they’re comfortable. What are we talking about? Why are we not talking about we have to get this massive population off these medicines? We’re talking about making sure they’re safe and monitored after surgery. Basically, there was some safety regarding that but mostly it was make sure the customer’s happy. If you look in terms of how things are practiced. If you think the ultimate paradigm is make sure the customer’s satisfied with their experience. You will find that explains much of medical behavior.

**AS:** The patient customer, together the two words.

**CJ:** The buzzword in the industry was the patient experience. You want the patient to have a good experience. You just take the term customer and replace it with patient. The customer experience. Just swap them out. There it is. The patient experience is the word in the industry for measuring how well you’re doing. It is not patient outcome. That is not the measure for how things are going. If you’re measuring patient outcome with pain meds and opiates we’re doing terribly. There’s more and more prescriptions coming out, more and more people becoming dependent, more people going into treatment. People are dying. If you’re measuring it by outcomes you’re doing awful and you’ve been doing awful for years. I talk about this in the articles, I’ll send them to you so you can review them. If you look at what governs how medicine is practiced in terms of what would make the most business sense you will find that is a streamlining paradigm to understanding how medicine behaves.

**AS:** How’s that for you as a physician?

**CJ:** I feel that there’s been a great bait and switch. We have the Hippocratic oath, we got the little white jacket, the health of the patient is the paradigm of everything. No it ain’t. There’s no data saying even back surgeries are helping. Back surgeries however make half a million dollars for one procedure. It is cash money. Hospitals have spine centers. Look at what’s serviced out there. Is it mental health? No. Why do you think there’s heart and vascular centers everywhere? Stents pay money. There’s actually very little data that stents do anything. If you’re in immediate heart attack it helps. It helps a small like three percent of the population that has what is called Severe Left Mane Disease which is the main artery coming out of the heart. Unless you have Severe Left Mane Disease for your heart or if you’re in the middle of an acute infraction but if you just have chest pain from exertion relieved by rest that’s typical anginal pain. A stint isn’t going to do anything. It isn’t going to make you live any longer. The only thing it’s says is it might improve your pain for about two years and then there’s no difference. Vascular centers and stents make huge dough. You can throw a rock and hit them. You can’t find a mental health clinic. You won’t find these other services which are neglected because they don’t pay.

**AS:** They’re nothing about technology.

**CJ:** As I’m doing all this chronic pain stuff I’m also observing this about how medicine is functioning and it increasingly looks like is the patient what they’re really thinking about or are they thinking about them? They’re thinking about them. The patient care is the means through which to maximize what’s benefitting them. It’s not like doing a stent doesn’t involve patients. It isn’t like their number one outcome is what they’re thinking about.

**AS:** It’s for profit.

**CJ:** If it’s not for profit it’s for revenue. Some hospitals are not for profit.

**AS:** Of course they are technically.

**CJ:** They are. You’ve probably studied this. You just don’t have shareholders but you have business interest that you answer to and high salaries you try to pay. They know that very well. If you look and see what you see all over the place is what’s paid for which is cancer centers, imaging centers, heart and vascular centers, neuro centers, even eating disorders, those pay.

**AS:** Even the addiction treatment centers and the recovery centers.

**CJ:** Those pay and you can hire cheap labor.

**AS:** People will keep coming back.

**CJ:** They don’t get well permanently. I’ve seen the data especially with the opioids. I’ve seen it get worse and worse and worse. I thought there would be this human cry from the medical profession, we’ve got to put a stop to this. As you’ve seen it’s been very tepid. You’re not seeing people up in arms. “Oh it’s so sad but you don’t want to cut off the people who need their medicines. You don’t want to have them suffer.”

**AS:** They’re starting to feel like bad people now.

**CJ:** It’s always these measured tones of “We’re not really doing that bad a job. You can’t make these people go through that.” If you look at from a standpoint of you want to keep your customer happy that makes sense. That has been spurring my research not into just pain but also into medicine as a business. I’ve done quite a bit of reading on that. I think the American system is fundamentally broken. If it really had the patient in mind the opioid epidemic would have been fixed a long time ago. But it doesn’t. It still isn’t.

**AS:** It’s rising. It’s not even falling yet.

**CJ:** What do you see in the news? You see we need more funding for treatment. It’s a very consoling answer because medicine creates the problem and sells more medicine to solve the problem.

**AS:** By medicine do you mean medication assisted treatment?

**CJ:** Medicated assisted therapy which is better than leaving untreated but they’re not doing what I advocate when I do all my talks. Stop writing for these medicines in the first place. Cut down drastically exposure. Just like you have to smoke more than one cigarette to become addicted to tobacco, more exposure equals higher risk. You need to drastically reduce the amount of pain medicines that you are exposing the populations to.

**AS:** This is just something that physicians can do. More people are overdosing on prescription pain pills than heroin.

**CJ:** Four out of five people who abuse heroin now started on pills. You understand how it started with OxyContin right? You’ve done all the research knowing that the opioid and heroin epidemic was not an accident. This was engineering, this was engineered by deliberate pharmacy campaign in the mid to late 90s with the introduction of OxyContin to persuade the medical community that chronic pain is an undertreated epidemic characterized by needless suffering. Opioids are safe and the risk of addiction has been greatly exaggerated. What were these long acting opioids used for primarily beforehand? Hospice patients mostly.

**AS:** Hospice and surgery recovery in hospital.

**CJ:** Acute injury in hospital and hospice patients but not back pain. Back pain doesn’t suddenly cure. Back pain’s an ongoing thing. You don’t take oral heroin ongoing for back pain. That’s what happened. You can’t get rich on hospice patients. You can make billions if you suddenly for every arthritis patient and every back pain patient you get them on these medicines which those things don’t go away, bulging disk and what have you. It’s just the back version of arthritis. Those things are lifelong. It’s a perfect drug for pharmacy. They don’t want to do antibiotics which you take for two weeks and are done. They want you to invent a drug that you’re on for the rest of your life. Lipitor, number one drug of all time. There’s not great data that says Lipitor helps anyone in the average population. It’s multi billions. They pay physician leaders. Cardiologists or the pain specialist at the Beth Israel Hospitals and Harvard recruit and pay the physician leaders at some of the top departments. Have them sort of fudge the data or find ways to manipulate the data. Spread the message down to the rest of us. We don’t have time to go back and reduplicate all these studies. We have to function with a level of trust like we do in all society. We trust that they’re giving us good information. Porter and Jick.

**AS:** It wasn’t even a study.

**CJ:** It wasn’t a study it was a paragraph.

**AS:** It was a paragraph in a letter to the editor.

**CJ:** It was a five sentence paragraph. It was an observation. Observations are useful in that they often can lead to studies.

**AS:** That was a level of trust, coming back to the idea of trusting you colleagues with what their research is. You reach a level of professionalism and you want to respect their opinion. Of course you’re not going to go back and recheck everything.

**CJ:** Are you going to do every study about every condition?

**AS:** You can’t. You can’t be a sceptic because you don’t have time. You’re taking care of people in pain.

**CJ:** You have to trust that there is a code of ethics and rigorous scientific skepticism and that the population you’re intending to use these medicines for, chronic pain patients, you’ve tested it on that population. With Porter and Jick they tested on hospitalized patients briefly.

**AS:** And said who was addicted? Who got addicted? One lady.

**CJ:** You got morphine after a fracture and you were likely to be okay. We knew that. It’s suspicious. That letter to the editor was 1980. Suddenly sixteen years later? Now it’s evidence that opiates aren’t addictive?

**AS:** For Purdue Pharma.

**CJ:** That could only change the medical culture if they could coopt and manipulate physicians and they did that, paid them well. I’m very critical of my own profession that we are as vulnerable as we are to having our mission compromised by money. I can reach no other conclusion based on what I’ve studied and learned. That’s what happened. The culture was changed. Pain became the fifth vital sign. The risks of opiates were exaggerated. The prescriptions if you’ve seen the numbers went from like eighty million in 1992 to over two hundred and fifty million now. You can just watch in lock step as the number of prescriptions went up.

**AS:** So did the deaths.

**CJ:** So did the deaths, so did treatment admissions. Which tells you another thing. I say this in my lectures. Traditionally addiction is a moral issue. Here’s where I strongly disagree with the recovery community that uses terms like character defect and moral inventory. What an extraordinary thing that as marketing and sales changed and sales increased. At the same time, you had a dramatic increase in the number of immoral people in this country.

**AS:** Which huge character flaws.

**CJ:** With huge character flaws. Who knew? What a coincidence. Right when you started throwing all these prescriptions and here’s five tablets, here’s thirty.

**AS:** And now we blame parents, parents blame themselves. It’s a perfect storm. You can blame poverty. There’s all these things that you can blame without having to look at what actually happened.

**CJ:** Everyone should recognize too; the reasons these medicines do anything is your brain has a receptor for it. Your body makes morphine. That’s what endorphins are. Endorphin is just a contraction of the two words endogenous, meaning made from within, morphine. Endorphines or endorphins. Your brain makes these chemicals. In physiological doses, not pharmacologic doses. Your brain doesn’t want you to be that happy all the time.

**AS:** You’ve got stuff to do.

**CJ:** Giggling like an idiot all the time isn’t good for survival. You need to be worried about is it too damn cold? Do we have enough water? Am I going to get eaten? The state of the brain that helps survival is what evolution selected for. It’s not giggling like an idiot all the time or that’s where we’d be.

**AS**: Or blissed out.

**CJ**: If you’re blissed out you’re not worried enough. That’s not good for survival.

**AS:** You’re bait.

**CJ:** The brain doesn’t actually want you to be that happy all the time. It wants you to be happy in selective situations and rewards them. It doesn’t want you to be happy all the time. What these chemicals do, you realize “I can be happy all the time. This is awesome. I’m happy all the time.” The brain pushes back. The brain realizes, the brain wants homeostasis. That’s a term in medicine that means the brain wants stability. It doesn’t want to be there. The brain pushes back. The brain stops reacting so well. You take that medicine the next time, “That was nice but it wasn’t really quite as nice as the time before.” The reasons these medicines work is they cause an increase in dopamine in your brain’s reward center. That’s simplified but it’s a basic enough chemistry for most purposes. It causes the release of dopamine, you feel euphoric, you feel awesome, “Why I shouldn’t I feel like that all the time?” That’s what leads people to keep going. I can be happy all the time, who wouldn’t want that.

The brain pushes back. Suddenly it doesn’t release so much dopamine. It down regulates its receptors. The morphine is there but there’s no receptor for it to bind to. That’s what happens when people use it for a while. When you start to alter the brain’s chemistry you alter its receptors, you alter its circuitry, you’re in real trouble. Now when you stop using the medicine all together the brain says, “Alright this is not good. This is not good. I don’t feel good.” Because the normal physiologic morphine, you’ve kind of switched it off. The brains notices, “Where the hell is my morphine?” Because you’ve stopped making it. Just as a body builder who takes testosterone their testicles shrink. The body says, “Why am I wasting all this metabolic energy making testosterone when I’m just getting it from the environment.” So the testicles shrink. Same thing happens in the brain. It realizes if it’s getting all this from the environment there’s no reason to make it myself. When patients who are using these medicines and take it for a long time have completely distorted their brain chemistry you can’t just stop it because once you just stop it they feel awful. Everyone would. I can put you, me, you put all of us on it for around the clock for two months you will not feel good if we suddenly say no. That is enough to change your brain chemistry. That’s the issue. It’s not even just an issue for chronic pain. Obviously chronic pain, guaranteed, since chronic pain never goes away you’re going to be on these medicines for at least three months. That’s plenty of time to change your chemistry. Now you’re on it for good.

**AS:** Then your pain comes back and you feel bad.

**CJ:** It doesn’t feel like I’m addicted it just feels like my pain came back. I’ve got to get back on. Withdrawal is painful. People coming off heroin say they feel awful, they’re in pain everywhere. Being on these medicines for chronic pain almost guarantees they’re going to be on it for life. Three months is plenty of time. It even is concerning when they have an acute injury like a surgery or something like that. Even if you have a knee replacement or have this bad fracture. It’s not like the brain says, “Oh well I’m not going to adjust to these medicines because look you broke your bone.” No. It will still start to change over time.

**AS:** Your brain will.

**CJ:** Your brain doesn’t care that your leg is broken, therefore I won’t respond to these medicines in a normal homeostatic reduced responsiveness over time way. Even if you do have a fracture don’t take these medicines for two months. Take it for two weeks and then realize it’s going to hurt while you heal. Then you go back to the customer service thing.

**AS:** It’s been three months and I’m still hurting.

**CJ:** I didn’t pay for this. How expensive health care is makes it worse too because when you’re paying so much for healthcare, you expect “I should have zero suffering in this.”

**AS:** But that’s a cultural construct about pain and money. If we have more money we’re paying a lot for something we should be getting something really good. It’s understandable in our cultural context.

**CJ:** You’re a paying customer and medicine in general has encouraged this.

**AS:** Then the hospital calls you and refers to you as the customer.

**CJ:** We sell you the idea that your health is a commodity to be bought and paid for. That we can provide you as the health care industry rather than something that is primarily and always has been your own. Health care can maybe be about fifteen percent of your health outcome. The other things are diet and your ability to keep active. If you don’t keep active your body ages and gets worse.

**AS:** Where we ever got the idea that we can’t be in pain, that we can’t have pain.

**CJ:** And you should have a great night sleep every night and you should always have sex like you’re eighteen. These are all things that are kind of a denial that the human condition is to age and things don’t go so well. They’re meant not to go well on purpose. For evolution to work you can’t have infinitely long lived organisms. That’s how mutation and evolution changes over time and the genes happen. You have to have temporary organisms and beings and humans otherwise change won’t happen. Evolution builds in the temporariness which is insulting to us as conscious beings. I’m so awesome I should be here forever. I should be able to do what I want forever until I decide I’m done. That contributes to this issue. You hear things like life is too short to be in pain. I’m like, “Life is too short for me not to be ecstatically happy all the time and for there not to be wizards and magic like *Harry Potter*.”

**AS:** Why don’t we have all that?

**CJ:** In a fourteen-billion-year old universe and I get like eighty, maybe if I’m hopeful. Yes. You get a fraction of a fraction of a fraction of an instant. Yes, you can justify. The truth is evolution and life don’t care. When you try to manipulate your brain and you try to manipulate your experience usually things don’t go well.

**AS:** I’m going to pause for a second. I need to use the bathroom.

[Pause]

**AS:** Okay. We’re back.

**CJ:** When I speak about selling medical assisted therapy as consoling to medicine it’s because you still get to sell more medicine. More importantly you don’t cross pharma. In other words, prevention. Reducing the amount of prescriptions, reducing the market share for these medicines there is very serious opposition to them.

**AS:** For reducing the opiate prescriptions?

**CJ:** Right. Instead of two hundred and fifty million prescriptions go back to like eighty million. Cut it by like two thirds. That’s a lot less many.

**AS:** The resistance is from pharma.

**CJ:** It would also be from the physicians who just write these medicines.

**AS:** When you say medication assisted treatment are you talking about things like methadone.

**CJ:** What I’m saying is methadone, Suboxone that’s why you hear politicians mostly talk about that. Access to treatment. They don’t talk about reducing prescriptions on the other sides. I’m saying that it’s a politically expedient answer, to increase funding for medical assisted therapy which does say lives.

**AS:** We’re going to open more methadone clinics.

**CJ:** We’re going to address the opioid epidemic by increasing access to treatment.

**AS:** But we’re not going to restrict…

**CJ:** We’re not going to turn down the faucet.

**AS:** I absolutely agree.

**CJ:** And reduce exposure of the population.

**AS:** It’s a total ruse.

**CJ:** Which is my focus.

**AS:** Your work is on reducing the opioids.

**CJ:** There’s no reason to put people on these medicines. It’s oral heroin. There’s nothing wrong with heroin. You understand heroin is used in the United Kingdom every day in hospitals. It’s called Diamorph for diacetylmorphine. Perfectly fine. You have a kidney stone you’re going to get two milliliters of Diamorph and you’re going say to the heroin, “Thank you.” But then they’re going to stop. Don’t take it again. You use heroin for acute injuries. Dilaudid, we use that all the time, Dilaudid is actually stronger.

**AS:** Fentanyl.

**CJ:** Fentanyl is even stronger. This is what infuriates me. When patients that are on these medicines find that they're not working and need more and are looking to get more. That's called aberrant behavior. They're violating their contracts. Having these medicines over time do less and less is exactly predicted by homeostasis and what the brain physiology is supposed to do. It isn't the patient breaking the promise. It's the body doing what's it's designed to do which is respond less and less as the environment changes. It wants to keep a constant environment. They look at that like you've violated your contract. You've committed a crime. Pain contracts have been around for a long time and haven't done a damn thing.

**AS:** What has?

**CJ:** These pain contracts. These agreements haven't done a damn thing. In my view they're a way for physicians to cover themselves. It also always them to not think about it.

**AS:** Think about what they're doing.

**CJ:** They don't have to think about what they're doing so the patient actually just does their contract. They just go, "Here you go." They don't have to think about it. The contract has taken over the management of the patient. The document now runs things. That is negligent.

**AS:** We're getting into Foucault territory.

**CJ:** It is negligent in my opinion. You're now letting this document run the care. If they fulfill their little obligations, you give them another ninety-day supply of oral heroin. "Well this contract says their okay. I'm doing what the contract says now too." All the while they're going to get worse and worse and worse. They're getting into higher risk situations with these contracts. Having a contract didn't prevent any people from becoming dependent. They just became dependent with a contract.

**AS:** Where do you see this going?

**CJ:** We didn't finish. Crossing pharma is a big deal. Pharma has among the most powerful lobbies.

**AS:** I understand what you're saying now. Crossing pharma. Like breaking down.

**CJ:** Like having major policy changes to dramatically reduce the number of pills that are flowing. They don't want that.

AS: It's probably not going to happen is it unless it's legislated.

**CJ:** Or the whole U.S. healthcare system blows up. Here's the thing. Other countries, Britain for example, they've got the same group of people. They're getting big like we are, they're getting over weight, they're getting arthritis, they've got back pain. They don't die like we die. They don't use these medicines for chronic pain like we do.

**AS:** Now Purdue, they're going globally.

**CJ:** They're going to see if they can. They don't have the same customer driven healthcare. They're going to have a harder sell if they know these medicines, they can see what happened in the United States. "Let's change so we can develop the same problems that are in the United States now."

**AS:** That's comforting at least.

**CJ:** I hope. In the British and the National Healthcare Service in Britain they have more data driven stuff. They have the acronym is NICE which stands for National Institute of Clinical Excellence or something. Their job is basically to see overall is the science being followed. In some cases, the science isn't clear but they do the best they can to make it sort of data driven. They also have fewer surgeries. They have fewer stents placed. Can you believe it? They don't die any younger from heart disease than we do. Even though they have like half or fewer of the stentings than we do. They have more data driven. The prescribe opiates like we used to back in the 80s.

**AS:** They can watch what's happened.

**CJ:** That's how they're functioning right now. They don't have much incentive to change and develop this problem. Given how their systems function either with a single payer or with the National Health Service they don't have an incentive to cause these problems. The tax payer takes responsibility for the patient from the time they're born to the time they die. It's in the tax payers interest not to cause opiate use disorder and treatment admissions. No. That is not in their interests. They have different economic incentives. They can try to export it but the United States being as customer and business oriented as we are we are more vulnerable to that. Honestly I think the opioid crisis is kind of a litmus test. If the U.S. healthcare industry can cause this problem and permit it to exist and hurt this many people, and kill this many people in flagrant disregard of the science and the oath. Does it deserve to exist?

**AS:** Does the system as it exists deserve to exist?

**CJ:** You could make a very strong case that if you can create and permit to persist the greatest public health issue that kills sixteen to nineteen thousand Americans per year then either one of two things. Either you blow the system up or actually tell the medical schools stop telling the kids to take the oath. That is not what their loyalty is. Get rid of that cognitive dissonance.

**AS:** That's chilling.

**CJ:** Get rid of it altogether. So you're not conflicted. You're in the business of healthcare. You're not here for the patient's best interest. You're here for the business of healthcare. Then at least you'd be consistent.

**AS:** Who are you speaking to? Are you going around?

**CJ:** That's my take on the responses to the opioid epidemic so far. They've been easy. Improve access to treatment.

**AS:** They're kind of lazy.

**CJ:** They don't cost anyone anything. They won't jeopardize. Pharma contributes more money to political campaigns than any other industry. You're going to say no to that money. "Who's running against you now? We've got a friend here. How would you like this much money?"

**AS:** What about the comprehensive, the CARA, the Comprehensive Addiction and Recovery Act. Did you look at that very much?

**CJ:** It was more focusing on the backend on treatment.

**AS:** It's a band aid.

**CJ:** I think there was one study I saw where the mortality of a person in medical assisted therapy per year is about one percent. If you're in medical assisted therapy, you're on Suboxone, you're on methadone or something, your risk of dying per year is one in one hundred. Now it's like five times higher if you're not in treatment. One percent is three times higher than if you never developed the problem at all. It depends on your age. If you're in the thirty-five to fifty your average mortality is like three per thousand percent. It's still three times more likely to die if you're on medical assisted therapy than if you never develop the problem. I'm saying let's never develop the problem. Your mortality if you're even younger like in your twenties is even lower. Granted you have car accidents and stuff like that but your mortality when you're younger in your twenties is even lower. Your five times more likely to survive if you never develop opioid abuse disorder. All of this tells you is what you already know which is prevention is better than treatment.

**AS:** Prevention is better than the cure which is what doctors have been saying for a long time.

**CJ:** It isn't so simple as diabetes and just saying, "We'll just get you on insulin." If you become a diabetic. You're sedentary, you get overweight, you develop insulin resistance, then you develop Type 2 diabetes. You get on regular insulin. I guess if you keep tight control of your sugar you can live a pretty long life. I don't think quite as long as you never develop. It's kind of seen like "Oh that's too bad but we got this." That's not true, medical assisted therapy should not be seen as just getting on insulin for diabetes in terms of your risk.

**AS:** Your risk for?

**CJ:** Dying. The other thing is this. It's not like insulin or glucagon. By the time you get to medical assisted therapy for opioids. You've probably lost your marriage, you've lost your house, your kids won't see you, you've got legal action. That's not true when you're diabetic when your blood sugar keeps going up until eventually you're on pills and then maybe going to insulin. You haven't lost your life prior to that treatment. The person who gets to medical assisted therapy has probably lost a great deal. If you never develop the problem in the first place you can avoid that. That is my big talk. Prevention. Focus on patient outcomes not patient satisfaction. Don't do what's just business savvy actually obey your oath and do what might be unpopular with a patient temporarily with their long term interest and their outcome.

**AS:** Are you talking to doctors?

**CJ:** I do. I've spoken around the state. I speak in communities. I’ve spoken in Montevideo. I've spoken in St. Cloud. Most of my talks are local. I did testify in front of the FDA Advisory Committee. I did speak at the Fed Up rally in D.C. in September. I give my talk all over. I speak to disability adjustors, like insurance companies. Why are we doing this? Is there any reason why we're still doing this?

**AS:** Is there some way to get at this...?

**CJ:** Payers, I've spoken to Medica. Payers have some stake in the game.

**AS:** I wonder is there some way to get at this to put it on your policy brain which you said you chose not to do it. It seems like you actually are moving in that way.

**CJ:** It came full circle back to my political science.

**AS:** That's what I was thinking.

**CJ:** This sort of overarching sort of ways to benefit people. I couldn't have done that at age twenty-three.

**AS:** Of course not. We have to have our life.

**CJ:** Treating one patient at a time and doing my medical career for as long as I have and understanding how the problem happens. Now I can come back with authority and experience.

**AS:** And evidence.

**CJ:** And street credit. This is what needs to happen. I can tell them you're going to do this and this and this for a year. We're going to be here in five years because nothing is going to change.

**AS:** Chris do you think it's possible to use the insurance companies to quit paying for these long term prescriptions? Is there some pressure in our own system the way it currently works or are they just as culpable as pharma and hospitals?

**CJ:** Insurance companies, you want to get stakeholders involved with an interest in having this problem not happen. Obviously patients and families have a stake in not having this, that's their lives. That's their homes they're going to lose, their jobs they're going to lose, their families they're going to lose. They have a stake in it. The medical industry doesn't have as much of a stake in it. Saving lives and saving people, honestly the more people get on medical assisted therapy, people who go into treatment that's business. People in chronic pain going to the pain clinic that's business.

**AS:** The idea of reducing it isn't...

**CJ:** Health care is paid for with consumption of health care services rather than outcomes. There's always this incentive, there's always going to be a problem when you're looking to reduce consumption of healthcare. That is business that's not happening. I'm not saying it's a good situation.

**AS:** I'm just feeling sad and cynical.

**CJ:** Until like the president's daughter dies.

**AS:** In a way those things don't even seem to matter. Deaths of icons.

**CJ:** Prince is dead.

**AS:** Prince and Phillip Seymour Hoffman.

**CJ:** Heath Ledger.

**AS:** Heath Ledger.

**CJ:** I mention all of them in my talk by the way.

**AS:** Not to mention all the sons and daughters and parents of kids.

**CJ:** I've been to these meetings where the doctors who are pain doctors who have been prescribing these opioids still say, "It's terrible but you can't take away the meds. Some of these people really need them and if you take that away from them they'll probably commit suicide." That's what they say.

**AS:** It always circles back to the pain.

**CJ:** Yes. Listen, it's oral heroin. It's all what it is. I show people the slide. This is what heroin looks like, here's what oxycodone looks like. It's basically the same. The ring structures. Their receptor is the same. There is no separate heroin receptor in the brain.

**AS:** Your purpose for saying that is to kind of bring heroin, because of its negative connotations, into the discussions of recognizing...

**CJ:** If you say, "Oh some people really need their opioids and they're in pain." They need their heroin. You might as well just say they need their heroin.

**AS:** You could explode the stigma.

**CJ:** Trying to destigmatize what heroin but you're also trying to stigmatize this dichotomy that they think they're being responsible.

**AS:** My kid wasn't a junkie.

**CJ:** "I'm responsible because I'm using opioids in the form of OxyContin for their chronic pain." I'm like, "You're just giving heroin for their chronic pain."

**AS:** When you say the oral heroin to other physicians what do they say? The same thing you just told me?

**CJ:** They don't like me saying that. They like to just call it opioids and use more scientific names and sterilize it and clean it up. They feel like they're doing responsible medicine. All they're doing is oral heroin for conditions that life just creates because life is life. Here's the other thing. Have they really helped people? Not if you look at the disability rolls. If you look and see are people "getting their lives back." Then you should see massive decreases in people with chronic back and joint pain who are back at work now that they're on their opioids. You absolutely do not see that. In fact, disability claims have done nothing but gone up. These patients will almost universally say they're helping.

**AS:** But they're still in pain and they can't work.

**CJ**: Right. When they come off the medicines...

**AS:** They actually are in pain.

**CJ:** They're withdrawing. Then when they take their medicines they feel like it's helping them. But they're not back at work. In terms of being engaged in life.

**AS:** And healing.

**CJ:** They're not doing that. It is giving emotional consolation so yes they say they're helping but especially because we're paying for their disability. Healthcare and insurance, they're paid for collectively. We're paying for that. We have a stake in helping you get back to work and pay into the system. We have a stake in the fact if you're not back and work and doing all this other stuff we're not getting what we paid for.

**AS:** We don't see it that way. Can you talk a little bit about how you got involved in the Steve Rummler Hope Foundation?

**CJ:** One of the other docs on the board, Reznikoff, I think it was after I gave a lecture in 2012 at Park Nicollet. I don't know who heard it. Somebody somewhere either heard that talk that I gave and told the Institute for Clinical Systems Improvement or ICSI about me. ICSI invited me to be on their pain management group. I participated in their document they produced. I think it was 2010 or something. Then they reconvened in 2015. I went back and did it again. Charlie was on this ICSI group. He learned who I was through ICSI. Then he approached me later. He was already on the Rummler Foundation and said, "Would you like to be on the board of the Rummler Foundation?" I met Judy and Bill. They told me their story and I told them my approach. I've been on their board. It's been a good relationship. I'm not sure how helpful I am to them. In the sense that a lot of their board meetings are about financials. A lot of what I do is advocacy and message. I'm not good with money. I'm not a fundraiser.

**AS:** They're raising money to get more Narcan kits.

**CJ:** They've been very good about; they bring me speaking opportunities. Can you go talk to this group? I also point out when they do their Narcan. Narcan is catching it, if you're at Narcan you've lost so much already. Granted let’s save your life and help you get back and give you a chance to get that stuff back. Let's stop it upstream so a person never needs Narcan. While I applaud Narcan and medical assisted therapy and helping people who've developed a problem. My main message is medicine had no business causing this problem in the first place. We are not helping people we're harming them. We have no accountability and we have a system that is geared to continue to have business proceed as usual. In what I view as a very egregious violation of the Hippocratic Oath. That's the message that I bring.

**AS:** I think that's a helpful message for them even. We need those voices.

**CJ:** A lot of the meetings do tend to be about, like any board meeting.

**AS:** It's not that exciting.

**CJ:** Is the organization functioning? The organization needs finances to function. Where's our finances? Where are we getting them from? Where's our donors? How do we get this? All of that is very important. They don't just spring up out of nowhere. I'm bad at that. I'm not good at that. In that sense I'm not a good board member. I look at a page of figures and I'm like "Sure. Is that good? I don't know."

**AS:** Boards need all kinds of people. They need people they can count on to go and speak articulately, be on message for them. That's important.

**CJ:** I have been told I'm a good speaker.

**AS:** You are. You're a very good speaker. What do you see happening in the next few years in this environment? You just said a few minutes ago you don't think it's going to change anytime soon. What would like to see?

**CJ:** I chair the Department of Human Services Opioid Prescribing Workgroup. I told that right?

**AS:** No.

**CJ:** The Department of Human Services has an Opioid Prescribing Workgroup that was, I forget who set it up.

**AS:** That's Mo.

**CJ:** I'm sure I brought cat hair with me. [Talks to cat]. I chair the Department of Human Services Opium Prescribing Workgroup. We've been at it for over a year now. We're coming up with our recommendations for chronic pain. They are going to reflect the things that I've said to you. We've got, Charlie Reznikoff is on this too. The recommendation that are going on the commission are going to be for policy. They're going to reflect the fact that you have to reduce exposure. Whatever it is you're doing, stop the patient after two weeks, whatever it is. Tell them "You're going to hurt. That'll be okay. Your body will heal." Healing is another way that things get better. The body heals.

**AS:** Nerves have to readjust.

**CJ:** Your brain stops responding enough to the nerves. Remember other countries live and function without it. That's going to be the message. The question is then, after this what kind of buy in are we going to get from the medical community? You need everyone to do the same thing at the same time. Sort of the way the ACA mandated insurance companies to stop discriminating against people with preexisting conditions.

**AS:** And women.

**CJ:** One insurance company couldn't have an epiphany of conscience and decide it's not right that these people with these expensive things that they can't get insurance. We're going to just start doing it. What happens when one company decides to do that? All the sick people go to that company. Right? Their premiums don't remotely cover the cost of their care. That would be an insurance company to go broke. You had to have a piece of policy that said everyone at the exact same time had to pick up these expensive patients. Granted you also had to mandate that people have to buy in. They're trying to get rid of that. "You do that we all go broke." That's why I think they need to stop this nonsense. Single payer, you take it right out of their check just like in Canada or Britain. You don't get the option and it's going to happen. The idea behind the ACA was they recognize you can't have one conscientious insurance company that just is going to do it by themselves. They would be destroyed. You have to make them all do it at the same time. That is the idea with a policy. If everyone sort of gets on board at the same time, "We're not doing as many meds." At the same time, we can decrease the exposure, we can decrease the number of prescriptions, decrease the number of pills that are getting to the population. That will bring the numbers back down.

**AS:** What's your target area for this committee, this policy?

**CJ:** We haven't finished yet. We have to finish these recommendations, they have to go to the commissioner, there's going to be a public comment, a revision process.

**AS:** To do actual legislation?

**CJ:** That's what we're going to find out.

**AS:** That is awesome.

**CJ:** Nothing might happen. It might be like, "Those are nice recommendations."

**AS:** For the state of Minnesota. That would be your first....

**CJ:** We need to track the number of prescriptions. Are we reducing the number of prescriptions? What's happening with that? Then watch it over time. Are the prescriptions going down and with it are we seeing treatment admissions going down and the deaths go down?

**AS:** I would think you would.

**CJ:** Considering the relationship that was very clearly evident when the problem started. You would like to see as the sales went up these other problems followed, as the sales go down the other problems go down. You'd like to see that relationship hold. There's nothing special about heroin. It doesn't become popular. There's no special sauce that changed. The reason heroin is popular is we created this whole new market for it with the pills.

**AS:** And it's cheaper and it's easier to get.

**CJ:** A person who then became dependent on the pills, whereas a forty-five-year-old woman with back pain would never just go to heroin for their back pain. You put them on pills for five years because that's medicine from a doctor and a pharmacy. They look the same as aspirin. You put them on that for five years and then say you're taking those away now that now fifty-year-old woman their brain's desperate. They will go to heroin. They can't feel like that anymore. It is not tolerable to their brain to continue feeling like that.

**AS:** Then kids who start playing around with the pain pills then aren't afraid of heroin. They don't have the same exposure and their not as afraid. It's not as shifty and dark.

**CJ:** Say they've snorted the pill. They know how it feels. "I can manage it." It's that halfway point that allows people to get over it. They would never go straight to recreational heroin.

**AS:** Although there are kids who are because of the way that it's being explained to them. It's not any different than the pain pills.

**CJ:** They're sort of this halfway house that allows someone to get over that psychological...

**AS:** There was a lot of stigma in my generation. I'm going to turn fifty soon. Heroin was like no.

**CJ:** Heroin was inner city, jazz musicians.

**AS:** It was Jim Morrison and The Doors died.

**CJ:** It was with blacks usually in poverty.

**AS:** To me it was like death. You saw the skull and crossbones when you thought of it.

**CJ:** The rock n' roll musicians it was the typical hard partying, the Janice Joplins, the Jimmy Hendrixes, the Kurt Cobains. Now it's different.

**AS:** It's different because of the opiate pain killers.

**CJ:** Prince was a Jehovah's Witness. They have their own beliefs. What is true is that he didn't drink and smoke and do all these typical rock n' roller things. His parties were clean. They didn't have alcohol. His brain was no less vulnerable just because it wasn't that type. That's why this problem has unfortunately drawn the attention. It has hit that segment of the population.

**AS:** Middle and upper class white people.

**CJ:** Middle class professionals with kids going to the good schools.

**AS:** The high school football hero. Thank you.

**CJ:** Is there anything else? Did I forget to cover something?

**AS:** Are you good? Are you getting cold?

**CJ:** I'm fine.

**AS:** I'm getting cold. Any last thoughts?

**CJ:** People wonder do I have a brother or family member who got addicted to opioids. The answer is no.

**AS:** I kind of assumed that because you didn't tell me.

**CJ:** Honestly I'm just filled with righteous anger.

**AS:** That's a motivator.

**CJ:** I really feel this naive crusader in me that wanted to break policy things and right wrongs. I thought I'd go to medicine to do it one at a time. Then as I learned in medicine, I'm not sure if I'm doing that. Don't get me wrong. Most people in medicine absolutely are trying to do the right thing. They want to do the right thing. We straighten out fractures and we intubated people in respiratory failure. We're doing that. That is the goal of most doctors. They still do great things. The motivations that people who create that climate don't do it with the patient's best outcomes in mind. When you hear these stories about patients being held in ERs for two days because there's no mental health bed for someone who's suicidal. There's a reason for that. The ER doctor who sees them puts them on a hold because they're trying to do the best thing for them. They are. But the reason they can't find a bed for them but they can get a heart attack patient up there in thirty minutes is a matter of economic priority and who is invested in that and where does that come from. That comes from the level above the level of doctor and patient.

Anyone who tells anyone that what your health outcome is just you talking to your doctor. Nonsense. It is never ever been you and your doctor. What determines that outcome is also a matter of economic investment and priority prior to that doctor ever getting there. That doctor who wants to do the best for their patient can get the acute heart attack up to the cath lab. They can do that right away. That same doctor is going to put their patient on hold and they're going to sit there for two days. There's no medical outlet. There's no place for them. We've decided this is not valued.

**AS:** Mental health and addiction are treated the same.

**CJ:** I sympathize with hospitals that are put in the position of losing money on some types of healthcare and having to make up for it by doing other stuff. You'd like to think that healthcare that provides a service and a value should always be in the positive. Like you're doing something good. You shouldn't lose money for doing a service that improves the health of someone. Hospitals are in the business where providing the service causes them to lose so they have to make up for it here. Don't think that doctors and hospital people are a different class of human that are removed from incentives. There's a reason you need a federal act to stop patient dumping. Do you know what the Emergency Medicine Treatment and Active Labor Act is?

**AS:** No.

**CJ:** EMTALA. It's in 1986. That was the act that stopped patient dumping. That's why you can go to an emergency room and you have to be seen.

**AS:** Any emergency room you go to now. Right because there were places that said "You can't come in here." You could turn them away.

**CJ:** They were poor patients they found that had appendicitis. We're going to send you to county. They do a lot more than we do.

**AS:** Now I remember this but not the name of it.

**CJ:** That's what George Bush said, or George W. said. That's what Mitt Romney said, "We do have a universal health care system. We have emergency departments." That's what they meant. You had to be seen.

**AS:** That was their big Reagan era contribution to healthcare.

**CJ:** Understand if doctors and other hospital healthcare people weren't sending off the poor patients you wouldn't have needed that law. If they were doing what their oath said. They were trying to maximize return on their time so they sent away the patients who weren't paying. They were forced by law to not do that. Don't think that you've got this different class of animal human in the healthcare industry that doesn't pay close attention to that.

**AS:** What do you want to do in the next few years? Where do you see your work and your career going?

**CJ:** I've moved to urgent care because the hours are better. It doesn't pay as well. I sleep at night better. Would I go back to emergency medicine? Probably not full time. The burn out in emergency medicine is really high. It's not what your body was meant to do. I don't have children so I don't need tons of time. This public health work I do does give me purpose. I feel this is a good mission to be on. It just so happens that this problem I began work on over a decade ago is now the number one public health problem in the country. That's why I'm front and center on it, at least in this state. Since it hasn't stopped I'm imagining that the work for me to do here is going to continue.

**AS:** For the meantime you'll stay in urgent care?

**CJ:** I'll just keep doing that unless I get to the point where the work I do public health wise, speaking educating, helping systems develop policy, that itself becomes compensated to a point where I could do that. At some point does North Dakota need help? I haven't talked there. Wisconsin do they have a problem? I don't know of anyone doing my job in either of those places.

**AS:** In this way. What's the name of the opioid group that you're working on?

**CJ:** The Department of Human Services? DHS is the Opioid Prescribing Workgroup. I'm also on the board on the National Organization of Physicians for Responsible Opioid Prescribing.

**AS:** I'm excited about your Opioid Workgroup. Let me know if you need any help with that.

**CJ:** I think you've got a system of incentives that are poorly designed to solve this as they are constructed now. With people, many of whom are well meaning, but are operating in a system they didn't set up. The people who can control how the incentives are set up don't want to change. That's our system right now.

**AS:** Thank you. Thanks so much. That was really great.