Rick Chavez, M.D.

Expert Consultant in Pain Medicine, Addiction Medicine, & Family Medicine

EDUCATION:

- BA in psychology, Stanford University; 4 yrs
- MD, UCLA David Geffen School of Medicine, 4 yrs
- 3 yr RESIDENCY TRAINING: Harbor-UCLA/SPPH Joint Family Medicine Residency Program;

EXPERT CONSULTANT: PAIN MEDICINE, ADDICTION MEDICINE, & FAMILY MEDICINE:

- The Pain & Addiction Integrated Network, Inc./ The P.A.I.N. Institute, Inc.
- Medical Expert in Pain Medicine, Addiction Medicine, & Family Medicine

CONSULTING ADDRESS::

- The Pain & Addiction Integrated Network, Inc. (The P.A.I.N. Institute)
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BOARD CERTIFICATION:

- Board Certified, American Board of Family Medicine, (ABFM) *(Thru 2025)
- Board Certified, American Board of Pain Medicine , (ABPM) (2007 — 2017)
- Board Certified, American Board of Addiction Medicine; (ABAM)**1 (Thru 2025
- Member AMA; CMA

CURRENT EMPLOYMENT:

- Urgent Point Medical Group, Inc. Marina Del Rey, Los Angeles, CA 90066; 323-438-0483, fax 310 862-6817; Rick.Chavez@urgentpoint.com; Chief Medical Officer 10/2020-Current

- Independent Consultant to the DEA (Drug Enforcement Agency)
  U.S. Department of Justice 2010 — CURRENT CONSULTANT

PREVIOUS EXPERT IN UTILIZATION REVIEW EDUCATION

- Medical Director, Health Care Resource Group (HCRG) Utilization Review (2009-10/2020)
  Medical Director
  6571 Altura Blvd, Ste 200
  Buena Park, CA 90620
  Tel: 562-945-7224

PRIOR PRIVATE PRACTICE:

Medical Director & founder, The P.A.I.N. Institute, The Pain & Addiction Integrated Network, Inc. (2004- 09!01!2018) 510 N. Prospect Ave. Suite 307, Redondo Beach, CA 90277

PREVIOUS EMPLOYMENT:

- Health Net Medical Director Appeals and Grievances (11/2019-03/20/20)
  21281 Burbank Blvd
  Woodland Hills, CA 91367
  (Administrative, non-clinical)

- Rick Chavez, MD, Medical Director, 10/2016 — 12/2018
  Medical Director,
  Pain & Addiction Medicine Program within the Dept. of Family Medicine
  Santa Clara County Valley Medical Center & Health System
  777 E. Santa Clara St. #300
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  The Internet site below provides an overview of the PAIN AND ADDICTION PROGRAM at Santa Clara County Valley Medical Center. Description of Program:
  https ://wmcresearchgate. net/project/DEVELOPME NT-OF-SANTA-CLARA-COUNTY-SYSTEM-FOR-MANAGEMENT-OF-OPIOID-DEPENDENT-PATIENTS

- **Founder and Medical Director of the P.A.I.N. Institute (the Pain & Addiction Integrated Network, Inc. 510 N. Prospect Ave. Suite 309, Redondo Beach, CA 90710. 2004-2016.**

- **Medical Director & founder, The PAIN Institute at Little Company of Mary Hospital. 510 N. Prospect Ave. Suite #209, Redondo Beach, CA 90710. 2002-2004.**

- **Co-Founder and Vice President Alliance of Private Practice IPA 1992-2000. Acquired by Health Care Partners Medical Group, later merged into DaVita HealthCare and then acquired by Optum HealthCare.**

- **Co-Founder and Vice President Coastal Physicians Medical Group, Inc. 1994-1998**

- **Founder and CEO Harbor Family Medical Group 1982-1994**

- **Clinical Instructor, UCLA School of Medicine 12 yrs (1990 thru 2002)**

- **Clinical Instructor, USC Keck School of Medicine 3 years (1989-1992)**

- **Clinical Instructor, UC Davis School of Medicine 1 year, (1991)**

- **Family Medicine Residency Clinical faculty and instructor (1982-1998)**

- **Assistant Clinical Professor of Family Medicine, UCLA David Geffen School of Medicine, 10 yrs, (2002 thru 2012)**

- **Awards & Accolades:**
  - **Member of American Academy of Pain Management,**
  - **American Society of Addiction Medicine,**
  - **American Medical Assoc., AMA,**
  - **California Society of Addiction Medicine,**
  - **Independent Consultant to the DEA-Dept of Justice, & the Medical Board of California,**
  - **Former assistant professor of family medicine, UCLA School of Medicine (2002-2012)**

PRIOR HOSPITAL PRIVILEGES:

- **Santa Clara County Valley Medical Center and Health System 2017-12/2018**
- **Torrance Memorial Medical Center, (1993-2017)**
- **Providence/Little Company of Mary Hospital & Medical Center (1992-2017)**
- **Providencr/Little Company of Mary San Pedro & Peninisula Hospital & Medical Center (1982-2004(assist surgeon, general medicine, ICU care, Psych care, Urgent care, Pediatrics, GYN care, addiction & alcohol medical services, Physical Medicine)**
- **Bay Harbor Hospital 1990-1998**

DIVERSITY: I am a member of the Federally Recognized Susanville Rancheria Native American Tribe. There are few native American physicians practicing in the United States. The more exposure that communities and families from underserved groups see professionals from those communities in leadership, the more we will foster changes in the care of individuals from communities. As an example of this is the fact that my cousin, recently graduated from Osteopathic Medical School and now, I am proud to say, she is a hospitalist at the Navajo Nation hospital in Arizona. In addition, my own daughter (a tribal member) is a practicing lawyer in Bakersfield.

EXPERTISE:

Pain medicine evaluation, treatment, & management; addiction treatment—outpatient medical management; Inpatient Consultative services, expert/patient advocate/second opinion to verify need

for surgery or discussing all options of care available; I have been exposed to virtually every single area of medicine, orthopedics, & surgery, and as a result, this experience has given me a broad level of expertise regarding each pain generator and thus I am able to give reasonable determinations explaining to the injured individual all possible options and alternative approaches available to them, but also to give a realistic prognostic assessment so that each patient understands the "risk/benefit RATIO"; Building Trust with the injured patient promotes physical, psychological, emotional, and spiritual wellbeing as a result of treating the individual patient with caring and compassion.

"*Treatment plans are customized to meet the physical, psychological, emotional, and spiritual needs of each patient—providing care and addressing most conditions in a healing, relaxing and comfortable environment."*

MEDICAL AND CLINICAL PRACTICE:

Prior to taking the position at Santa Clara County Valley Medical Center Health System to create the Pain and Addiction Medicine program I had created "The P.A.I.N. Institute in the SouthBay of Los Angeles. It was created and envisioned as a `virtual clinic without walls'—providing the South Bay communities access to a patient-focused approach to the evaluation, diagnosis, treatment and ultimately, the long-term management of chronic pain and co-existing addiction to "doctor prescribed pain medications or other controlled drugs." The focus of treatment is to offer holistic, individualized, and compassionate medical care.

A "virtual clinic" places the physician treating pain, addictive, and other general clinical issues in the position whereby we manage the individual from a global and holistic "PRIMARY CARE" approach, essentially becoming the "HUB" of a spoked wheel , in which all specialty consultantions, Surgical assessment, diagnostic studies, hospital admissions, and ER / Urgent Care evaluations are funneled back through the spokes and into the central HUB of care to provide appropriate and comprehensive medical care. Individuals who are carefully monitored by a well-trained and knowledgeable physician who understands the medical conditions and co-morbidities involved can better address chronic disease. When I worked with HealthCare Partners in 2000 as Associate Director of Ambulatory Care, I was part of a project where I did house calls and supervised a nurse practitioner. We focused on "frequent Flyers" or patients who recurrently were readmitted for the same problems over and over and we were able to prevent "bounce back" hospitalizations and unnecessary diagnostic procedures by assisting the patient in understanding how to best approach their medical condition. However, this requires patient agreement to be successful. Unfortunately, this same problem is much more difficult to address when treating

Addictive disorders. Addiction is a medical condition and yet the current problem in our nation is that addiction treatment no longer follows evidence -based scientific treatment and, unfortunately the focus has been on AA/NA tenets for every type of addiction and this has resulted in an estimated >-80% relapse rate with some individuals cycling through rehabilitation 10-20 times unsuccessfully. . Similarly, chronic persistent pain requires identification of the most accurate working diagnosis which scientifically explains the objective pathophysiologic disorder and it is only when we understand and address the underlying pain disorders and pathophysiology can we begin to focus therapeutic approaches to the successful management and treatment of identified 'pain generators.' As an expert in Primary Care with added expertise in the fields of addiction & pain medicine, I have been successful in my approach because of my broad and holistic approach to the assessment in the management and identification of specific pain generators, source(s) of pain, and addictive disorders. By assessing the patient holistically and matching the pieces of the clinical puzzle and by focusing on the complaints and findings to verify that the current therapy is the appropriate treatment and continuously re-evaluating the differential diagnosis are we able to establish the correct approach to the management of the painful disorder. Without an accurate diagnosis, one cannot determine if the patient's existing

dependence on doctor-prescribed medications and other drugs have been appropriately prescribed and maximized. My primary focus requires a regular review of the current medication regimen, and, this allows me to assess whether the medications continue to be necessary, or whether there exists a potential problem with iatrogenic addiction.

Incredibly and unfortunately, it is a fact that in some communities in our nation, greater than 50% of diagnosed spinal and joint disorders may have been incorrectly diagnosed and, as a result, may have resulted in many patients suffering from chronic spinal disorders to have been incorrectly diagnosed resulting in inappropriate surgery and invasive interventions. Some patients may never improve physically, psychologically, or emotionally as a result of erroneous therapeutic recommendations. Ultimately, physicians are bound by the Hippocratic Oath, "first, do no harm." So, while it is true that a delay in diagnosis and treatment might not be directly harmful for many patients, any delay in diagnosis can have a staggering effect on individual patients because latrogenic-surgery and trauma are irreversible and can be very disabling because many Americans end up undergoing unnecessary invasive surgeries and procedures like spinal cord stimulation implants, and morphine infusion pumps out of desperation. Add to this problem the large number of AMERICANS who have become addicted or dependent on doctor prescribed opioid analgesics, or who have suffered co-morbidities related to inappropriate treatment, and medication side effects, and not only undergoing unnecessary surgery but they may also suffer due to worsening pain and the development of other major complications. I take immense pride in knowing that the approach I take has helped many individuals by avoiding unnecessary and dangerous surgeries and procedures. Imagine being told that you need spinal surgery and waking from anesthesia postoperatively in worse pain or finding that you are now incontinent of urine and stool because of neurologic trauma or spinal cord damage. Believe it or not, FORBES magazine estimates that more than a quarter of a million U.S. hospital patients die each year as a result of MEDICAL ERRORS, making MEDICAL ERRORS by Hospitals and physicians, the third leading cause of death, behind heart disease and cancer. Imagine, 250,000 people, or an entire mid-sized American city, may be wiped out every year due to medical errors. The majority of physicians in the United States are the best trained and educated doctors in the world, and just like we require the airline industry to maintain high standards in pilot training, so too we expect our physicians to be constantly vigilant and focusing care on scientifically proven approaches in offering excellent medical care.

ADDICTION / PAIN / RESEARCH

In an ABSTRACT / STUDY that I did with renowned spine surgeon William Dillin, M.D. and renowned BUPRENORPHINE researcher Leslie Amass, Ph.D., titled "BUPRENORPHINE DETOX OF THE OPIOID DEPENDENT PRE-OPERATIVE SPINE SURGERY CANDIDATE AS AN ALTERNATIVE TO SPINE SURGERY," we were able to prove that chronic spine "pain" is the driving force pushing patients towards pursuing spine surgery, even when the MRI and clinical history and physical exam do not match rather than addressing the underlying pain. The abstract showed that just by detoxing the patient using BUPRENORPHINE & continuing a maintenance dosing schedule, followed by a slowly Buprenorphine protocol 6-36 months only 1 of 17 patients chose to undergo surgery after only a **period of less than 2 weeks on this regimen. Interestingly, even that patient returned to my care because of surgical failure, and he was detoxed off of narcotics.**

Part of the clinical goal is to manage each individual's health by helping every patient take a step back from the precipice of potentially undergoing unnecessary invasive procedures and surgical interventions. While many surgeries and procedures may be ultimately necessary, it is often difficult for the patient to ask the necessary questions of their providers and weigh the consequences of the wrong decision and, or to fully understand whether a procedure is really necessary or the recommended approach will ultimately benefit the individual. Unfortunately, to be sure that a recommended intervention is the best option, each case must be thoroughly

reviewed to fully understand the probable outcomes which may occur. Each patient should trust their physician to become their advocate, who will answer all of their questions and issues of concern and disagree with an intervention if they are uncertain about the benefits. I make it a point to only utilizes the most highly trained team of medical specialists with world class experience and know-how when referring to a consultant. I review and analyze every case and proposed treatment made by the consultant or surgeon carefully as if the patient were my spouse, daughter, brother, or parent because as a second opinion and consultant during any pre-operative assessment and management it is my responsibility to help the individual patient and their family members thoroughly understand the potential outcomes of care. I work with the surgeon and other specialists and I will request other consultants in other specialties of medicine if I feel that other opinions are needed as part of the team if necessary. Over 40 years of clinical experience caring for both inpatients and outpatients have taught me that being assigned to a "new" hospitalist physician who doesn't know the individual's clinical history, is not ideal during the post-operative inhospital phase of care. Prior to "OBAMA-CARE" and the rise of large medical groups, your family physician or internist was the "HUB" of your medical care, managing all of the various consultants, specialists, surgeons, including the monitoring of lab results and radiologic data, ensuring that there was a "CAPTAIN" or "TEAM LEADER" looking out for their patients and always ensuring quality medical care. Patients are often unaware that the young, recently graduated physicians who is now a "hospitalist" may be making major decisions about the health of the individual but, do not have sufficient experience in treating basic conditions. Remember, every year it is estimated that a minimum of 250,000 patients die due to medical errors in U.S. hospitals. One entire American City wiped off the map EVERY SINGLE YEAR. Look it up on GOOGLE, it is a true observation, yet no one talks about it. So, consider an evaluation pre-operatively by an experienced physician before proceeding with elective surgery, after all, what have you got to lose? Most PPO insurance and Medicare will cover the evaluation. Pain and Addiction symptoms may be seen in every single specialty of medicine from Newborn to Geriatrics, Dermatology to Orthopedics, Neurosurgery to Emergency Room, Pediatrics to Psychiatry, Neurology to Rheumatology, and, in fact, are seen in every single specialty of medicine except Pathology.

Both issues must be treated "Holistically" because all disease must be addressed by physicians who understand that severe disorders cannot be compartmentalized within one specialty of care because disorders of pain and addiction must be treated holistically and globally, because misdirected treatment can ultimately affect and afflict the well-being of every individual's "Body, Mind, and Spirit."

An example of this is an individual who suffers from diabetic neuropathy. The pain alone is substantial. But, in addition, the holistic physician must address the hyperglycemia of diabetes, the nutritional and hormonal issues and deficiencies, along with other related issues that affect renal function, cardiovascular health, and gastrointestinal affects.

DR. CHAVEZ, what would you like potential patients to know about you?

"There isn't a week that goes by that I don't see a patient who underwent an unneeded surgery or intervention. Despite the fact that more than 25% of American families have to deal with pain and/or addictive medical issues amongst family members, there are few physicians who understand the holistic approach necessary to the assessment of pain, addiction, and general medical problems. Dr. Chavez understands the broad array of medical conditions and disorders that cause chronic pain, addictive disorders, and general medicine. Often patients are mis-diagnosed and/or inadequately treated, individuals who suffer from a disease process that results in severe intractable chronic pain or causes the development of an addictive disorder or, as occurs with some pain medications patients can develop both pain and addictive disorders, often resulting in a

marked deterioration of the individual's quality of life. Treating the whole person and not just the disease is where the creativity required in the art of medicine combines with the clinical science of medicine in the ultimate pursuit of reducing pain & suffering and, attaining the best quality of life possible!" Add to this the current backlash facing Americans who can no longer find a physician who can provide recommendations regarding future treatment because of the complexities involved in the care of pain and addiction, and it is apparent that we are faced with many insurmountable challenges in many communities. My review of overdose death autopsies indicates that the majority of accidental overdose deaths are not occurring in chronic pain patients, but rather occur amongst younger patients addicted to both opiates, benzodiazepines, and a host of other drugs that are poorly monitored because of illicit "polypharmacy" conditions. As a result, despite the fact that the number of prescriptions written by physicians has decreased by 33%, opioid overdose deaths have risen by 25%! Why? Because the addiction to opiates is not due to properly prescribed medications by physicians, but rather, because of illicit opioid addiction amongst our youth and the flood of cheap heroin, fentanyl, and methadone into our Country. Unless our government addresses this problem correctly, the massive amounts of money being poured into the treatment of addiction will not put a dent into this problem. 2020 saw more overdose deaths than any prior year.

WHAT DOES THE FUTURE HOLD FOR ADDICTION & PAIN MANAGEMENT?

When I was offered the ability to transfer my holistic concept to Santa Clara County Valley Medical Center department of Family Medicine I was excited by the fact that I could change the concept of one physician changing the way pain and addiction is treated to one physician teaching a cadre of physicians to bring compassion and caring back into the focus of patient care and, make a huge difference in the lives of those in our society who suffer from chronic pain and addictive disorders. The "art of medicine" will soon be lost as those of us who have been practicing for 30 years will soon be gone, and it is imperative that the younger physicians learn to thoroughly review the clinical history of their patients and emphasize a different perspective in the analysis of chronic pain and addictive disorders in their medical care and treatment of these varied and complex disorders.

We focused on holistically evaluating patients, their families, and their current use of opiate pain medications and other medicinal agents in order to identify patients who may have a predisposition to the issue of addiction or who might benefit from cutting edge treatment approaches in the area of health management.

Addressing the complex set of problems utilizing new and innovative patterns of care blending individual physiological, psychological, and emotional therapies in order to provide the complex patient who suffers with pain, addiction, and various general medical conditions with the best possible quality of life managed with care and compassion. After a thorough evaluation, the individual who suffers with a chronic pain or addictive disorder must be educated as to all of the options available in order to realistically treat and address these serious conditions. Often patients have been told that surgery or other invasive options are the only therapies available to them to treat their chronic condition, only to be abandoned, frustrated, and emotionally drained and depressed when the symptoms continue after failed surgery, and often still addicted to medications. Our approach is to prevent this cycle from beginning, and to help guide the patient on a journey of recovery from their chronic medical syndrome, addictive disorder, and reliance on potentially dangerous opioid analgesic medications.

In addition, the current epidemic of drug dependence to "doctor prescribed pain medications" and the unfortunate increased access to marijuana amongst our youth may damage our nation irreparably. While marijuana can be viewed as a medication, it is still a drug that affects people the

same way as any other drug or medication. Just as heroin is natural, as a result of the Poppy Flower, it is still deadly and killing many young Americans. All drugs, both those related to natural herbs, and those related to pharmaceutical development must be utilized with maximal care.. Natural approaches and nutritional supplementation should be encouraged when possible in the treatment of disease.

Amongst youth under the age of 25 who use marijuana regularly over many years, we have seen a doubling of the rate of schizophrenia in the 10 to 25 year age group and, in addition medical science has proven that youth also face the potential risk of a permanent drop in IQ points by up to 8% points in people who smoke marijuana on a regular basis before the age of 25. We should all be afraid of this observation. Unfortunately, refusing to become educated about the proven effects of marijuana, and sticking one's head in the sand will not change the proven scientific data. So many people are so passionate about their beliefs regarding marijuana use that they are willing to damage the next generation of individuals in order to pursue Marijuana legalization. The unwillingness for patients and society to confront these issues head-on and look at the problems without denying the facts have been one of the most disappointing parts of my practice and career as a primary care physician who treats addiction and pain . Few individuals understand that Marijuana is a poor pain killer, and it's psychiatric effects on the brain in the under age 25 group are extremely dangerous. I have had so many youth deny this fact and end up suffering with psychosis, chronic anxiety, insomnia, paranoia, and depression, even though when they were using marijuana they claimed that it was the best therapy for these conditions. Marijuana is still addictive, and just because it is "naturally grown" does not mean that it can be viewed as a safe drug. Wanting to believe a false promise at the expense of the ultimate outcome because one chooses not to believe it is dangerous and may affect a whole generation of youth in our nation.

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CAREER MILESTONE

The current inpatient treatment of addiction is costly and unnecessary in 90% of all addictions. Medically Assisted Treatment as an outpatient is a newer and clinically effective approach which, when properly monitored with the physician becoming the patient's "personal guide & advocate," encouraging the physician, patient and their families to work together and address the many complex and difficult issues related to the diagnosis and treatment of chronic pain, addictive disorders, and medical conditions. Additionally, amongst these concerns, the growing problems associated with the long-term use of "doctor-prescribed opioid pain medications" is a growing

challenge. Solving the revolving door of readmissions from one drug treatment program to the next is the challenge that our nation faces. Far too many individuals remain addicted and readmitted to sober living programs to solve lack of housing and support. Psychiatric illness becomes a chronic lifestyle with individuals staying addicted in order to be taken care of by the community and society. Our current system of care is imploding with more addicted individuals and psychiatrically unstable individuals choosing to remain in treatment as a lifestyle.

PAIN, ADDICTION, and other medical conditions are insidious problems that affect greater than one in four Americans (120 million people) and this issue crosses virtually every single specialty of medicine. Despite the current epidemic of illnesses related to these destructive disorders, the number of physicians trained to adequately deal with these essentially "PRIMARY CARE" medical conditions is woefully inadequate and, as a result, our country is now dealing with an epidemic of up to 120 opioid overdose deaths every single day. I am one of a handful of American physicians who has been triple boarded in Pain Medicine, Addiction Medicine, and Family Medicine practicing in the United States today.

Providing compassionate & individualized care and treatment in a healing outpatient environment must be customized to meet the physical, psychological, and emotional needs of each unique patient. Both Pain & Addiction treatment should be easily available as an outpatient program addressing chronic illness in the same manner as we treat diabetes, heart disease, osteoarthritis, and hypertension and, not as an episodic therapy which is just a revolving door to more pain, suffering and, if addicted, likely relapse. The treatment of addiction is a long-term problem that may require years of follow-up and clinical care using "Medically Assisted Therapy." Just as diabetes, heart disease, renal disease, thyroid disease, arthritis, lupus and, in fact, all diseases are chronic, so is addiction management. The goal is always to create "quality of life and maintain sobriety." Every single patient, who is properly treated for addiction can safely be handled as an outpatient and properly treated with Medication Assisted Therapy. Knowledgeable medication management can treat opioid, alcohol, and stimulant addiction very well. Allowing admission and re-admission without demanding responsible interaction is futile.

RECOMMENDATIONS:

If one finds themselves trying to desperately break out of the cycle of treatment of "doctor-prescribed opiate medications" and desires to finally break the cycle, there is hope but only if we follow Scientifically proven models of treatment and only if we insist that addicts enter a milieu that constructively rebuilds self-esteem, promotes individual responsibility, and heals by teaching compassion and empathy. Use of MAT (Medication Assisted Therapy) FOCUSES on STOPPING the BRAIN FROM CRAVING DRUGS! Inpatient rehab programs have to be used efficiently at the onset of freeing oneself of the shackles of drug dependence. Chronic pain treated with progressively increasing ineffective opioid pain medications, often means that the "DOCTOR PRESCRIBED OPIATE MEDICATIONS" are no longer improving the situation. Breaking the pain cycle of persistent discomfort, misery, and suffering is easier to do than most patients and doctors realize. Even the medical community is not aware of how safe and effective the in-office outpatient treatment process can be.

Most individuals are shocked to discover that the chronic pain that started them down the road of dependence on "DOCTOR PRESCRIBED OPIATES" may often dissipate dramatically when the cycle of OPIATE pain medications is no longer part of their treatment. Hard to believe? But true none-the-less! This is called "Opioid induced Hyperalgesia."

PHILOSOPHY:

Pain and Addiction are primary care disorders. Many physicians are not trained or experienced to address these two areas of medicine. Successful diagnosis and treatment requires that the primary care physician understand the patient from a holistic perspective. There are many factors which play a role in a patient's illness. Specialists will focus on the primary addictive or pain

disorder but ignore other treatable factors which, in turn, often reduces the likelihood of successful therapy and maintenance of sobriety. For instance, hormonal disorders, diabetes, underlying rheumatologic disorders, psychiatric disorders, cardiovascular disorders, etc. cannot be managed separately because each identifiable disorder may affect the "whole" patient substantially, and this, in turn, affects successful treatment of the "whole" individual. Determining the true source and cause of pain is the first step in diagnosing chronic pain, because only when we identify the actual pain generator(s) or SOURCE(s) of pain can we accurately evaluate, diagnose, and treat the chronic painful disorder. Identifying the actual source of pain and discomfort is not an easy undertaking because we know that the majority of painful disorders are a complex merging of multiple anatomical, physiological, emotional, and psychological factors which are the determinants that preceded the original progenitors of the underlying painful disorders. Every painful diagnosis may actually represent 2-3 or more different sources of pain, and treatment must address each source of pain directly both separately and in unison to successfully reduce the individual's disabling condition. Imagine undergoing a surgery or a procedure which does not solve the painful disorder. Hundreds of thousands of patients undergo unwarranted surgeries and invasive procedures every year and, in fact, it is estimated that over 250,000 people die every single year as a result of medical mis-diagnosis, errors in treatment, and inadequate evaluation. No patient should ever accept a diagnosis without having gotten a second or third opinion. Just because an MRI or X-ray points out an abnormality does not mean that the observed finding is the actual reason for the patient's painful condition. If the clinical findings, history, and symptoms do not match the diagnostic tests than one should not assume that the "picture seen on CT, MRI, or X-Ray are the "REAL" source and cause of chronic pain. >50% of all spinal surgeries and interventions are unnecessary, so common sense would indicate that too many medical approaches are dangerous and inappropriate. Our philosophy of care must be based on the Hippocratic Oath, "Doctor, first do no harm!"

TREATING ADDICTION:

Addiction is America's cancer and it is eating away the heart and soul of our nation. Addiction to opiates, methamphetamine, cocaine, alcohol, sedatives, food, tobacco, and sleeping pills, and now marijuana, impacts every single family in the United States and, like Covid-19, continues at epidemic proportions. The fact is that 80% of all illicit drugs in the entire world come to the United States, yet we represent only 4% of the world's population. With the recent legalization of Marijuana in California, the 6th largest economy in the world, and now legal in 24 states, we will soon be faced with dealing with a drug that may damage our young people. It is a fact that young people who smoke marijuana regularly under the age of 25, increase their risk of developing schizophrenia by 100% or a doubling of the risk. In addition, the effects of marijuana can cause chronic anxiety, depression, insomnia, attention deficit disorder, paranoia, and many other psychiatric conditions. In addition, regular daily marijuana use under the age of 25 may result in a loss of up to 8 IQ points PERMANENTLY. Imagine, Marijuana use can irreversibly reduce a young person's IQ permanently by 8 points! In Colorado, where Marijuana has been legal for several years, there has been a doubling of DUI's, accidents, motor vehicle deaths, work related injuries, and many other problems due to the legalization of Marijuana. Contrary to popular beliefs, Marijuana is not viewed as medicinal agent because of its psychological effects and difficulty controlling its use as a medication. While there is study about CBDs and other components of Marijuana, Marijuana, like all drugs, whether natural or synthetic have a limited value in treating disease. It is very difficult for most individuals to understand the difference and that is why people argue so passionately about Marijuana's usefulness but, fail to see the real and very negative issues associated with Marijuana legalization. Medical marijuana is useful only in treating some mild pain conditions, seizures, and a few other disorders, like glaucoma. But its usefulness for insomnia, anxiety, and depression, are similar to the effects of alcohol. Long-term use is dangerous and Marijuana addiction is a very REAL problems, especially amongst our youth. Most people do not realize that chronic use of Marijuana increases the risk of psychosis and schizophrenia by 100%. I have seen young people

develop schizophrenia and other psychiatric disorders after using Marijuana long-term. Marijuana is not a substitute for opiates when treating chronic pain. CBDs will become useful as science localizes which receptors are benefitted, but THC is of little medicinal use in severe pain and since it is addictive may create problems much like has occurred with Alcohol use disorder. Unfortunately, Americans have a need to believe in the idea of Marijuana being a useful medication and ignore the dangers that it may pose. Marijuana legalization should have been focused more on decriminalization because there are so many indications that chronic THC use can result in lower IQ, memory loss, learning dysfunction, and is twice as likely to be used in psychiatrically ill individuals suffering from chronic anxiety, depression, psychosis, schizophrenia, and addiction. Our country may never be the same as a result. Liberalization of chronic THC use for recreational use.

40 YEARS OF CLINICAL EXPERIENCE

I practiced primary care medicine for the first 20 years of my practice and, in addition I added my board certification in Addiction medicine in 2004 and Pain Medicine in 2007. Few primary care physicians have had the breadth in medicine that I have experienced over 39 years of clinical practice. I am quite proud of my level of medical expertise and when I speak to a patient about a hip replacement or a hysterectomy, I have actually first assisted in literally hundreds of hip, lumbar spine, and knee replacements and I actually performed 37 C-sections as the primary surgeon at Harbor UCLA when I was a 3rd year Family Medicine Resident when, during my OB elective one of the OB residents left the program and I was asked to take over for the 3rd year OB resident. I have treated every kind of acute and chronic disorder during my career and I know when someone is in need of immediate resolution of their pain, addiction, or other clinical problems, so I make it my priority to be there to comfort and care for my patients holistically, often saving the patient a trip to urgent care or the emergency room. Elderly patients, especially those who suffer with dementia need medical expertise and relief of their pain and suffering urgently. Their quality of life is of utmost importance, so preventing an unneeded emergency room trip or handling their urgent situation rapidly and accurately can mean so much to the suffering geriatric patient who are often mentally & emotionally challenged.

Primary care medicine: newborn care, well-child-care, geriatric care, internal medicine, gynecology, occupational medicine, orthopedics, neurology, cardiology, urgent care, behavioral disorders, chemical dependency and addiction management, along with chronic pain management and pain related interventions.

Experience with Practice Partner Electronic Medical Record System, HealthFusion EMR, Amazing Charts EMR, EPIC, extensive experience with Dragon Speak Medical Auto-Dictation System, Meditech, Versyss, and PAX radiology system.

OUTPATIENT MEDICINE

After 39 years of clinical experience in medical practice and experience with teaching young doctors and medical students in training there is very little that I have not experienced or seen. Procedures include: minor trauma and laceration care, excisional biopsies of skin neoplasms, Norplant implantation, sigmoidoscopies, applying casts and splints for uncomplicated fractures and ligamentous injuries, trigger point and joint injections of the hip, knee, wrist, fingers, metacarpel, ankle, elbow, shoulder, cervical spine, scapula, deltoid, Acromio-Clavicular joint, TMJ, toes, groin, facet blocks, culdocentesis, lumbar puncture, plantar wart therapy, Bursa, ganglion and sebaceous cyst removal and aspiration, abscess Incision and Drainage, Ingrown toenail removal, ear lavage, bladder cath, corneal abrasion recognition and treatment, nasopharyngeal cautery of bleeding, cryotherapy, nerve blocks include greater and lesser occipital nerves,

Femoral Nerve, Abdominal Wall Rectus Abdominis Nerves, Costochondral, and many more Nerves. Experience with botox injections, Tendon and bursa injections, Schiotz tonometry, venous cutdowns, neonatal circumcision, Synvisc injection to the knee, Blind thoracic, lumbar, and sacral Facet Blocks, Dermabrasion, and indirect laryngoscopy.

INPATIENT CLINICAL EXPERIENCE

Unrestricted Admission privileges to all medical and surgical floors, telemetry, nursery, intensive care units- Intensive care management, Surgical Intensive Care management, Inpatient Psychiatric care, inpatient addiction treatment, Pediatrics, Psychiatry, Chemical Dependency Units, Step Down Units, SNF, and Rehabilitation at Torrance Memorial Medical Center and Little Company of Mary Medical Center. The first 20 years of my clinical experience involved extensive inpatient experience. The last 20 years have focused on outpatient care with the advent of Hospitalists. My experience with hospitalist care has been that there is still a loss of communication between the hospitalist and the primary care physician. Unless hospitalists aggressively monitor the patient through discharge and coordinate care with the specialists and primary care doctors involved complications may occur.

As the Medical Director of Pain Medicine at Santa Clara Valley County Medical Center I designed and created the Pain Medicine program. I was contracted to see all of the county valley IPA patients (400,000 patients). Between February 2017 and December 2018 I saw all referrals for chronic pain evaluation, assessment, that treatment. Prior to the pain medicine program, all county patients were referred to Stanford and UCSF. But during the interval above, not one referral was sent to Stanford because the chronic pain issues were handled by our program. In addition, I assessed many cases for proper utilization review to make sure that the primary care physicians were addressing the issues appropriately. In addition, I changed the approach by focusing on accurately diagnosing the "pain generators," listening to the patient's questions and complaints, and intervening in efforts to break the cycle of recurrent pain.

PSYCHOLOGICAL TRAINING:

Dr. Chavez received his BA in Psychology from Stanford University. He knew that training in the areas of Psychological Disorders would be important in whatever area of medicine that he chose to specialize in. Combining his training in Psychiatry and Family Medicine at UCLA and his BA degree in Psychology from Stanford University has been essential in his management of patients suffering with Addictive disorders and dual diagnosis dual diagnosis disorders in general medicine.

FIRST SURGICAL ASSISTING EXPERIENCE.

I provide this List because physicians who have participated is surgical assisting are better able to explain the surgery to patients, understand Utilization, make realistic recommendations for suggesting a particular procedure, are effective in teaching medical students and residents, and are better able to understand the pathophysiology of disease.

I started in family medicine out of residency in San Pedro and at that time I had a hospital census of 5-14 patients in the hospital daily including pediatrics, ICU, Drug Rehab, Stroke Rehab, and med-surg and as a result I have first assisted in thousands of surgeries which has given me experience assisting surgeons doing hysterectomies, mastectomies, colon cancer and diverticular resections, lumbar laminectomies, head and neck cancer resections, hip/knee/shoulder joint replacements, thyroidectomies, roux en Y procedures, laparoscopic cholecystectomies and exploration, and every other procedure seen in medicine during my time in private practice. Including major trauma and gunshot wounds. By my having actually first-assisted surgeons in many different

procedures, it has given me a unique perspective, level of knowledge, and additional confidence to honestly counsel and reassure patients who may have to undergo these procedures, and better understand all of the potential complications that may occur, along with the pre and post op care medical and post-surgical care that will be required. The same is true in treating painful disorders.

My Extensive surgical assisting experience over 30 years as the First Assistant in the following procedures: Appendectomy, Open Cholecystectomy, Herniorraphy, Total Abdominal and Partial Vaginal Hysterectomy and Oophorectomy, Pelvic Laparoscopy, Radical Prostatectomy, Total and partial Mastectomy, Partial Colon and Small Intestine Resections, Breast Suspension, Plastic Surgery Breast Implants, Lumbar Laminectomy and disk decompression, Abdominoplasty, Radical Neck Resection, Partial Gastrectomies, Vagotomy and Pyloroplasty, Hiatel Hernia Repair, Roux-en Y Bypass, Aortic Aneurysm Resection, Plastic surgery rhinoplasty, Aorto-Bifem Bypass, Splenectomy, Nephrectomy, Bladder Suspension and Repair, Adrenal Gland Resection, Thyroidectomy, Intestinal Resection, Colectomy, Parathyroidectomy, Radical Neck Dissection, Elbow/Shoulder/Wrist Fracture Repair and Nerve Decompression, Arterio-Venous Shunt creation for dialysis, Total Knee replacement and arthroplasty, Shoulder and Hip Replacement and Arthoplasty, AC Joint Repair, Knee Arthroscopy, Lumbar Laminectomy and Diskectomy, Bunion and Hammertoe Repair, AV Shunt Creation, Vein stripping, Hemorroidectomy, Extremity Amputation, Carotid Artery Endarterectomy, Cesarean Section, Laparoscopic and open Cholecystectomy, Tubal Ligation, Penile Implants, Orchiectomy, Skin Grafting, Acute Trauma Surgery -Repair of stabbings, Bullet and buckshot removal, and Vasectomy, Newborn circumcision. Wound and Burn care, Decubitus Ulcer Debridement, Melanoma Resection, short arm and walking cast placement.

PRIOR OBSTETRICAL EXPERIENCE:

Previous Obstetrical experience, during my residency, includes over 250+ normal vaginal deliveries and experience with use of vacuum and forceps, and 4th degree rectal episiotomy tears. Last delivery 1982. Pre-natal care and outpatient visits. Also, 37 cesarean sections as the primary OB Resident while serving as the supervising resident on OB for 3 months at Harbor General/UCLA Medical Center in the 3rd year of my residency to replace an ill OB resident. In addition, I have served as Clinical Faculty at various times with the UCLA School of Medicine, USC School of Medicine and UC Davis School of Medicine. *Rick Chavez, M.D.*
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