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Routing

Treating Doctors as Drug Dealers The DEA's War on Prescription Painkillers

by Ronald T. Libby

Executive Summary

The medical field of treating chronic pain is still in its infancy. It was only in the late 1980s that leading physicians trained in treating the chronic pain of terminally ill cancer patients began to recommend that the “opioid therapy” (treatment involving narcotics related to opium) used on their patients also be used for patients suffering from nonterminal conditions. The new therapies proved successful, and prescription pain medications saw a huge leap in sales throughout the 1990s. But opioid therapy has always been controversial. The habit-forming nature of some prescription pain medications made many physicians, medical boards, and law enforcement officials wary of their use in treating acute pain in nonterminal patients. Consequently, many physicians and pain specialists have shied away from opioid treatment, causing millions of Americans to suffer from chronic pain even as therapies were available to treat it.

The problem was exacerbated when the media began reporting that the popular narcotic

pain medication OxyContin was finding its way to the black market for illicit drugs, resulting in an outbreak of related crime, overdoses, and deaths. Though many of those reports proved to be exaggerated or unfounded, critics in Congress and the Department of Justice scolded the U.S. Drug Enforcement Administration for the alleged pervasiveness of OxyContin abuse.

The DEA responded with an aggressive plan to eradicate the illegal use or “diversion” of OxyContin. The plan uses familiar law enforcement methods from the War on Drugs, such as aggressive undercover investigation, asset forfeiture, and informers. The DEA’s painkiller campaign has cast a chill over the doctor-patient candor necessary for successful treatment. It has resulted in the pursuit and prosecution of well-meaning doctors. It has also scared many doctors out of pain management altogether, and likely persuaded others not to enter it, thus worsening the already widespread problem of undertreated or untreated chronic pain.

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Introduction

Untreated pain is a serious problem in the United States. Given the difficulties in measuring a condition that's untreated, estimates vary, but most experts agree that tens of millions of Americans suffer from undertreated or untreated pain. The Society for Neuroscience, the largest organization of brain researchers, estimates that 100 million Americans suffer from chronic pain.¹ The American Pain Foundation, a professional organization of pain specialists, puts the number at 75 million—50 million from serious chronic pain (pain lasting six months or more), and an additional 25 million from acute pain caused by accidents, surgeries, and injuries. The societal costs associated with untreated and undertreated pain are substantial. In addition to the obvious cost of needless suffering, damages include broken marriages, alcoholism and family violence, absenteeism and job loss, depression, and suicide.² The American Pain Society, another professional group, estimates that in 1995 untreated pain cost American business more than \$100 billion in medical expenses, lost wages, and other costs, including 50 million workdays.³ A 2003 article in the *Journal of the American Medical Association* puts the economic impact of common ailments alone—such as arthritis, back pain, and headache—at \$61.2 billion per year.⁴

Chronic pain can be brought on by a wide range of illnesses, including cancer, lower back disorders, rheumatoid arthritis, shingles, post-surgical pain, fibromyalgia, sickle cell anemia, diabetes, HIV/AIDS, migraine and cluster headaches, pain from broken bones, sports injuries, and other trauma.

According to one 1999 survey, just one in four pain patients received treatment adequate to alleviate suffering.⁵ Another study of children who died from cancer at two Boston hospitals between 1990 and 1997 found that almost 90 percent of them had “substantial suffering in the last month, and attempts to control their symptoms were often unsuccessful.”⁶ In a formal policy statement issued in 1999, the California medical board found “systematic undertreatment of chronic pain,”

which it attributed to “low priority of pain management in our health care system, incomplete integration of current knowledge into medical education and clinical practice, lack of knowledge among consumers about pain management, exaggerated fears of opioid side effects and addiction, and fear of legal consequences when controlled substances are used.”⁷ The American Medical Association stated in a 1997 news release that 40 million Americans suffer from serious headache pain each year, 36 million from backaches, 24 million from muscle pains, and 20 million from neck pain. An additional 13 million suffer from intense, intractable, unrelenting pain not related to cancer. Most of those patients, the AMA warned, receive inadequate care because of barriers to pain treatment.⁸ A 2004 survey of the medical literature published in the *Annals of Health Law* found documented widespread undertreatment of pain among the terminally ill, cancer patients, nursing home residents, the elderly, and chronic pain patients, as well as in emergency rooms, postoperative units, and intensive care units.⁹

One reason chronic pain remains undertreated is that there are few doctors who specialize in the field. Dr. J. David Haddox, the vice president of health affairs at Purdue Pharma L.D., the manufacturer of long-acting opioid medications OxyContin and MSContin, estimates that between four or five thousand doctors who specialize in pain management treat the 30 million chronic pain patients who seek treatment in the United States¹⁰—about one doctor for every 6,000 patients. In Florida, just 1 percent or 574 of the state's 56,926 doctors prescribed the vast majority of narcotic drugs paid for by Medicaid in 2003.¹¹

The shortage of pain doctors can in part be explained by the relatively new, dynamic nature of pain medicine as well as society's aversion to narcotics. It wasn't until the 1980s that physicians who specialized in opioid treatment for pain associated with terminal cancer began to advocate the same treatment for nonterminal chronic pain patients.¹² The fact that the field is so novel has not only prevented physicians from seeking it out as a spe-

cialty, it initially caused a great deal of debate within the medical community. Though many physicians now approve of opioid therapy for nonterminal chronic pain, there was some initial resistance, from both inside and outside the medical community. “There’s still a fear of opiates,” University of California at San Francisco pain expert Allan Basbaum told the *San Francisco Chronicle*, “The word ‘morphine’ scares the hell out of people. To many patients, morphine either means death or addiction.”¹³ In an article for *Ramifications*, a newsletter for pain specialists, Dr. Karsten F. Konerding of the Richmond Academy of Medicine compares the contemporary practice of pain medicine with the infant field of radiology at the turn of the 19th century. One London newspaper at the time, Konerding notes, called radiographs of bones and organs “a revolting indecency.”¹⁴

In addition to a reluctance to enter an emerging and not altogether accepted field, physicians specializing in pain medicine can also find themselves caught in a damned-if-you-do, damned-if-you-don’t conundrum with some patients. This study deals primarily with the government’s efforts to minimize the overprescribing of painkillers, but several physicians have also been sued for *underprescribing*, including one California physician who was successfully sued in 2001 for \$1.5 million.¹⁵

But a significant reason pain is undertreated—and increasingly so—is the government’s decision to prosecute pain doctors who it says overprescribe prescription narcotics. According to the federal government, a small group of doctors is prescribing hundreds of millions of dollars of such drugs, many of which are finding their way to the black market, contributing to an epidemic of addiction, crime, and death.¹⁶ Over the last several years, federal and state prosecutors have prosecuted licensed physicians for drug distribution, fraud, manslaughter, and even murder for the deaths of people who misused and/or overdosed on prescription painkillers. If convicted, those physicians are subject to the same mandatory drug sentencing guidelines designed to punish conventional

drug dealers. Those highly publicized indictments and prosecutions have frightened many physicians out of the field of pain management, leaving only a few thousand doctors in the country who are still willing to risk prosecution and ruin in order to treat patients suffering from severe chronic pain.¹⁷ One 1991 study in Wisconsin, for example, found that over half the doctors surveyed knowingly undertreated pain in their patients out of fear of retaliation from regulators.¹⁸ Another 2001 study of California doctors found that 40 percent of primary care physicians said fear of investigation affected how they treated chronic pain.¹⁹ In states where state regulatory bodies aggressively monitor physicians’ narcotics-prescribing habits, there is even more reticence among doctors to adequately treat pain.²⁰

“The medical ambiguity is being turned into allegations of criminal behavior,” Dr. Russell K. Portenoy told the *Washington Post*. Portenoy is a pain specialist at Beth Israel Medical Center in New York, and is considered one of the fathers of opioid pain therapy. “We have to draw a line in the sand here, or else the treatment will be lost, and millions of patients will suffer.”²¹

A Brief History of Painkillers and the Law

From the introduction of heroin from the 1880s until about 1920, narcotics were unregulated and widely available in the United States.²² Drug addiction was largely accidental, due to the public’s ignorance about the habit-forming properties of morphine, the most popular highly addictive drug of the era. Though widely used for medical operations and convalescence, morphine was also used in everyday potions and elixirs. The drug was commonly regarded as a universal panacea, used to treat as many as 54 diseases, including insanity, diarrhea, dysentery, menstrual and menopausal pain, and nymphomania.²³ Opiates were as readily available in drug stores and grocery stores as aspirin, serving many of the same functions that alcohol, tranquilizers, and antidepressants do

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today. That perception changed during the progressive era of the early 20th century, when the government criminalized the common use of opium.²⁴

The first federal law to criminalize the non-medical use of drugs was the Harrison Act of 1914, which outlawed the nonmedical use of opium, morphine, and cocaine.²⁵ The law was supported by advocates of Prohibition.²⁶

Section 2 of the Harrison Act made it illegal for any physician or druggist to prescribe narcotics to an addict, effectively turning a quarter-million drug-addicted citizens and their doctors into criminals.²⁷ By 1916, 124,000 physicians; 47,000 druggists; 37,000 dentists; 11,000 veterinarians; and 1,600 manufacturers, wholesalers, and importers had registered with the Treasury Department, as required by the Harrison Act.²⁸ Almost as soon as they had registered, hundreds of doctors were arrested and prosecuted for prescribing narcotics to addicted patients.²⁹ During the first 14 years of the act, U.S. attorneys prosecuted more than 77,000 people, mostly medical professionals, for violating the act.³⁰ Between 1914 and 1938, about 25,000 doctors were arrested under the terms of the Harrison Act for giving narcotic prescriptions to addicts.³¹ Many were eventually put on trial, and most lost their reputations, careers, and/or life savings. By 1928, the average sentence for violation of the Harrison Act was one year and 10 months in prison.³² More than 19 percent of all federal prisoners were incarcerated for narcotics offenses.³³ Clinics closed down, and physicians had little choice but to abandon thousands of addicted patients. A black market for narcotics soon arose.

With the endorsement of powerful public figures such as Secretary of State William Jennings Bryan, Captain Richmond Pearson Hobson (the “Great Destroyer” of alcohol and narcotics addiction and the Anti-Saloon League’s highest-paid publicist), and Harry J. Anslinger (the first commissioner of narcotics and former assistant commissioner of Prohibition), the U.S. government inaugurated an aggressive, unprecedented pursuit of physicians and their addicted patients.³⁴

The Harrison Narcotics Act was repealed in 1970, but was replaced by the Drug Abuse Prevention and Control Act.³⁵ DAPCA, along with the 1975 Supreme Court ruling in the case *U.S. v. Moore*, reaffirmed the legality of the Harrison Act’s criminalization of doctors who treat addicts by prescribing controlled pharmaceuticals.³⁶ In *Moore*, the Supreme Court confirmed that physicians who are licensed by the Drug Enforcement Agency to prescribe narcotics under Title II of DAPCA (called the federal Controlled Substances Act) “can be prosecuted when their activities fall outside the usual course of professional practice.”³⁷ A doctor could be criminally charged with unlawfully prescribing (or “diverting”) highly addictive narcotic drugs that the DEA classifies as Schedule II “controlled substances.” Even though it was passed during a period of general drug tolerance, DAPCA would prove to be a potent weapon in later years as the War on Drugs intensified.

A New Mission for the DEA

As the federal government’s chief drug law enforcement agency since 1973, the DEA’s mission has been to “bring to the criminal and civil justice system substances destined for illicit traffic in the U.S.”³⁸ Until the 1990s, the DEA focused its resources primarily on illegal black market drugs, such as heroin, cocaine, crack cocaine, ecstasy, and marijuana, in urban areas.

But in 1999 the DEA came under heavy criticism from Congress on the grounds that there was no “measurable proof” that it had reduced the illegal drug supply in the country.³⁹ In 2000 and 2001 the Department of Justice, which administers the DEA, gave the agency a highly critical rebuke, and asserted that the Drug Enforcement Agency’s goals were not consistent with the president’s federal National Drug Control Strategy.⁴⁰ The DEA would need to find a new front for the War on Drugs, one that could produce tangible, measurable results.

The Controlled Substances Act empowered the DEA to regulate all pharmaceutical drugs. In 2002 Glen A. Fine, the inspector general of the Department of Justice, asked why the DEA wasn't doing more to combat prescription drug abuse when it was "a problem equal to cocaine."⁴¹ Fine claimed that, while 4.1 million Americans used cocaine in 2001, 6.4 million illegally used prescription narcotic painkillers that same year. He also claimed that the illicit use of pain medication accounted for 30 percent of all emergency room drug-related deaths and injuries.

In 2001 the DEA had already announced a major new anti-drug campaign: the OxyContin Action Plan.⁴² The agency underscored the threat of prescription drug abuse by asserting that the number of people who "abuse controlled pharmaceuticals each year equals the number who abuse cocaine—2 to 4 percent of the U.S. population."⁴³ The agency also claimed that prescription drugs increased the number of overdose deaths by 25 percent and accounted for 20 percent of all emergency room visits for drug overdoses.⁴⁴ Criticism from Congress and the Department of Justice the following year reaffirmed the agency's determination to crack down on prescription drugs. The OxyContin plan would elevate a legal, prescription drug to the status of cocaine and other Schedule II substances. That shift put pain doctors in the DEA's crosshairs, as susceptible to investigation as conventional drug dealers. In September of 2003, at the 69-count indictment of Virginia doctor William Hurwitz, U.S. Attorney Mark Lytle claimed that the physician was complicit in the deaths of three patients, and compared William Hurwitz to a "street-corner crack dealer." Lytle further argued that Dr. Hurwitz posed such a threat to the community that he should be denied bail.⁴⁵

The OxyContin Action Plan bore a remarkable resemblance to the Harrison Act in that it enabled the federal government to prosecute physicians who prescribed an otherwise legal narcotic drug, due to unfounded fears of a "dope menace" sweeping the country. DEA commissioner Asa Hutchinson described the nonmedical use of OxyContin as a deadly new

drug epidemic beginning in Appalachia and spreading to the East Coast and Midwest, infecting suburban, urban, and rural neighborhoods across the country:

In the past, Americans viewed drug abuse and addiction as an overwhelmingly urban problem. As the drug problem escalated, drugs began to stream into rural neighborhoods throughout small town America. Residents began to feel the impact of drugs such as marijuana, cocaine, methamphetamine, MDMA, heroin, and OxyContin, which entered their towns at an alarming rate. Violence associated with drug trafficking also became part of the landscape in small cities and rural areas.⁴⁶

This was the first time that the DEA had grouped a legal, prescription drug with illicit drugs, though it wouldn't be the last. Government officials like Hutchinson have gone on to make frequent public statements putting OxyContin in close rhetorical proximity to cocaine, heroin, and other drugs with a proven record for generating public fear. During congressional testimony in April 2002, Hutchinson explained the necessity for renewed vigilance in the War on Drugs, and why the new front against prescription painkillers was necessary. He announced that the DEA would reallocate many of its resources from illegal drugs in urban areas to illicit prescription drugs in rural areas in order to address the emerging opioid threat. Hutchinson said that the DEA would work with local and state law enforcement agencies in the effort, and would use its Asset Forfeiture Fund to help state and local officials finance the new initiative.⁴⁷

The DEA's public relations effort linking a pain medication like OxyContin to cocaine, heroin, and other prohibited substances was a marked departure from its traditional mission. In fact, the DEA had created a new mission for itself—combating the illegal diversion of otherwise legal medication. Where the conventional drug war targeted black

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markets and the unknown, hard-to-quantify entities that come with them, the new mission offered in practicing physicians a pool of registered, licensed, cooperative targets who kept records, paid taxes, and filled out a variety of forms.

Justifying the OxyContin Campaign

In an effort to justify its national campaign against OxyContin, the DEA contacted 775 medical examiners from the National Association of Medical Examiners in 2001 and instructed them to report “OxyContin-related deaths” for 2000 and 2001.⁴⁸ On the basis of those reports, the DEA subsequently announced 464 “OxyContin-related deaths” over those two years.⁴⁹

But the conclusions the DEA drew from this data are significantly flawed.

First, the DEA’s criteria for “OxyContin-related deaths” are problematic. There are 58 pain relief drugs that contain oxycodone. OxyContin is simply one of three single-entity, long-acting, oxycodone drugs. There are numerous other less potent, short-acting, oxycodone drugs, such as Percocet, Percodan, and Roxicet that also contain nonnarcotic pain relievers such as aspirin or Tylenol. OxyContin is Purdue Pharma’s brand name drug. It’s popular because it provides long-acting relief from pain for up to 12 hours, which enables pain sufferers to sleep through the night. Since there is no chemical test to distinguish OxyContin from the other oxycodone drugs, it is difficult to see how the DEA could definitively assert that a death attributable to oxycodone is due to OxyContin and not other short-acting oxycodone drugs. Nevertheless, the DEA counts as an “OxyContin-related death” any death in which oxycodone is detected without the presence of aspirin or Tylenol.⁵⁰

Second, if an OxyContin tablet is found in the gastrointestinal tract of a deceased person, the DEA labels it an “OxyContin-verified death,” regardless of other circumstances. Even more problematic, if investigators find

OxyContin pills or prescriptions at a crime scene, or a family member or witness merely mentions the presence of OxyContin, the death is also confirmed as “OxyContin-verified.”⁵¹ Obviously the mere presence of OxyContin in the system of the deceased, or the mere mention of the drug by friends or family members is far from verification that OxyContin—either alone or in conjunction with other factors—actually caused a premature death.

Third, overdose victims tend to have multiple drugs in their bodies.⁵² Approximately 40 percent of the autopsy reports of OxyContin-related deaths showed the presence of Valium-like drugs. Another 40 percent contained a second opiate such as Vicodan, Lortab, or Lorcet, in addition to oxycodone. Thirty percent showed an antidepressant such as Prozac, 15 percent showed cocaine, and 14 percent indicated the presence of over-the-counter antihistamines or cold medications. Deaths like those could be the result of any of the drugs present, drugs working in combination, or one or more drugs plus the effects of other conditions, such as illness or disease. Indeed, the March 2003 issue of the *Journal of Analytical Toxicology* found that of the 919 deaths related to oxycodone in 23 states over a three-year period, only 12 showed confirmed evidence of the presence of oxycodone alone in the system of the deceased.⁵³ About 70 percent of the deaths were due to “multiple drug poisoning” of other oxycodone-containing drugs in combination with Valium-type tranquilizers, alcohol, cocaine, marijuana, and/or other narcotics and anti-depressants.⁵⁴ That is strong evidence that many of the deaths attributed to OxyContin by government officials are not the result of unknowing pain patients who grew addicted and overdosed, but of habitual drug users who may have used the drug with any number of other substances, any one of which could have contributed to overdose and death.

In the absence of opioids like OxyContin, habitual users will, in all likelihood, merely switch to more available drugs. However, pain patients who rely on the drug for relief

don't have that option. They're far more likely to suffer from the scarcity caused by the DEA's crackdown than are the common drug abusers the agency claims it is targeting.

A final problem with the DEA's claims of an OxyContin epidemic is the agency's inflated estimate of risk of death. In 2000 physicians wrote 7.1 million prescriptions for oxycodone products without aspirin or Tylenol, 5.8 million of them for OxyContin.⁵⁵ According to the DEA's own autopsy data, there were 146 "OxyContin-verified deaths" that year, and 318 "OxyContin-likely deaths," for a total of 464 "OxyContin-related deaths."⁵⁶ That amounts to a risk of just 0.00008 percent, or eight deaths per 100,000 OxyContin prescriptions—2.5 "verified," and 5.5 "likely-related." Even *those* figures are calculated only after taking the DEA's troubling conclusions about causation at face value.

By contrast, approximately 16,500 people die each year from gastrointestinal bleeding associated with nonsteroidal anti-inflammatory drugs (NSAIDs) like aspirin or ibuprofen.⁵⁷ NSAIDs aren't as effective as opioids at treating severe, chronic pain. Both classes of painkillers have beneficial medical uses. One is also found on the black market and may lead to occasional deaths by overdose. The other isn't used recreationally, but causes 35 times more deaths per year.

Given these numbers, all of the time, energy, tax dollars, and worry expended on eradicating the OxyContin "threat"—not to mention the menace to civil liberties—seems unfounded.

Another Bout of Drug Hysteria

In order to justify its crackdown on prescription painkillers, the federal government would first need to persuade the public of the threat posed by prescription opioids. Unfortunately, the media has been far too willing to accept the DEA's claims at face value, just as it has with previous drug "epidemics."⁵⁸

To convince the public that there is an opioid drug threat, the DEA compared OxyContin to crack, cocaine, and heroin, the most feared drugs of the 1980s and '90s. Commissioner Asa

Hutchinson testified before Congress in 2002 that OxyContin delivers a "heroin-like high," and that the drug has led to an "increase in criminal activity."⁵⁹ Many mainstream media reports echoed these claims. *Newsweek*, for example, ran a story in 2002 about "Oxybabies," the children of pregnant women on OxyContin, who bore a striking resemblance to the rash of "crack babies" reported in the 1980s.⁶⁰ The article did point out that despite stories that OxyContin abuse has "swept through parts of Appalachia and rural New England," the number of documented cases of addicted newborns is small, "in the dozens," and that "OxyContin, like other opiates, doesn't appear to cause birth defects." After citing a few anecdotal cases of newborns with some health problems that may or may not have been related to OxyContin, reporter Debra Rosenberg still ended the article by questioning whether Oxybabies are a "blip—or an epidemic in the making." But the article's evidence indicates the former, so strongly in fact that one wonders why an article on Oxybabies was necessary in the first place.

Newspapers and magazines reported on the alleged rising death toll from OxyContin, and that the outbreak in opioid abuse posed a greater threat to public health and welfare than cocaine. Soon, arrest and overdose statistics were juxtaposed with OxyContin sales figures, painting the grim picture of an American pharmaceutical company willing to peddle addiction and death for a quick buck.

A few examples:

- *Time* ran a story in January 2001, reporting that "OxyContin may succeed crack cocaine on the street."⁶¹ In Pulaski, Virginia, OxyContin had overtaken cocaine and marijuana, *Time* reported, and property crime was up 50 percent. Police in three states reported robberies of pharmacies, as well as the homes of people known to take OxyContin legitimately (how the burglars knew who was taking the drug isn't clear). Both of course are means by which OxyContin may have found its way to the street that wouldn't

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require prescriptions from a diverting doctor. Still, the article seemed to focus on physicians. U.S. attorney Jay McCloskey was described in the article as a man “waging a war against the doctors who write prescriptions.”

- On February 3, 2001, *US News and World Report* published an article about the danger of OxyContin under the headline “The ‘Poor Man’s Heroin.’”⁶² The article featured Dr. John F. Lilly, a 48-year-old orthopedist and proprietor of a pain clinic who was also under investigation for diversion. Prosecutors claimed that Dr. Lilly ran a “pill mill” that supplied illegal narcotics to addicts in the slums of the industrial city of Portsmouth, Ohio. Local law enforcement officials told the magazine that OxyContin abuse was reaching near-epidemic levels in rural areas. Shortly after Dr. Lilly opened his clinic, drug-related crimes apparently started to increase. But police also claimed that burglaries increased 20 percent in 2000, again suggesting that the drug was getting to the street by means other than doctors’ prescriptions.
- On February 8, 2001, the *New York Times* reported a claim by U.S. attorney Joseph Famularo that at least 59 people had died from OxyContin overdoses in Eastern Kentucky in 2000 alone.⁶³ He said OxyContin had set off a wave of pharmacy burglaries, emergency room visits, and physician arrests. Rick Moorer, an investigator with the state medical examiner’s office in Roanoke, Virginia, reported that there were 16 deaths in southwestern Virginia due to OxyContin in combination with other drugs and alcohol.

Again, there’s simply no test to determine whether or not OxyContin caused or contributed to those overdose deaths. And even if there *were* such a test, it’s just as likely the drugs came from Internet pharmacies, or home or drug store robberies as from diverting doctors. The *Times* article also reported data showing hospital emergency room visits by people

“involving oxycodone” increased from 3,190 in 1996 to 6,429 in 1999. The *Times* article doesn’t give a source or context when it reports that “federal data” show an increase in ER visits “involving oxycodone.” But presumably, they come from the Drug Abuse Warning Network—or DAWN—report, published by the U.S. Department of Health and Human Services. That report’s findings seem to mirror the numbers in the *Times*.⁶⁴ But the DAWN report only cites “mentions” of oxycodone-related drugs in emergency room reports, which can include cases in which oxycodone medication had nothing to do with why the patient came to the emergency room. In fact, in more than 70 percent of emergency room visits involving oxycodone, patients mentioned the drug in conjunction with at least one other controlled drug. Certainly, abuse of increasingly abundant oxycodone medication will lead to some increase in emergency room visits attributable solely to the drug. But the drug’s increasing availability also means that it’s going to be present in more people who visit emergency rooms for other reasons. And that more people are abusing the drug is also no reason to suspect that corrupt physicians are the source of the problem.

The most unfortunate effect of these kinds of stories is that they reinforce existing qualms about opioids. Patients, their families, and even caretakers understandably get nervous when they hear “morphine,” or “opioid therapy,” which naturally sounds a lot like “opium.” In truth, however, the medical evidence overwhelmingly indicates that when administered properly, opioid therapy rarely, if ever, results in “accidental addiction” or opioid abuse.⁶⁵ Most recently, a 2005 study by researchers at the Minneapolis VA Medical Center concluded, “doubts or concerns about opioid efficacy, toxicity, tolerance, and abuse or addiction should not be used to justify the withholding of opioids from patients who have pain.”⁶⁶

Temple pharmacology professor Robert Raffa told *Time* magazine, “The idea that your mom will go into a hospital, be exposed to morphine, and automatically become an addict is just plain wrong.”⁶⁷

The distinction—which seems especially difficult for law enforcement officials and policymakers to make—is between “physical dependence” and “addiction.” A patient incapacitated by pain will naturally become dependent on any medication that gives him relief. But that’s quite different from addiction. Opioid therapy can give patients the freedom to lead normal lives, whereas addiction ruins lives. It’s a confusion that can be tragic. One doctor told *Time* he was treating a terminally ill boy whose father didn’t want his son on morphine because he was “afraid the boy would become an addict.” As the *Time* reporter wrote, “In his grief over the imminent loss of his son, it seems, the father failed to see the absurdity of worrying about long-term addiction in a child who is dying in pain.”⁶⁸

The odd thing is that well before the OxyContin hysteria and ensuing DEA campaign, many media outlets were making those same points and providing balanced reporting on the undertreatment of pain. The *Time* article noted above came out in 1997. Also in 1997, *U.S. News and World Report* ran a 4,400-word cover story on the plight of pain patients.⁶⁹ In one passage, the magazine eloquently laid out the problem:

What is lacking is not the way to treat pain effectively but the will to do it. For a quarter of a century, pain specialists have been warning with increasing stridency that pain is undertreated in America. But a wide array of social forces continue to thwart efforts to improve treatment. Narcotics are the most powerful painkillers available, but doctors are afraid to prescribe them out of fear they will be prosecuted by overzealous law enforcers, or that they will turn their patients into addicts “We are pharmacological Calvinists,” says Dr. Steven Hyman, director of the National Institute of Mental Health.⁷⁰

The authors go on to state:

But at the heart of the debate is confusion about what constitutes addiction

and what is simply physical dependence. Most people who take morphine for more than a few days become physically dependent, suffering temporary withdrawal symptoms—nausea, muscle cramps, chills—if they stop taking it abruptly, without tapering the dose. But few exhibit the classic signs of addiction: a compulsive craving for the drug’s euphoric or calming effects, and continued abuse of the drug even when to do so is obviously self-destructive.

In three studies involving nearly 25,000 cancer patients, [researcher Russell] Portenoy found that only seven became addicted to the narcotics they were taking “If we called this drug by another name, if morphine didn’t have a stigma, we wouldn’t be fighting about it,” says [researcher Kathleen] Foley.⁷¹

Even physicians can fall victim to the “addiction” versus “dependence” confusion—giving rise to yet another cause of undertreatment. Twenty-five percent of Texas physicians in one survey said they believed any patient given opioids is at risk of addiction.⁷² Thirty-five percent of physicians in a 2001 study said they’d *never* prescribe opioids on a short-term basis, even after a thorough evaluation, a response the survey’s researchers attributed to unfounded fears of addiction.⁷³ Again, this despite overwhelming evidence that properly prescribed and used opioids rarely, if ever, lead to addiction.

“OxyContin under Fire”

One of the more egregious examples of media-induced OxyContin hysteria was Doris Bloodsworth’s five-part *Orlando Sentinel* series from October 19–23, 2003, entitled “OxyContin under Fire.”⁷⁴

The *Sentinel* series was heavily advertised and promoted as an exposé of the OxyContin epidemic sweeping the country. Including Bloodsworth’s pieces, the *Sentinel* ran 19 OxyContin-related articles and editorials that month, complete with photos of victims,

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It would be difficult to overstate how much the *Sentinel* series contributed to nationwide OxyContin fears.

flashy layouts, and insert boxes designed to elicit maximum emotional impact. The series spotlighted several patients described as “accidentally addicted” to OxyContin. Some of them, Bloodsworth reported, experienced painful withdrawal effects. Some saw their families fall apart. Some died of overdoses or committed suicide. Bloodsworth alleged that white males aged 30 to 60 who experience back pain are particularly likely to become addicted to OxyContin, and to eventually die from that addiction.⁷⁵

One of the featured victims was David Rokisky, a 36-year-old former Army Airborne soldier and police officer living in Tampa, Florida. According to Bloodsworth, Rokisky had a bodybuilder’s physique, a beautiful young wife, a high-paying job as a computer company executive, and a beachfront condo. Rokisky’s life was idyllic, Bloodsworth reported, until a doctor prescribed OxyContin to treat a minor backache. According to the *Sentinel*, Rokisky quickly became an innocent victim of drug addiction. He eventually lost his job and had to undergo painful detoxification.

The series also featured Gerry Cover, a 39-year-old Kissimmee, Florida, handyman and father of three. Bloodsworth reported that Cover became an addict after a doctor prescribed OxyContin to relieve his pain from a mild herniated disc in his back. Cover subsequently died from an accidental overdose of the drug.

Bloodsworth wrote that although members of Congress and the FDA were aware of “the devastation (OxyContin) has carved through Appalachia where the drug became known as ‘hillbilly heroin,’” neither had done anything to slow down the epidemic. She blamed Purdue Pharma for aggressively marketing OxyContin to naïve and unscrupulous doctors, who likewise used the drug to “boost their profits.”⁷⁶ According to Bloodsworth, there were 573 deaths in Florida linked to oxycodone in 2001 and 2002. By comparison, Bloodsworth reported that only 521 people died of heroin overdoses during the same period.⁷⁷ The 573 figure apparently came from the

Sentinel’s review of thousands of documents, including 500 autopsy reports by Florida’s medical examiners. The paper claimed that a remarkable 83 percent of the 247 cases of reported drug overdose deaths over that period were directly attributable to OxyContin.⁷⁸

It would be difficult to overstate how much the *Sentinel* series contributed to nationwide OxyContin fears. It prompted an anti-opioid grass-roots protest movement in Florida. The newspaper’s critique of lawmakers for “doing nothing” stirred emotion and legislative action on the local, state, and national level. In November 2003, one month after the series appeared, protestors from all over the country converged on Florida to picket Gov. Jeb Bush and his wife, who were attending a three-day conference on youth drug abuse in Orlando. Members of “Relatives against Purdue Pharma” carried poster-sized photos of family and friends who allegedly died from OxyContin overdoses.⁷⁹ Victor Del Regno, a Rhode Island business executive whose 20-year-old son died, allegedly from OxyContin, told the *Sentinel*, “We feel there has to be a way to get the word out about how deadly this drug can be.”⁸⁰

Governor Bush and state lawmakers were sympathetic, and promised to put an end to the “hemorrhaging of lost lives” allegedly caused by prescription painkillers.⁸¹ During congressional testimony inspired by the *Sentinel* series and its aftermath, Florida director of drug control James McDonough praised Doris Bloodsworth’s series, and cited her estimates of OxyContin overdose deaths. He said that in response to the *Sentinel* and other reports, Florida had taken “aggressive action against [diversion] criminal practices.”⁸²

McDonough boasted that Florida law enforcement had taken action since the *Sentinel* series, including the prosecutions of Dr. James Graves (a former Navy flight surgeon), convicted on four counts of manslaughter for prescribing oxycodone; Dr. Sarfraz Mirza, convicted of trafficking in OxyContin; and Dr. Michell Wich and Dr. Asuncion Luyao, convicted of prescription overdose deaths.⁸³

Bloodsworth’s claims about the OxyContin epidemic were picked up and repeated in news-

papers and media outlets all over the country. They were even included in a General Accounting Office report on OxyContin abuse requested by Congress. GAO cited the *Sentinel* series and said that the newspaper's investigation of autopsy reports involving oxycodone-related deaths found that OxyContin had been involved in more than 200 overdose deaths in Florida since 2000.⁸⁴

Thanks in large part to the *Sentinel* series, Florida today is one of the most difficult states in the country for pain patients to get treatment, and its legislature only narrowly voted down a bill establishing a statewide database to track and monitor painkiller prescriptions.⁸⁵

The *Sentinel* Series Unravels

In February of 2004, the *Orlando Sentinel* series on OxyContin began to fall apart. Investigations by Purdue Pharma and advocates for pain patients uncovered numerous and grievous errors in Bloodsworth's reports. The *Washington Post* reported that David Rokisky had pled guilty to drug conspiracy in a cocaine case four years previous to the series' publication. Far from leading an idyllic life wrecked by OxyContin, Rokisky in fact had a long history of domestic-abuse allegations and financial problems.⁸⁶ "Accidental addict" Gerry Cover proved to be a longtime drug abuser too, and had been hospitalized for an overdose on other drugs three months before he had been prescribed OxyContin.⁸⁷

Bloodsworth's misrepresentation of OxyContin overdose deaths was even more egregious than her mischaracterizations of the alleged victims of the drug. The series completely distorted the Florida medical examiners' drug overdose deaths data for 2000 and 2001. Instead of more than 570 deaths linked to OxyContin the *Sentinel* reported for those years, the medical examiners' reports reveal the actual total for those years was 71–35 in 2001, and 36 in 2002.⁸⁸ The *Sentinel* had included not only deaths where oxycodone alone was present in the system of the deceased, but also deaths in which any oxycodone product was present in combination with any number of other drugs.

There were 317 such deaths in 2001, and 220 in 2002, giving the *Sentinel* its 573 deaths.⁸⁹ In truth, even those 71 overdose deaths over the *Sentinel*'s two-year period are suspect. That's because Florida's medical examiners report only 14 drug groups in autopsy reports.⁹⁰ It's likely that there were any number of unreported drugs in the systems of 71 people where only oxycodone was found, not to mention that any number of them might have died for reasons completely unrelated to drugs. For example, the deceased may also have been taking antidepressants, heart medication, and/or diabetic medications, any of which could have potentially contributed to the cause of death. That's particularly likely where the deceased is over 50 years of age—true of about a third of the 71 Florida cases.⁹¹

After a barrage of criticism, the *Orlando Sentinel* finally acknowledged its errors in the series, and in February 2004 announced Doris Bloodsworth's resignation from the paper. The two editors who worked on the series were also reassigned.⁹²

In a front-page correction, the *Sentinel* wrote the following:

An *Orlando Sentinel* series in October about the drug OxyContin used a key statistic incorrectly and overstated the number of overdoses caused solely by oxycodone, the active ingredient in OxyContin and other prescription painkillers. . . .

In roughly three out of four cases, medical examiners concluded that at least one other drug also contributed to the victims' deaths. . . .

According to the *Sentinel*'s re-examination, blood samples in about 38 percent of the oxycodone-related deaths showed the presence of heroin, cocaine, methamphetamine and/or marijuana. Many other victims also had consumed one or more commonly abused prescription drugs, such as Xanax or Vicodin.

In February, the *Sentinel* published a story correcting factual errors about two men featured in the series. The

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newspaper had labeled one of them, David Rokisky, an “accidental addict” without doing background reporting that would have shown he had a federal drug conviction. The other, the late Gerry Cover, died from an overdose caused by a combination of drugs rather than oxycodone alone.⁹³

Despite the *Sentinel's* retraction, other media outlets have continued to drum up the OxyContin threat, many of them making the same errors the *Sentinel* did. Here are a few examples:

- In late August of 2004, the *Montreal Gazette* reported that “the prescription painkiller nicknamed ‘hillbilly heroin’ in the U.S., was a contributing factor in at least 26 overdose deaths in Quebec since 1999.”⁹⁴ Remarkably, the paper went on to draw the same conclusions about autopsy reporting as the *Sentinel*. The *Gazette* reported that “other narcotic substances were also detected, suggesting that OxyContin alone might not have caused some deaths,” a caveat that severely undermines the alarming lead.
- That same month, the *Ottawa Citizen* reported that “in the past five years there were 300 deaths in which oxycodone, the opiate found in OxyContin and the drug brand Percocet, was detected in the body.”⁹⁵ That number again means very little when not supported with other information, such as what other drugs were found in the bodies, what illnesses the deceased were suffering from, and how many OxyContin prescriptions were written in comparison to those 300 deaths.
- Also in August 2004, the *Boston Globe* ran a story on federal grants coming to the Boston area that would be used to target OxyContin abuse.⁹⁶ One local official told the *Globe*, “we are going to . . . bring the danger of OxyContin right out there so everyone is going to know how bad it is,” and that “OxyContin use can lead to

heroin use.” A local mayor called OxyContin “the number one health crisis in cities and towns at this time.”⁹⁷

Despite the *Sentinel* fiasco, media outlets continued to perpetuate OxyContin fears by reiterating overdose statistics based on questionable science and quoting public officials without a bit of skepticism or any effort to elicit rebuttals from drug war critics or pain patient advocates.

Eradicating the Prescription Painkiller “Threat”

The DEA's new mission to thwart the diversion of prescription painkillers was a significant undertaking, one that would require extra manpower and resources. As part of its OxyContin Action Plan, the agency carried out more than 400 investigations resulting in the arrest of 600 individuals from May 2001 to January 2004. Sixty percent of those cases involved medical professionals, most of them doctors and pharmacists (the remaining cases could include manufacturers and wholesalers).⁹⁸

To implement its new program, the DEA participated in the Organized Crime Drug Enforcement Task Force and worked cooperatively with state and local drug task forces. OCDEF combines the resources of federal, state, and local law enforcement under the coordination of U.S. attorneys. In 2001 the DEA deputized 1,554 state and local officers from large and small police departments across the country to coordinate prescription drug investigations. In 2002, 1,172 DEA Special Agents worked alongside 1,916 state and local police officers in 207 separate task forces.⁹⁹ This sharing of resources significantly expanded the OxyContin Plan's reach. To see how the task force plan gave the DEA more reach, consider drug war statistics from 1999. In that year, the DEA initiated 1,699 investigations on its own but was able to extend its investigative reach by working cooperatively with state and local law enforcement officials

Table 1
DEA Registrant Population

Retail Level		Wholesale Level	
Practitioners (doctors)	928,677	Researchers	6,843
Nurse Practitioners & Physician Assistants	71,169	Analytical Labs	1,591
Pharmacies	61,05	Narcotic Programs	1,151
Hospitals/Clinics	14,462	Distributors	876
Teaching Institutions	424	Manufacturers	453
Importers	136	Exporters	206

Source: DEA Update, National Association of State Controlled Substance Authorities, Myrtle Beach, South Carolina, October 2002.

in more than 9,000 additional task force cases.¹⁰⁰ The DEA also trained more than 64,000 state and local law enforcement personnel in 2001 at its Training Academy in Quantico, Virginia, as well as at the agency's 22 domestic field divisions throughout the United States.¹⁰¹ These task forces accounted for 40 percent of the DEA's prescription narcotics seizure and forfeiture cases.¹⁰²

The DEA's Diversion Control Program is also a self-financing, autonomous law enforcement agency that is largely unaccountable to congressional oversight. It's mostly financed by the licenses it requires all doctors, manufacturers, pharmacists and wholesalers to purchase, and in part by the assets it seizes when it raids the businesses and personal finances of those same licensees. Table 1 shows the breakdown of the DEA's controlled substance license holders as of 2002. Physicians constituted 928,677 of 1,087,045 registrants, or 85 percent of all those approved by the DEA to produce, distribute, and dispense narcotics. Because prescription narcotics are legal and regulated, the DEA can easily monitor the way physicians prescribe them. Unlike illicit drug dealers, most physicians are law-abiding, legitimate professionals. That also makes them easier targets.

The DEA sets annual production quotas for the manufacturers of narcotic drugs, and the agency attempts to monitor the wholesale and retail distribution of those drugs,

though with decidedly mixed results. In fact, large quantities of narcotics routinely go missing en route from manufacturers to wholesalers and from wholesalers to retailers. The DEA itself acknowledges this problem. The agency notes that there is an increase in OxyContin burglaries, thefts, and robberies of hospitals and pharmacies throughout the country, including at Purdue Pharma, the manufacturer of OxyContin.¹⁰³

In one recent case in Arizona, nearly 475,000 tablets of narcotic drugs disappeared from Kino Community Hospital's pharmacy between May 1, 2002, and April 30, 2004.¹⁰⁴ Drug stores in rural areas have also been targets for burglars seeking OxyContin, and the Internet has become a major underground source for the drug.¹⁰⁵ In an investigative series, the *Star-Ledger* newspaper in New Jersey actually ordered OxyContin over the Internet, along with other prescription narcotics. The paper reported no contact with a physician, and the drugs were delivered to a rented mailbox within days of placing the order.¹⁰⁶ Given the poor job the DEA is doing of monitoring the narcotics it's charged with overseeing, and the various ways the drug apparently can move from manufacturers and wholesalers to the black market, the DEA's blame and pursuit of physicians for the drug's street availability seems all the more arbitrary, unjustified, and capricious. "Pills are a problem in Southwest

The DEA's attempt to blame physicians for the drug's street availability seems arbitrary, unjustified, and capricious.

If criminal charges are never filed, a police department can still bring a civil action against a suspected doctor to recover the cost of an investigation.

Virginia,” one assistant U.S. attorney told the *Roanoke Times* in 2001, “And the *only* way you can get prescription pills is to go to the doctor.”¹⁰⁷ But that’s clearly not the case.

In 1993 Congress created the self-financed Diversion Control Fund, which was to be funded by narcotics licensing fees. The DEA is authorized to increase the license fees to make sure the Diversion Control Program remains fully funded. The setup is similar to that of the Health Care Fraud and Abuse Control Program, which monitors doctors for alleged fraud and abuse with respect to Medicaid and Medicare. In 2003 the DEA doubled its license fees to pay for the cost of the program. Under DEA rules, doctors must buy licenses for three-year periods at \$131, while pharmaceutical companies pay \$1,605 per annum for licenses to make drugs. These licensing fees bring in about \$118 million a year. The Diversion Control Program currently costs about \$154 million per year. The rest of the DCP’s funding comes from the annual congressional budget for the DEA, and from the DOJ’s Asset Forfeiture Fund, which is financed by seizures of assets from doctors and pharmacists under investigation for drug diversion, as well as from illicit drug dealers and users. In 2005 the DEA requested an additional \$245.4 million for drug enforcement, including \$32.6 million for diversion control.¹⁰⁸

According to the Controlled Substances Act, all monies or other things of value furnished by any person in exchange for controlled substances are subject to forfeiture.¹⁰⁹ The money from these seizures get split between the law enforcement agencies making the bust, and the remainder goes to the DOJ’s Forfeiture Fund, where it’s used to coordinate more investigations. In 2002 drug asset forfeitures totaled \$441 million. And in 2001 the DEA shared \$179,264,498 of its asset forfeitures with local and state police departments.¹¹⁰ The total forfeiture fund was worth about \$1.2 billion by 2002.¹¹¹ The vast majority of asset forfeiture money is distributed by the DEA to state and local law enforcement agencies who work with the agency on drug cases. It is a perverse system

that allows law enforcement officials to keep the assets of suspected drug defendants for their own, local police departments.

Detective Dennis M. Luken, of the Warren-Clinton Drug and Strategic Operations Task Force in Lebanon, Ohio, and Treasurer of the National Association of Diversion Drug Investigators, laid out the financial necessity of targeting physicians for investigation at a 2003 training conference for drug diversion agents.¹¹² Luken, who worked on an asset forfeiture squad for three and a half years, said that in an “era of budget cuts, forfeitures are an important way to make up for the losses.”¹¹³ Luken said that the task force arrests five doctors a year in the Cincinnati area alone. Seizing a doctor’s assets to supplement strained law enforcement budgets was a recurring theme at the NADDI training conference, held in Ft. Lauderdale, Florida. Greg Aspinwall of the Miami Dade Drug Task Force, for example, stressed the importance of taking a task force approach to diversion investigations by using the theme “spreading the love.”¹¹⁴ He instructed trainees to get as many law enforcement agencies as possible involved in investigations. The method reduces costs, he said, and guarantees that “everybody gets their fair cut from the forfeitures.”¹¹⁵ He pointed out that even if criminal charges are never filed, a police department can still bring a civil action against a suspected doctor to recover the cost of an investigation.

In his lecture, Detective Luken also focused on “drug-diverting” doctors and stressed the importance of seizing their assets. He urged investigators to serve search warrants on doctors’ offices and bank accounts and to take possession of their contents. If the doctor does not have a sizable bank account, Luken said, investigators should look at a physician’s home or office building, given that both were likely paid for with the proceeds of drug distribution. Luken implored agents to “remember that asset forfeiture investigation should begin at the start of your criminal case.”¹¹⁶ Detective Luken discussed the cases of several physicians he had overseen and noted that investigators seized money and property from them

before they were indicted or tried for any crime.

Luken then cited a number of cases in which physicians had had their assets seized before ever being charged. One case he mentioned, that of Dr. Eli Schneider, resulted in the seizure of \$220,000. Of that money, the Ohio Medicaid Fraud Control Unit received \$3,752, the Ohio Department of Health and Human Services got \$24,000, the Cincinnati Police Department \$29,000, the FBI \$14,000, and the U.S. Department of Health and Human Services \$50,000. Calls to local authorities and public records searches don't reveal whether or not Dr. Schneider was ultimately convicted. Many times, however, such forfeitures result in plea bargains or civil settlements, given that the cases can drag on for years, and asset seizure leaves the accused with no means to live, much less to pay attorney's fees and court costs. The case of Kentucky physician Dr. Ghassan Haj-Hamed is a good example. The DEA sued Dr. Haj-Hamed in 2002, accusing his clinic of diversion and drug distribution. After more than two years, the doctor agreed to settle, paying \$17,000 and handing over two automobiles in exchange for the federal government dropping its suit for \$133,000. Haj-Hamed's lawyer told the *Kentucky Post* that the government's practice of seizing all of a doctor's assets, then expecting him to fight the case, all while still paying taxes and earning a living, "inevitably puts the person in a position where they have to settle."¹¹⁷ Prosecutors haven't yet decided whether or not to pursue criminal charges.

Because the Diversion Control Program is self-financed, it is nearly immune from congressional oversight. Its administrators aren't required to justify its existence, its tactics, or its efficacy when it comes time for appropriations. The program also creates a scenario wherein doctors are required to finance investigations of their colleagues, copractitioners, or even themselves. Should the doctors' colleagues be investigated, law enforcement officials are encouraged to seize their colleagues' assets, much of the proceeds of which then go toward financing more investigations.

From October 1999 through March 2002, the DEA investigated 247 OxyContin diversion cases leading to 328 arrests.¹¹⁸ In 2001 there were 3,097 total diversion investigations, including 861 investigations of doctors.¹¹⁹ In 2003 the DEA investigated 732 doctors, sanctioned 584, and arrested 50.¹²⁰ These numbers do not include physicians investigated and arrested by the 207 DEA-deputized state and local task forces throughout the country.

Putting a total number on how many doctors, nurses, and pharmacists have been investigated, charged, or convicted is difficult. The DEA says it no longer keeps track of such statistics. Some states account for physician arrests; others don't. Virginia, for example, says it prosecutes on average one health care professional per week.¹²¹ Many doctors do as Dr. Ghassan Haj-Hamed did and settle before charges are brought—because after forfeiture, they generally have no assets left to fight the charges.

Investigating and Apprehending Pain Patients and their Doctors

The DEA defines an "addict" as "any individual who habitually uses any narcotic drug so as to endanger the public morals, health, safety, or welfare, or who is so far addicted to the use of narcotic drugs as to have lost the power of self-control with reference to his addiction."¹²² The DEA's conception of an addict, then, includes what pain specialists call "pseudoaddicts"—pain patients who require opiates to lead a normal life. Pain specialists make an important distinction between patients who depend on opiates to function normally—to get out of bed, tend to household chores, and hold down jobs—and addicts who take drugs for euphoria, and whose lifestyles *deteriorate* as a result of taking opiates, instead of improving. The DEA makes no such distinction. And by classifying pain patients as addicts, the agency is able to pursue their doctors as "distributors."

What's worse, due to unwavering drug laws mandating that possession of any controlled substance over a specified amount constitutes an intent to distribute, pain patients are often considered "dealers" too—even if (as is most

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The DEA continues to lower its evidentiary standards, making it nearly impossible for many doctors to determine what is and isn't permitted.

often the case) their entire supply of prescription drugs are for their own use.

That's exactly what happened to Florida pain patient Richard Paey.¹²³ Paey suffers from multiple sclerosis, as well as from injuries incurred in a car accident and a botched back surgery. Given the anti-drug climate in Florida, Paey found it difficult to find a physician who would prescribe the high-dose pain medication he needed to live with his injuries. So Paey turned to his old doctor in New Jersey, who wrote Paey undated prescriptions that Paey then photocopied and filled. Though he conceded that Paey's medication was for his own use, Paey's prosecutor nonetheless charged him with "intent to distribute," because the amount of narcotics Paey had in his possession exceeded the limit needed to be charged with distribution. After two mistrials, Paey was convicted at a third trial. Mandatory minimum sentencing guidelines gave a reluctant judge no choice but to send Paey to prison for 25 years and fine him \$500,000. Today, Paey sits in a Florida prison with a morphine pump, paid for by Florida taxpayers.

More often, however, prosecutors use the threat of imprisonment to get pain patients to turn in their doctors, who make better targets. And, of course, once pain patients can be called "addicts," the government is free to go after the doctors who treat them as "conspirators" in the illegal drug trade. In the case of Dr. Hurwitz, around 15 of his more than 500 pain patients over three years were lying to him and selling the drugs he prescribed on the black market. Investigators could have alerted Hurwitz to his unlawful patients and asked for his help in nabbing them—he had already openly cooperated with law enforcement, offering access to vast amounts of patient paperwork over the course of four years. Instead, investigators continued to let Hurwitz prescribe to known dealers, then later offered the lying patients lenient sentences in exchange for testimony against Hurwitz.¹²⁴

In his speech at the NADDI conference, Detective Luken likened pain specialists to illegal drug dealers, and explained that pain doctors sell pain medication for money, sex,

or to feed their drug habits or those of family members or girlfriends—just as common drug pushers do. Doctors in practice by themselves and older doctors are often painted by investigators as rubes, easily duped by addicts or unable to stop freely prescribing narcotics in the manner they did during more permissive times.¹²⁵

To target doctors, investigators look for "red flags" they believe are indicative of potentially criminal behavior. These red flags are generally circumstantial evidence found during standard criminal investigative procedures. The problem with red flags is that what may appear to be evidence of criminal behavior to an investigator without medical training is often perfectly consistent with legitimate medical practice, particularly in a dynamic field like pain management. Criminal investigators without medical training simply aren't qualified to tell the difference. Yet they routinely make such decisions, and such close judgment calls can cause the criminal prosecution of an otherwise legitimate physician.

According to the DEA, the prosecution of any given doctor is based on whether there is a "legitimate medical purpose" for a prescription he has written or whether it is "beyond the bounds of medical practice." But prosecutors concede that there are no specific guidelines or procedures to evaluate either of those standards. At a Healthcare Fraud Prevention and Funds Recovery Summit in Washington, DC, in 2004, Greg Wood, a federal investigator for the U.S. attorney's office in Virginia, said the government's aim is to produce probable cause that a doctor (a) intentionally wrote a narcotics prescription for patients without legitimate medical needs, (b) knew the patients getting the prescriptions were addicts, or (c) knew the patients getting the prescriptions were selling the drugs.¹²⁶ Any of those is sufficient for an arrest.

But even those guidelines are apparently subject to change without notice. The DEA continues to lower its evidentiary standards, making it nearly impossible for many doctors to determine what is and isn't permitted. In October 2004, the DEA disavowed the con-

tents of a pamphlet it had published for pain doctors and pulled the digital version of the document down from its website.¹²⁷ The FAQ was a working collaboration with input from leading physicians and researchers in pain medicine that purported to give guidance to pain specialists worried about the DEA's crackdown.¹²⁸ The reversal infuriated advocates for pain physicians and patients, some of whom had worked with the DEA for several years to "strike a balance" between adequately treating pain and preventing diversion.¹²⁹ The original document included such conciliatory language as, "any physician can be duped" and pointed out that patient behavior commonly thought to indicate criminal behavior could instead be "the possible effects of unrelieved pain." It warned that "stereotypes of what an abuser 'looks like' can harm legitimate patients because people who abuse prescription medicine exhibit some of the same behaviors as patients who have unrelieved pain."¹³⁰ The pamphlet also made clear that DEA red flags, such as prescribing prescription narcotics to patients with a history of drug abuse or not reporting patients whom physicians suspect of abusing pain medication, are *not* in violation of federal law. Most notably, the pamphlet explicitly stated, "For a physician to be convicted of illegal sale, the authorities must show that that the physician *knowingly* and *intentionally* prescribed or dispensed controlled substances outside the scope of legitimate practice."¹³¹

The DEA took the extraordinary step of disavowing the document, just as lawyers for Dr. William Hurwitz, the pain specialist on trial for diversion in Virginia, attempted to introduce the pamphlet as evidence at his trial. Hurwitz's prosecutors objected, and a federal judge decided in favor of the prosecutors, ruling that the DEA guide did not carry the force of law, and therefore was not admissible.¹³²

The DEA later explained that it disavowed the pamphlet because of language at odds with the DEA's insistence that they are not bound by any standard of evidentiary requirement to commence an investigation, including the well-established principle in federal law that the enforcement of the Controlled

Substances Act should in no way interfere the ethical practice of medicine. The DEA's explanation noted that "the Government can investigate merely on suspicion that the law is being violated, or even just because it wants assurances that it is not."¹³³ The statement went on to repudiate whole passages from the original pamphlet, and said the agency would continue its red flag system of deciding which pain doctors to investigate. Those red flags in the interim policy statement include the number of tablets a doctor prescribes to his patients, the practice of writing more than one prescription for a patient on the same day, marked for later dispensing, and using "street slang" rather than medical terminology when discussing pain medication with patients.¹³⁴ All, incidentally, were dismissed by the DEA's original pamphlet as reasons in and of themselves to launch a criminal investigation.

The DEA's move caused three professional associations of pain management specialists to take the unusual step of sending a letter to the DEA calling its decision "an unfortunate step backward" that encourages a return to "an adversarial relationship between [doctors] and the DEA."¹³⁵

The DEA's disavowal of its pamphlet was also enough to push into action state officials increasingly alarmed by the agency's pursuit of physicians. In January of 2005 the National Association of Attorneys General sent a letter to the DEA expressing the organization's concern about the DEA's more strident approach to fighting diversion. Thirty state attorneys general signed the letter, which said, in part,

Having consulted with your Agency about our respective views, we were surprised to learn that DEA has apparently shifted its policy regarding the balancing of legitimate prescription of pain medication with enforcement to prevent diversion, without consulting those of us with similar responsibilities in the states. . . .

The Frequently Asked Questions and Answers for Health Care Professionals

In January of 2005 the National Association of Attorneys General sent a letter to the DEA expressing the organization's concern about the DEA's more strident approach to fighting diversion.

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and Law Enforcement Personnel issued in 2004 appeared to be consistent with these principles, so we were surprised when they were withdrawn. The Interim Policy Statement, "Dispensing of Controlled Substances for the Treatment of Pain," which was published in the Federal Register on November 16, 2004, emphasizes enforcement, and seems likely to have a chilling effect on physicians engaged in the legitimate practice of medicine. As Attorneys General have worked to remove barriers to quality care for citizens of our states at the end of life, we have learned that adequate pain management is often difficult to obtain because many physicians fear investigations and enforcement actions if they prescribe adequate levels of opioids or have many patients with prescriptions for pain medications.¹³⁶

The end result of these procedures is that investigators and prosecutors without medical training are now in the position of interpreting whether or not a suspected physician's actions are consistent with traditional medical practice or worthy of an investigation. The red flag system is meant to aid them in that decision. At the July 2003 NADDI conference, investigators were told what practices—or red flags—might indicate criminal behavior. These included

- Long lines of patients waiting to see doctors.
- Patients who are poorly dressed.
- Out-of-state automobile licenses in doctors' parking lots.
- Patients who arrive and are taken without appointments.
- Patient visits lasting less than 25 minutes.
- Doctors who are licensed to practice in more than one state.
- Doctors who dispense large amounts of narcotics from one office.¹³⁷

One of the many problems with the red flag system is that investigative bodies use

invasive procedures to uncover red flags. The National Association of Drug Diversion Investigators, for example, instructs cops to conduct video surveillance of doctors' offices as if they were "crack houses."¹³⁸ Investigators have also picked through trash at doctors' offices and private residences. Employees of suspected doctors have been interviewed at their homes. Police have sought out disgruntled former employees who might incriminate their former employers.¹³⁹

The relationship between a doctor and his patient is crucial to the proper assessment and treatment of the patient's condition. The DEA's aggressive investigative procedures poison that relationship from both sides. Pain patients have been asked to testify against their doctors. Pain patient advocacy groups report patients being accosted in the parking lots of their physicians' offices. These kinds of procedures threaten to make some doctors suspicious of every patient they see—even longtime patients—a situation further complicated by the DEA's disavowing its guidelines pamphlet. Doctors and patients are then forced to play a game. Patients must negotiate between indicating enough pain to their doctors to warrant more medication, but to avoid appearing desperate—one sign doctors are supposed to look for in identifying diverting patients. Some patients simply stop reporting pain and suffer silently, for fear of becoming burdensome.¹⁴⁰ One study published in the *Journal of Clinical Oncology* found that when asked to match their patients' pain intensity on a scale of 1 to 10, 35 percent of physicians failed to match their patients' descriptions within two points.¹⁴¹ It's now not at all clear to doctors at what point they're legally obligated to report a patient they suspect of diverting prescribed medication.

One pain patient and mother of three told her local newspaper, "Doctors and nurses look at you different if they know the medications you are on. They flag your file and view you as an addict."¹⁴² Pain specialists at a professional conference in Tucson, Arizona, advised doctors to install security cameras, mandate urine tests, and frisk patients upon entering their

offices to ensure they weren't bringing in someone else's urine—all to ensure that the patients weren't lying to them and protect the doctors from prosecution down the line.¹⁴³ "I have to be a detective," a Tennessee doctor told the *Wall Street Journal*.¹⁴⁴ One of Dr. Hurwitz's patients told the *Washington Post* that Hurwitz's treatment saved his life and was worried what he'd do when Hurwitz lost his license. He found another doctor, but only after considerable searching. Even then, "they treat me like a criminal," he said. "I only get a one-week supply at a time, and sometimes I have to wait for hours at the pharmacy. And the pharmacist who fills my prescriptions is the only one in town who will do it, so if he goes, then I'm finished."¹⁴⁵

The DEA has also set up a hotline to report doctors whom patients suspect of overprescribing, an odd move that further complicates the doctor-patient relationship.¹⁴⁶ Common sense suggests that people posing as pain patients to illegally divert narcotics or pain patients getting excessive pain medication prescribed to them are *least* likely to report their doctors to the DEA. Conversely, it isn't difficult to see how a legitimate pain patient dissatisfied with how much medication he has been prescribed might be tempted to report his doctor out of spite.

Investigators have also sent undercover agents, typically from sheriffs' departments, to pose as pain patients with fake insurance cards. Agents schedule appointments over the phone and carefully document everything that happens during office visits. They make audio and, when possible, video recordings of everything that transpires. Undercover agents tend to be female—investigators believe women are less threatening, less suspicious, and more likely to elicit sympathy from doctors. Agents make numerous visits to doctors' offices to befriend staff members and win their trust. They then attempt to accumulate incriminating evidence against the doctors. They are instructed to engage in informal, personal conversation with a "target" and his employees. Once an undercover agent wins the trust of a doctor and his staff, she is instructed to begin looking for more red flags. These additional red flags have

included

- A doctor who told a pain patient where he could get his prescriptions filled.
- A physician who asked his patients which drugs they prefer and which dosage worked best for them.
- Doctors who prescribed the same drug in the same dosage to many patients, including to more than one member of the same family.¹⁴⁷

These aggressive procedures haven't always been the norm. University of Florida professor of pharmacy and lawyer David Brushwood told one newspaper that doctors once had a more cordial, cooperative relationship with investigators.

"Five years ago, if law enforcement saw a problem beginning to develop—say a doctor or pharmacist dispensing in ways they thought were problematic—they would very early on go to the doctor or pharmacist and say, 'We think there's a problem here.' By the same token, physicians or pharmacists felt comfortable calling law enforcement and saying, 'Something strange is going on. Come help us out.' It was a culture of the early consult. The early consult is gone," Brushwood said.¹⁴⁸

Brushwood also noted that many times, investigators will wait for more problematic situations to develop in an effort to have more evidence with which to go after a doctor. Law enforcement officials "watch as a small problem becomes a much larger problem. They wait, and when there is a large problem that could have been caught before it got large, they bring the SWAT team in with bulletproof vests and M16s, and they mercilessly enforce the law. They'll come in with charges on multiple counts. Murder, manslaughter, 350 counts of drug diversion. Many of which arose after they first discovered it, when it was a small problem," Brushwood said.¹⁴⁹

Because doctors are now being prosecuted for not adequately discerning the motives and intentions of their patients, pain patients know that doctors will be looking them over for signs of abuse, so many strate-

Professor David Brushwood says that doctors once had a more cordial, cooperative relationship with investigators.

There seems to be no evidentiary standard at all that doctors can rely on to thwart a conviction.

gically underreport or overreport their pain, depending on how much medication they have, how much they think they need, and how suspicious they believe a doctor to be of their motives. Doctors have no choice but to give extra scrutiny to everything a patient says, not just out of a desire to keep a patient from hurting himself or diverting drugs to the black market, but because the patient may be an undercover cop. Even longtime patients can be duped by police into turning in their doctors under threat of arrest.

A doctor's billing practices can also trigger a red flag. Investigators have contacted private insurance companies' fraud units as well as those within Medicare and Medicaid. They comb records to find more potential red flags for a suspected doctor. Investigators have also obtained the prescription purchase reports gathered by the DEA from pharmaceutical companies to track a suspected physician's prescribing history.¹⁵⁰

The case of Dr. William Hurwitz is again an excellent example. He was prosecuted in 2004 as part of a two-year DEA operation called "Cotton Candy" (for OxyContin) involving between 60 and 80 doctors, pharmacists, and patients. Hurwitz was eventually charged with "conspiring to traffic drugs, drug trafficking resulting in death and serious injury, engaging in a criminal enterprise, and health care fraud."¹⁵¹ He was arrested at his home by 20 armed agents in the presence of his two young daughters. Investigators seized his assets, including his retirement account, jailed him, and imposed a \$2 million bond.¹⁵² Hurwitz was eventually convicted, essentially of being unknowingly duped by pain patients who later sold his prescriptions.¹⁵³ The jury's foreman told the *Washington Post* that Hurwitz was "sloppy," "a bit cavalier," and that, "no, he wasn't running a criminal enterprise." Yet the jury convicted Hurwitz of "conspiracy to distribute controlled substances and trafficking resulting in death and serious injury."¹⁵⁴ In April 2005 Hurwitz was sentenced to 25 years in prison and fined \$1 million.¹⁵⁵

The DEA now insists that prosecutors do not have to prove a doctor's malicious intent

or desire to profit from narcotics diversion to secure a conviction.¹⁵⁶ In fact, it's not even necessary for the government to have expert medical testimony that a doctor's actions were illegitimate or outside the usual course of professional practice. The DEA believes it can bring charges against doctors even if they never actually distributed drugs or their prescriptions were never actually filled. In fact, there seems to be no evidentiary standard at all that doctors can rely on to thwart a conviction.¹⁵⁷

Perhaps no case illustrates the injustice of aggressive law enforcement tactics better than that of Dr. Frank Fisher.¹⁵⁸ Fisher was a Harvard-trained physician whose California practice served about 3,000 patients, most of them rural and poor. About 5–10 percent of Fisher's cases were pain patients. In 1999, the police arrested Fisher and charged him with multiple counts of fraud and drug diversion. More notably, Fisher was originally charged with several counts of murder. State prosecutors attempted to make the case that Fisher's overprescribing of narcotics made him criminally culpable for the deaths of a pain patient who died in an unrelated automobile accident, a man who received narcotics after they had been stolen from the home of one of his patients, and a patient who died after her prescription ran out and Dr. Fisher had already been arrested and imprisoned. Fisher was further besmirched in the press. Prosecutors described him as a "mass murderer" and common drug pusher who addicted thousands of Californians to prescription painkillers.

Upon his arrest, all of Dr. Fisher's assets were seized, and he was held on \$15 million bond. It took just a 21-day preliminary hearing for a judge to dismiss the murder charges and lower the bail, releasing Dr. Fisher from prison. It took another four years to dismiss the remaining felony charges, including fraud and manslaughter. Finally, in May of 2004, a jury acquitted Fisher of the remaining misdemeanor charges. One juror described the pursuit of him as a "witch hunt." Fisher spent five months in jail, lost all of his assets and—at the

age of 50—was forced to move in with his elderly parents.

Conclusion

The government is waging an aggressive, intemperate, unjustified war on pain doctors. This war bears a remarkable resemblance to the campaign against doctors under the Harrison Act of 1914, which made it a criminal felony for physicians to prescribe narcotics to addicts. In the early 20th century, the prosecutions of doctors were highly publicized by the media and turned public opinion against physicians, painting them not as healers of the sick but as suppliers of narcotics to degenerate addicts and threats to the health and security of the nation.

Since 2001 the federal government has similarly accelerated its pursuit of physicians it says are contributing to the alleged rising tide of prescription drug addiction. By demonizing physicians as drug dealers and exaggerating the health risks of pain management, the federal government has made physicians scapegoats for the failed drug war. In that they are generally legitimate, well-meaning professionals who keep accurate records, pain physicians also present a better target than underground, black-market drug dealers for a DEA that has been subject to increasing criticism from Congress and the Department of Justice for its inability to measurably reduce the domestic drug supply. Even worse, the DEA's renewed war on pain doctors has frightened many physicians out of pain management altogether, exacerbating an already serious health crisis—the widespread undertreatment of intractable pain. Despite the DEA's insistence that it's not pursuing "good" doctors, it isn't hard to see how rhetoric from law enforcement officials and prosecutors would make doctors think otherwise. Hurwitz's prosecutor, for example, promised to root out bad doctors "like the Taliban."¹⁵⁹ Another assistant U.S. attorney said, upon the sentencing of one doctor to eight years in prison for having worked for 57 days at a pain clinic: "I believe and I hope that this case has

sent a clear message to the medical community that they need to be sure the controlled substances they prescribe are medically necessary. If doctors have a doubt about whether they could get in trouble, this case should answer that"—a statement that implores doctors to err on the side of undertreatment.¹⁶⁰

It isn't hard to see how all of this would make it more difficult for pain patients to find treatment. "You worry every day that the medicine won't be available for much longer," one patient told the *Village Voice*, "or your doctor won't be there tomorrow because he's been arrested by the DEA."¹⁶¹ One doctor flatly told the *Wall Street Journal*, "I will not treat pain patients ever again."¹⁶² Still another told *Time* magazine, "I tend to underprescribe instead of using stronger drugs that could really help my patients. I can't afford to lose my ability to support my family." The *Voice* also reports that many medical schools now "advise students not to choose pain management as a career because the field is too fraught with potential legal dangers."¹⁶³

The most obvious (though least likely) course of action to address these problems would be for Congress to end the costly, regrettable War on Drugs. Barring that, the best way for law enforcement officials to battle the problem of diversion would be to combat the theft of the drugs from warehouses, manufacturing facilities, and en route to pharmacies. More importantly, the DEA, DOJ, Congress, and state and local authorities should end the senseless persecution of doctors and allow them to pursue whatever treatment options they feel are in the best interests of their patients, free from the watchful eye of law enforcement.

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