
Treating Doctors as Drug Dealers

The Drug Enforcement Administration's War on Prescription Painkillers

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Untreated pain is a serious problem in the United States. Given the difficulties in measuring a condition that is untreated, estimates of the number of people affected 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 (Hall 1999). The American Pain Foundation, a professional organizations 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, family violence, absenteeism and job loss, depression, and suicide (American Pain Foundation n.d.). The American Pain Society, another professional group, estimates that in 1995, untreated pain cost American business more than \$100 billion in medical expenses,

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lost wages, and other costs, including 50 million workdays (American Pain Foundation 2002, 1) A 2003 article in the *Journal of the American Medical Association* puts the economic impact of common ailments such as arthritis, back pain, and headache alone at \$61.2 billion per year (Stewart et al. 2003).

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

According to one 1999 survey, just one in four pain patients received treatment adequate to alleviate suffering (American Pain Foundation 2004; see also Wisconsin Medical Society 2004, 16). 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” (Wolfe et al. 2000, 326). 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” (Hall 1999). The American Medical Association (AMA) 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. 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 (Dilcher 2004).

One reason chronic pain remains undertreated is that few doctors specialize in the field. Dr. J. David Haddox, the vice president of health affairs at Purdue Pharma L.D., the manufacturer of the long-acting opioid medications OxyContin and MSContin, estimates that only 4,000 to 5,000 doctors who specialize in pain management treat the 30 million chronic pain patients who seek treatment in the United States (personal communication, November 11, 2004)—about one doctor for every 6,000 patients.¹

1. See also “FDA Panel” 2003. Four professional boards of medicine offer certification in pain management. As of November 2004, 5,869 physicians were certified in pain medicine, but not all of them prescribe opiates for the treatment of chronic pain. The boards and the number of doctors certified are as follows: American Board of Anesthesiology (ABA), 3,127; American Board of Pain Medicine (ABPM), 1,768; American Board of Physical Medicine and Rehabilitation (ABPMR), 875; American Board of Psychiatry and Neurology (ABPN), 99. Data compiled from personal communications with Kris Haskins (ABPM) on November 11, 2004; Steve Glick (ABPN) on November 17, 2004; Joseph McClintock (ABA) on November 22, 2004; and Donna Morris (ABPMR) on November 17, 2004.

In Florida, just one percent, or 574, of the state's 56,926 doctors prescribed the vast majority of narcotic drugs paid for by Medicaid in 2003 (Schulte 2003, 1).

The shortage of pain doctors can be explained in part by the relatively new, dynamic nature of pain medicine as well as by many people's aversion to narcotics. Not until the 1980s did physicians who specialized in opioid treatment for the pain associated with terminal cancer begin to advocate the same treatment for nonterminal chronic pain patients (Long 2002, 4). The field's novelty has not only prevented physicians from seeking it out as a specialty, but also caused a great deal of debate initially within the medical community. Although many physicians now approve of opioid therapy for nonterminal chronic pain, some initial resistance arose 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" (Hall 1999). In an article for *Ramifications*, a newsletter for pain specialists, Dr. Karsten F. Konnerding of the Richmond Academy of Medicine compares the contemporary practice of pain medicine with the infant field of radiology at the turn of the twentieth century. One London newspaper at that time, Konnerding notes, called radiographs of bones and organs "a revolting indecency" (2002, 1).

Having overcome their reluctance to enter an emerging and not-altogether-accepted field, physicians specializing in pain medicine can find themselves caught in a "damned if you do, damned if you don't" conundrum with some patients. My own 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 (Rosenthal 2002, 4; see also *Bergman v. Eden Medical Center*, Alameda County Ct., no. H205732-1 [June 13, 2000]).

Such cases notwithstanding, a significant reason why 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 worth of such drugs, many of which are finding their way to the black market, contributing to an epidemic of addiction, crime, and death ("OxyContin Special" 2001).² Over the past 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 or overdosed on prescription painkillers. If convicted, those physicians are subject to the same mandatory drug-sentencing guidelines designed to punish

2. See also Asa Hutchinson, administrator, Drug Enforcement Administration, testimony before the House Committee on Appropriations, Subcommittee for the Departments of Commerce, Justice, State, the Judiciary, and Related Agencies, 107th Cong., 2nd sess., March 20, 2002.

conventional drug dealers. These 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.³ One 1991 study in Wisconsin, for example, found that more than half the doctors surveyed knowingly undertreated pain in their patients out of fear of retaliation from regulators (Weissman et al. 1991, 671). Another 2001 study of California doctors found that 40 percent of primary-care physicians said fear of investigation affected how they treated chronic pain (Potter et al. 2001, 148). In states where state regulatory bodies aggressively monitor physicians' prescriptions of narcotics, doctors are even more reticent to treat pain adequately (Brushwood 2003, 41 and n. 13).

"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" (qtd. in Kaufman 2003b).

A Brief History of Painkillers and the Law

From the 1880s until about 1920, narcotics were unregulated and widely available in the United States (Musto 1999, 1–23). Drug addiction was largely accidental, owing to the public's ignorance of 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 fifty-four diseases, including insanity, diarrhea, dysentery, menstrual and menopausal pain, and nymphomania.⁴ Opiates were as readily available in drug stores and grocery stores as aspirin, serving many of the same functions that alcohol, tranquilizers, and antidepressants serve today. That perception changed during the Progressive Era, when the government criminalized the common use of opium (Musto 1989; Hohenstein 2001).

The first federal law to criminalize the nonmedical use of drugs was the Harrison Narcotics Act of 1914 (Public Law 223, 63rd Cong., 3rd sess., December 17), which outlawed the nonmedical use of opium, morphine, and cocaine. The law was supported by advocates of Prohibition (Sterling 2000; Levine 2002, 3).

Section 2 of the Harrison Act made it illegal for any physician or druggist to prescribe narcotics to an addict, effectively turning one-quarter of a million drug-

3. See, for example, Fleischer 2003a ("Almost any doctor in the state could prescribe the one class of chemicals that could ease Paul's pain, but many are afraid to do so. . . . The result is an increasing number of medical practices displaying signs that say 'No OxyContin prescribed here'"). See also Alberts and Adams 2001.

4. From H. H. Kane's *The Hypodermic Injection of Morphine: Its History, Advantages, and Dangers*, a work published in 1880, as discussed by Edward M. Brecher and the editors of *Consumer Reports Magazine* (Brecher and Editors 1972).

addicted citizens and their doctors into criminals (Musto 1999, 181–82; Hohenstein 2001, 253). 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 (Musto 1999, 121). Hundreds of doctors were arrested almost as soon as they had registered, however, and were prosecuted for prescribing narcotics to addicted patients. During the first fourteen years after the act's passage, U.S. attorneys prosecuted more than 77,000 people, most of them medical professionals, for violating the act (Hohenstein 2001, 245). Between 1914 and 1938, approximately 25,000 doctors were arrested under the terms of the Harrison Act for giving narcotic prescriptions to addicts (Epstein 1977, 104). Many were eventually put on trial, and most lost their reputations, careers, or life savings. By 1928, the average sentence for violation of the Harrison Act was one year and ten months in prison (U.S. Department of the Treasury 1928, 473; Musto 1999, 368 n. 6). More than 19 percent of all federal prisoners were incarcerated for narcotics offenses (King 1972, 786). 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 (Musto 1999, 59, 67, 211).

The Harrison Act was repealed in 1970, but was replaced by the Drug Abuse Prevention and Control Act (DAPCA) (Musto 1999, 255).⁵ The DAPCA, along with the 1975 Supreme Court ruling in the case *United States v. Moore* (423 U.S. 122, 124 [1975]) reaffirmed the legality of the Harrison Act’s criminalization of doctors who treat addicts by prescribing controlled pharmaceuticals. In *Moore*, the Supreme Court confirmed that physicians who are licensed by the Drug Enforcement Administration (DEA) 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.”⁶ A doctor may be criminally charged with unlawfully pre-

5. The Controlled Substances Act is Title II of the DAPCA of 1970. It initiated the war on drugs and started a national campaign against illicit drugs and associated crime. It also gave the Bureau of Narcotics and Dangerous Drugs the authority to regulate legal prescription drugs. When the DEA was created in 1973, it acquired this bureau’s authority.

6. The Controlled Substances Act created five categories of drugs based on their approved medical use and the potential to addict patients. Schedule I drugs, such as heroin and marijuana, have no approved medical use and were said to have a high potential for addiction. They are authorized for medical research only. Schedule II drugs are narcotics and nonnarcotics such as cocaine, methadone, oxycodone, and OxyContin. They also include nonnarcotic drugs such as amphetamines and barbiturates that are approved for medical use but have the highest addictive potential. Schedules III, IV, and V include narcotics combined with nonnarcotic drugs, such as codeine and aspirin, and caffeine and mild depressants, and tranquilizers that have a low risk of addiction.

scribing (or “diverting”) highly addictive narcotic drugs that the DEA classifies as Schedule II “controlled substances.” Even though the DAPCA was enacted during a period of general drug tolerance, it 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 has sought to “bring to the criminal and civil justice system substances destined for illicit traffic in the U.S.”⁷ Until the 1990s, the DEA focused its resources primarily on illegal drugs, such as heroin, cocaine, crack cocaine, ecstasy, and marijuana, sold on the black market in urban areas.

In 1999, the DEA came under heavy criticism from Congress on the grounds that no “measurable proof” existed to show that it had reduced the country’s illegal drug supply (U.S. GAO 1999, 7, 61, 72–73, 78). In 2000 and 2001, the Department of Justice, which administers the DEA, gave the agency a highly critical rebuke and asserted that its goals were not consistent with the president’s federal National Drug Control Strategy (U.S. Department of Justice 2001). The DEA now needed to find a new front for the war on drugs on which it 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 was not doing more to combat prescription-drug abuse when it was “a problem equal to cocaine” (DEA 2002b). Fine claimed that whereas 4.1 million Americans used cocaine in 2001, 6.4 million used prescription narcotic painkillers illegally 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 antidrug campaign, the OxyContin Action Plan (DEA 2001a; Nagel and Good 2001). 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” (DEA 2002b, 1). 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 (DEA 2002b). 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 I substances. That shift put pain doctors in the DEA’s crosshairs, making them as susceptible to investigation as conventional drug dealers. In September 2003, at the sixty-nine-count indictment of Virginia doctor William Hurwitz, U.S. attorney Mark Lytle claimed that the physician was complicit in the deaths of three

7. “DEA Mission Statement,” available at: www.dea.gov/agency/mission.htm.

patients, and he compared Dr. Hurwitz to a “street-corner crack dealer.” He further argued that Hurwitz posed such a threat to the community that he should be denied bail (qtd. in White and Kaufman 2003).

Based on unfounded fears of a “dope menace” sweeping the country, 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. 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.⁸

This was the first time the DEA had grouped a legal prescription drug with illicit drugs, though it would not be the last. Government officials such as Hutchinson have gone on to make frequent public statements that put 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 deal with the emerging opioid threat. He 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.⁹

The DEA’s public-relations effort linking a pain medication such as 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. Whereas the conventional drug war targeted black markets and the unknown, hard-to-quantify entities associated with them, the new mission now had in practicing physicians a pool of registered, licensed, cooperative targets who kept records, paid taxes, and filled out a variety of forms.

8. Statement of Asa Hutchinson, Administrator, Drug Enforcement Administration before the United States Senate Caucus on International Narcotics Control, Executive Summary, April 11, 2002, 107th Cong., 2nd sess., available at: <http://www.dea.gov/pubs/cngrtest/ct041102p.html>.

9. *Ibid.*

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 (DEA Diversion Control Program 2002). On the basis of those reports, the DEA subsequently announced that there had been 464 “OxyContin-related deaths” over those two years (DEA Diversion Control Program 2002, 4).

The conclusions the DEA drew from these data, however, are significantly flawed. First, the DEA’s criteria for “OxyContin-related deaths” are problematic. Fifty-eight pain relief drugs contain oxycodone. OxyContin is simply one of three single-entity, long-acting oxycodone drugs. Numerous less-potent, short-acting oxycodone drugs such as Percocet, Percodan, and Roxicet also contain nonnarcotic pain relievers such as aspirin or Tylenol. OxyContin is Purdue Pharma’s brand-name drug. It is popular because it provides long-acting relief from pain for up to twelve hours, which enables pain sufferers to sleep through the night. Because no chemical test distinguishes OxyContin from the other oxycodone drugs, it is difficult to see how the DEA could definitively assert that a death attributable to oxycodone was also attributable to OxyContin and not to 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 (DEA Diversion Control Program 2002, 1–2).

Second, if an OxyContin tablet is found in the gastrointestinal tract of a deceased person, the DEA regards that finding as indicative of an “OxyContin-*verified* death,” regardless of other circumstances. Even more problematic, if investigators find OxyContin pills or prescriptions at a crime scene or if a family member or witness merely mentions the presence of OxyContin, the death is also confirmed as “OxyContin-verified” (DEA Diversion Control Program 2002, 2). 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 (DEA Diversion Control Program 2002). Approximately 40 percent of the autopsy reports of OxyContin-related deaths showed the presence of Valium-like drugs. Another 40 percent indicated the presence of 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. These deaths might be the result of any of the drugs present, of drugs acting in combination, or of 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 twenty-three states over a three-year period, only 12 showed confirmed evidence of the presence of oxycodone alone in the system of the deceased (Cone et

al. 2003).¹⁰ Approximately 70 percent of the deaths were attributable to “multiple drug poisoning” involving other oxycodone-containing drugs in combination with Valium-type tranquilizers, alcohol, cocaine, marijuana, or other narcotics and antidepressants (Cone et al. 2003). That evidence suggests strongly that many of the deaths attributed to OxyContin by government officials are not the result of pain patients unknowingly becoming addicted to OxyContin and then overdosing, but of habitual drug users taking that drug with any number of other substances, any one of which might have contributed to overdose and death.

In the absence of opioids such as OxyContin, habitual users will in all likelihood merely switch to more available drugs. Pain patients who rely on the drug for relief, however, do not have that option. They are 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 (DEA Diversion Control Program 2002, 1). According to the DEA’s own autopsy data, 146 “OxyContin-verified deaths” and 318 “OxyContin-likely deaths” occurred that year, for a total of 464 “OxyContin-related deaths” (DEA Diversion Control Program 2002, 4). That total implies a risk of just 0.00008 percent, or 8 deaths per 100,000 OxyContin prescriptions—2.5 of them “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) such as aspirin or ibuprofen (Singh 1998). NSAIDs are not as effective as opioids in 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 is not used recreationally, but causes thirty-five times more deaths per year. Given these numbers, all of the time, energy, tax dollars, and worry expended on eradicating the OxyContin “threat” seems unfounded—not to mention the menace to civil liberties.

Another Bout of Drug Hysteria

To justify its crackdown on prescription painkillers, the federal government would first need to persuade the public of the threat that prescription opioids pose. Unfortunately, the news media have been far too willing to accept the DEA’s claims at face value, just as they were during previous so-called drug epidemics (Gray 1988; see also Epstein 1977).

To convince the public that an opioid drug threat exists, the DEA compared OxyContin to crack, cocaine, and heroin, the most feared drugs of the 1980s and

10. This study was funded by Purdue Pharma, manufacturer of OxyContin, but was subjected to the normal peer review process.

1990s. Commissioner 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.”¹¹ Many mainstream media reports echoed these claims. *Newsweek*, for example, ran a story in 2002 about “Oxybabies,” the children of pregnant women on OxyContin, which bore a striking resemblance to the rash of “crack baby” stories in the 1980s (Rosenberg 2002, 37). 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.” The article’s evidence indicates the former so strongly, however, that one wonders why an article on Oxybabies was necessary in the first place.

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

- *Time* magazine ran a story in January 2001 reporting that “OxyContin may succeed crack cocaine on the street” (Roche 2001, 47). In Pulaska, 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 is not clear). Both kinds of crime, of course, are means by which OxyContin may have found its way to the street other than by diversion through doctors’ prescriptions. Nevertheless, 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 & World Report* published an article about the danger of OxyContin under the headline “The ‘Poor Man’s Heroin’” (Cohen 2001). The article featured Dr. John F. Lilly, a forty-eight-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 reach-

11. Asa Hutchinson, statement before the House Committee on Appropriations, Subcommittee on Commerce, Justice, State, and Judiciary, 107th Cong., 1st sess., December 11, 2001, pp.1ff.; Hutchinson, April 11, 2002, p. 1. Hutchinson, testimony before the House Committee on Appropriations Subcommittee, March 20, 2002.

ing near-epidemic levels in rural areas. Shortly after Dr. Lilly opened his clinic, drug-related crimes apparently started to increase. Yet police also claimed that burglaries had increased by 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 fifty-nine people had died from OxyContin overdoses in eastern Kentucky in 2000 alone (Clines 2001). 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 sixteen deaths in southwestern Virginia were attributable to OxyContin in combination with other drugs and alcohol.

Again, no test exists to determine whether or not OxyContin caused or contributed to those overdose deaths. Even if there *were* such a test, it is just as likely the drugs came from Internet pharmacies or from robberies of homes or drug stores as from diverting doctors. The *Times* article also reported data showing hospital emergency-room visits somehow "involving oxycodone" increased from 3,190 in 1996 to 6,429 in 1999. The *Times* article did not give a source or context for its claim that "federal data" show an increase in emergency-room visits "involving oxycodone," but one presumes that the data come from the *Drug Abuse Warning Network (DAWN) Report*, published by the U.S. Department of Health and Human Services (2004). That report's findings seem to mirror the numbers in the *Times*. The *DAWN Report*, however, only cites mere "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 that drug. Yet the drug's increasing availability also means that it will be present in more people who visit emergency rooms for other reasons. Moreover, that more people are abusing the drug is 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 the words *morphine* or *opioid therapy*, with the latter sounding a lot like *opium*. In truth, however, the medical evidence overwhelmingly indicates that properly administered opioid therapy rarely if ever results in "accidental addiction" or opioid abuse.¹² Most recently, a 2005 study by researchers at the Min-

12. See Porter and Jick 1980, 123. Also, Medina and Diamond's (1977) survey of patients treated at a large headache center during eleven months could identify only three problem cases (two codeine abusers and one propoxyphene abuser) among the 2,369 patients who had access to opioid analgesics. A study by Moulin and colleagues (1996) used a crossover design to compare the opioid against a placebo (benztropine) to

neapolis 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” (“Opioids” 2005). 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” (qtd. in Gorman 1997, 65).

The distinction that 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 such dependency is quite different from addiction. Opioid therapy can give patients the freedom to lead normal lives, whereas addiction ruins lives. Confusing the two situations can be tragic. One doctor told *Time* he was treating a terminally ill boy whose father did not 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” (Gorman 1997, 66).

The odd thing is that well before the OxyContin hysteria and ensuing DEA campaign, many media outlets were making these same points and providing balanced reporting on the undertreatment of pain. The *Time* article noted earlier came out in 1997. Also in 1997, *U.S. News & World Report* ran a 4,400-word cover story on the plight of pain patients (Brownlee et al. 1997, 54). 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. (Brownlee et al. 1997, 54)

The authors of the story went 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

ensure blinding of the therapy. The study evaluated a broad range of outcomes related to subjective effects and function. The results demonstrated a significant reduction in pain during morphine therapy, without change in physical or psychological functioning, and without evidence of psychological dependence or aberrant drug-related behavior.

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. (Brownlee et al. 1997, 54)

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 (Weinstein et al. 2000). Thirty-five percent of physicians in a 2001 study said they would *never* prescribe opioids on a short-term basis, even after a thorough evaluation—a response that the survey's researchers attributed to unfounded fears of addiction (Potter et al. 2001, 147–48). Again, these fears exist 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 of October 19–23, 2003, entitled "OxyContin under Fire" (Bloodsworth 2003c; see also Bloodsworth 2003d).

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 nineteen OxyContin-related articles and editorials that month, complete with photos of victims, flashy layouts, and insert boxes designed to illicit 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 part. Some died of overdoses or committed suicide. Bloodsworth alleged that white males ages thirty to sixty who experience back pain are especially likely to become addicted to OxyContin and eventually to die from that addiction (Bloodsworth's report cited in Tracy and Leusner 2004).

One of the featured victims was David Rokisky, a thirty-six-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 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 thirty-nine-year-old Kissimmee, Florida, handyman and father of three. Bloodsworth reported that Cover became an addict

after a doctor prescribed OxyContin to relieve the 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 Food and Drug Administration (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 so-called epidemic. She blamed Purdue Pharma for aggressively marketing OxyContin either to naive doctors or to unscrupulous doctors who used the drug to “boost their profits” (Bloodsworth 2003b). According to Bloodsworth, 573 deaths in Florida were linked to oxycodone in 2001 and 2002. By comparison, she reported that only 521 people died of heroin overdoses during the same period. The 573 figure apparently came from the *Sentinel*’s review of thousands of documents, including five hundred autopsy reports by Florida’s medical examiners. The paper claimed that a remarkable 83 percent of the 247 cases of reported drug overdose deaths during that period were directly attributable to OxyContin (Bloodsworth 2003b).

It would be difficult to overstate how much the *Sentinel* series contributed to nationwide OxyContin fears. It prompted an anti-opioid grassroots 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 Governor 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-size photos of family and friends who allegedly died from OxyContin overdoses (“Congress Tackles OxyContin” 2003). Victor Del Regno, a Rhode Island business executive whose twenty-year-old son allegedly died 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” (Bloodsworth 2003a).

Governor Bush and state lawmakers were sympathetic, and they promised to put an end to the “hemorrhaging of lost lives” allegedly caused by prescription painkillers (Bloodsworth 2003a). 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.”¹³

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, tried for trafficking in OxyContin; Dr. Michell Wich and Dr. Asuncion Luyao, convicted of prescription-overdose deaths.¹⁴

13. James R. McDonough, testimony before the Government Reform Committee, House Subcommittee on Criminal Justice, Drug Policy and Human Resources, 108th Cong., 2nd sess., February 9, 2004.

Bloodsworth's claims about the OxyContin epidemic were picked up and repeated in newspapers and media outlets all over the country. They were even included in a U.S. General Accounting Office (GAO) report on OxyContin abuse requested by Congress. The 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 (2003, 10).

Thanks in large part to the *Sentinel* series, Florida today is one of the states in which it is most difficult 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 (Hollis 2004).

The Sentinel Series Unravels

In February 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 before 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 (Kurtz 2004). "Accidental addict" Gerry Cover also proved to be a longtime drug abuser, and he had been hospitalized for an overdose of other drugs three months before he had been prescribed OxyContin (Tracy and Leusner 2004).

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' data on drug overdose deaths in 2000 and 2001. Instead of the more than 570 deaths linked to OxyContin that the *Sentinel* reported for those years, the medical examiner's reports revealed the actual total for those years was only 71, with 35 in 2001 and 36 in 2002 (Florida Department of Law Enforcement 2001, 11, and 2002, 6). The *Sentinel* had included not only deaths in which 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 figure of 573 deaths (Florida Department of Law Enforcement 2001, 2002).

In truth, even the 71 overdose deaths during the two-year period studied by the *Sentinel* are suspect because the Florida medical examiners are required to report only fourteen drug groups in autopsy reports.¹⁵ It is likely that any number of unreported

14. Ibid. MacDonough's boasts were not completely accurate: As of December 21, 2005, Dr. Mirza still awaits trial; and Dr. Luyao, whose first trial ended in a hung jury, is to be retried.

15. The state medical examiners collected data on the following drugs: ethyl alcohol, benzodiazepine, cannabinoids, cocaine, Gamma hydroxybutyrate (GHB), heroin, hydrocodone, oxycodone, ketamine,

drugs were in the systems of the 71 people in whom 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 might also have been taking antidepressants, heart medication, or diabetic medications, any of which might have contributed to the cause of death. That possibility is especially likely where the deceased was older than fifty years of age—true of about one-third of the 71 Florida cases (Florida Department of Law Enforcement 2001, 12, and 2002, 7).

After a barrage of criticism, the *Orlando Sentinel* finally acknowledged its errors in the series, and in February 2004 it announced Doris Bloodsworth’s resignation from the paper’s staff. The two editors who worked on the series were reassigned (Butterworth 2004, 1; “*Orlando Sentinel* Reporter Resigns” 2004, 1).

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 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. (“*Sentinel* Overstated Deaths” 2004)

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 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” (Derfel 2004). 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,

methadone, methylated amphetamines, nitrous oxide, phencyclidine (PCP), and Rohypnol (flunitrazepam) (Florida Department of Law Enforcement 2002, i).

suggesting that OxyContin alone might not have caused some deaths,” a caveat that severely undermined 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” (Mandal and Antle 2004). 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 three hundred deaths.
- Also in August 2004, the *Boston Globe* ran a story on federal grants that would be used to target OxyContin abuse in the Boston area (Laidler 2004). 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,” claiming 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.”

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

Eradicating the Prescription Painkiller Threat

The DEA’s new mission to thwart the diversion of prescription painkillers was a significant undertaking that would require extra manpower and resources. As part of its OxyContin Action Plan, the agency carried out more than four hundred investigations, resulting in the arrest of six hundred individuals from May 2001 to January 2004. Sixty percent of those cases involved medical professionals, most of them doctors and pharmacists (the remaining cases included manufacturers and wholesalers).¹⁶

To implement its new program, the DEA participated in the Organized Crime Drug Enforcement Task Force (OCDETF) and worked cooperatively with state and local drug task forces. The OCDETF combined 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 investigations involving prescription drugs. In 2002, a total of 1,172 DEA special agents worked alongside 1,916 state and local police

16. Thomas W. Raffanello, Special Agent in Charge, Miami Division, U.S. Drug Enforcement Administration, statement before the U.S. House of Representatives Committee on Government Reform, Subcommittee on Criminal Justice, Drug Policy and Human Resources, 108th Cong., 2nd sess., February 9, 2004, p. 4.

officers in 207 separate task forces.¹⁷ 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 for 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 in more than 9,000 additional task force cases.¹⁸ 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 its twenty-two domestic field divisions throughout the United States.¹⁹ These task forces accounted for 40 percent of the DEA's prescription-narcotics seizure and forfeiture cases.²⁰

The DEA's Diversion Control Program is also a self-financing, autonomous law enforcement agency that is largely unaccountable to congressional oversight. It is financed for the most part 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 out 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 how physicians prescribe them. Unlike illicit drug dealers, most physicians are law-abiding, legitimate professionals. That condition also makes them easier targets.

The DEA sets annual production quotas for the manufacturers of narcotic drugs and 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, noting an increase in OxyContin burglaries, thefts, and robberies of hospitals and pharmacies throughout the country, including at Purdue Pharma, the manufacturer of OxyContin (DEA 2002a).

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 (Burchell, Marizco, and Volante 2004). Drug stores in rural areas have also been targets for burglars seeking OxyContin, and the Internet has become a major underground source of the drug (Associated Press 2004). 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 the order (Orr 2003). Given

17. Hutchinson, April 11, 2002, Executive Summary.

18. See the appendix in U.S. OMB 1999, 606–9. DOCID:1999-app-jus-7.

19. Hutchinson, April 11, 2002, p. 7.

20. Rogelio E. Guevara, chief of operations, DEA, statement before House Judiciary Committee, Subcommittee on Crime, Terrorism, and Homeland Security, 107th Cong., 2nd sess., May 6, 2003, p. 5.

Table 1
DEA Registrant Population in 2002

Retail Level		Wholesale Level	
Practitioners (doctors)	928,677	Researchers	6,843
Nurse practitioners and physicians assistants	71,169	Analytical labs	1,591
Pharmacies	61,057	Narcotic programs	1,151
Hospitals/clinics	14,462	Distributors	876
Teaching institutions	424	Manufacturers	453
Importers	136	Exporters	206

Source: National Association of State Controlled Substance Authorities 2002.

the poor job the DEA is doing of monitoring the narcotics it is charged with overseeing, as well as 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 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" (Hammack 2001a, emphasis added). But that is 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, and pharmaceutical companies must 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 program's funding comes from the annual congressional budget for the DEA and from the Department of Justice Asset Forfeiture Fund, which is financed by seizures of assets from illicit drug dealers and users, as well as from doctors and pharmacists under investigation for drug diversion. In 2005, the DEA requested from Congress an additional \$245.4 million for drug enforcement, including \$32.6 million for diversion control.²¹

21. Alberto R. Gonzales, U.S. attorney general, statement before the U.S. House of Representatives, Committee on Appropriations, Subcommittee on Science, the Departments of State, Justice, Commerce, and Related Agencies, 109th Cong., 1st sess., March 1, 2005, available at: <http://www.justice.gov/ag/testimony/2005/022805fy06aghousetestimonyfinal.htm>.

According to the Controlled Substances Act (21 USC Sec 853:1–2), all monies or other things of value furnished by any person in exchange for controlled substances are subject to forfeiture. The money from these seizures is divided among the law enforcement agencies making the bust, and the remainder goes to the Asset Forfeiture Fund, where it is used to coordinate more investigations. In 2002, drug asset forfeitures totaled \$441 million. In 2001, the DEA shared \$179,264,498 of its asset forfeitures with local and state police departments (DEA 2003).²² The total forfeiture fund was worth approximately \$1.2 billion by 2002 (U.S. Department of Justice 2003, 1). The DEA distributes the vast majority of asset forfeiture money to state and local law enforcement agencies that work with the agency on drug cases. This perverse system allows law enforcement officials to keep the assets of suspected drug defendants for their own local police departments.

At a 2003 training conference for drug diversion agents, Detective Dennis M. Luken of the Warren-Clinton Drug and Strategic Operations Task Force in Lebanon, Ohio, who is also treasurer of the National Association of Diversion Drug Investigators (NADDI), laid out the financial necessity of targeting physicians for investigation.²³ Luken, who worked on an asset forfeiture squad for three and one-half years, said that in an “era of budget cuts, forfeitures are an important way to make up for the losses” (Luken 2003). He 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. By using the theme “spreading the love,” Greg Aspinwall (2003) of the Miami Dade Drug Task Force, for example, stressed the importance of taking a task force approach to diversion investigations. He instructed trainees to get as many law enforcement agencies as possible involved in investigations. This method reduces costs, he said, and guarantees that “everybody gets their fair cut from the forfeitures.” He pointed out that even if criminal charges are never filed, a police department can still bring civil action against a suspected doctor to recover the cost of an investigation.

In his lecture, Detective Luken (2003) 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 his or her 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.” He

22. See also Hutchinson, April 11, 2002, p. 6.

23. NADDI was founded in 1987 for the purpose of investigating and prosecuting pharmaceutical drug diversion. Approximately 2,400 NADDI members from local and state and police departments, the DEA, insurance companies, drug companies’ and pharmacies’ loss-prevention departments, and state medical board and pharmacy regulatory agencies investigate and prosecute the diversion of prescription drugs. NADDI has fourteen state chapters in Alabama, California, the Carolinas, Florida, Indiana, Kentucky, Maryland, New England, New York, Ohio, Pennsylvania, Tennessee, Texas, and Virginia. It hosts training seminars for the purpose of coordinating methods of investigating and prosecuting drug diverters.

discussed the cases of several physicians he had overseen and noted that investigators seized money and property from the suspects *before* they were indicted or tried for any crime.

Luken then cited a number of cases in which physicians' assets were seized before the doctors were even 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 do not reveal whether 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's 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 but then expecting him to fight the case while still paying taxes and earning a living "inevitably puts the person in a position where they [*sic*] have to settle" (Eigelbach 2004). Prosecutors have not yet decided whether to pursue criminal charges.

As noted earlier, because the Diversion Control Program is self-financed, it is nearly immune from congressional oversight. Its administrators are not required to justify its existence, tactics, or efficacy through the legislative appropriations process. The program also creates a scenario in which doctors are legally required to finance investigations of their colleagues, copractitioners, or even themselves. Should the doctors' colleagues be investigated, law enforcement officials are encouraged to seize the colleagues' assets, much of the proceeds of which then goes toward financing more investigations.

From October 1999 through March 2002, the DEA investigated what it considered 247 OxyContin diversion cases, leading to 328 arrests (DEA Diversion Control Program 2003, 5). In 2001, it conducted a total of 3,097 drug diversion investigations, including 861 investigations of doctors (National Association of State Controlled Substance Authorities 2002). In 2003, the DEA investigated 732 doctors, sanctioned 584, and arrested 50 (DEA and Last Acts Partnership 2004, 42–43). 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 do not. Virginia, for example, says it prosecutes on average one health-care professional per week (Hammack

2001b). Just as Dr. Haj-Hamed did, many doctors 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” (21 USC, Section 802, *Definitions* [1]). 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*, instead of improving, as a result of taking opiates. The DEA makes no such distinction. By classifying pain patients as addicts, the agency justifies its pursuit of their doctors, now regarded as potentially illicit “distributors.”

Worse, owing to the drug laws’ unwavering stipulation that possession of more than a specified amount of any controlled substance constitutes an intent to distribute, pain patients themselves are often considered “dealers,” even if (as is most often the case) their entire supply of prescription drugs is for their own use.

Consider what happened to Florida pain patient Richard Paey (Sullum 2004). Paey suffers from multiple sclerosis as well as from injuries incurred in a car accident and a botched back surgery. Given the antidrug 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 he turned to his old doctor in New Jersey, who wrote him undated prescriptions that he then photocopied and filled. Though Paey’s prosecutor conceded that the medication Paey possessed was for his own use, he nonetheless charged him with “intent to distribute” because the amount of narcotics he had in his possession exceeded the limit needed to charge a suspect 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 twenty-five years and to 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. Of course, once pain patients can be called “addicts,” the government is free to go after the treating doctors as “conspirators” in the illegal drug trade. In the case of Dr. Hurwitz, approximately fifteen of his more than five hundred 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 cooperated openly 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 (Glueck and Cihak 2005).

In his speech at the NADDI conference, Detective Luken likened pain specialists to illegal drug dealers, and he explained that pain doctors sell pain medication for money, sex, or drugs to feed their own habits or those of family members or girlfriends—just as common drug pushers do. Investigators often paint doctors who are in practice by themselves and older doctors as rubes, easily duped by addict pain patients or unable to stop prescribing narcotics freely as they were permitted to do during more permissive times (Luken 2003).

To target doctors, investigators look for “red flags” they believe are indicative of potentially criminal behavior. These flags are generally circumstantial evidence found during standard criminal investigative procedures. Although to an investigator without medical training such flags may appear to be evidence of criminal behavior, they are often perfectly consistent with legitimate medical practice, especially in a dynamic field such as pain management. Criminal investigators without medical training simply are not qualified to tell the difference. Yet they routinely make such decisions, and such close judgment calls can trigger the criminal prosecution of an otherwise legitimate physician.

According to the DEA, the prosecution of any given doctor is based on whether a “legitimate medical purpose” exists for a prescription he has written or whether it is “beyond the bounds of medical practice.” Prosecutors concede, however, that they have no specific guidelines or procedures to evaluate either of those standards. At the Healthcare Fraud Prevention and Funds Recovery Summit in Washington, D.C., 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 intentionally wrote a narcotics prescription for patients without legitimate medical needs or that he or she knew the patients getting the prescriptions were addicts or knew the patients getting the prescriptions were selling the drugs (Wood 2004, 8–9). Any of these grounds suffices for an arrest.

Even these guidelines, however, 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 is not permitted. In October 2004, the DEA disavowed the contents of a pamphlet it had published for pain doctors and pulled the digital version of the document from its Web site (Kaufman 2004b). The pamphlet 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 (DEA n.d.; see also DEA 2004b; DEA and Last Acts Partnership 2004). 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 treating pain adequately and preventing diversion (DEA 2001b). 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” (DEA n.d.). The pamphlet also made clear that certain DEA red-flag actions or inactions, such as prescribing narcotics to patients with a history of drug abuse or not reporting patients whom physicians suspect of abusing pain medication, are *not* violations of federal law. Most notably, the pamphlet explicitly stated, “For a physician to be convicted of illegal sale, the authorities must show that the physician *knowingly* and *intentionally* prescribed or dispensed controlled substances outside the scope of legitimate practice” (DEA n.d., emphasis added).

The DEA took the extraordinary step of disavowing the document just as lawyers for Dr. Hurwitz, the pain specialist on trial for diversion in Virginia, attempted to introduce it as evidence at his trial. Hurwitz’s prosecutors objected to the introduction of the pamphlet into the proceedings, and a federal judge decided in their favor, ruling that the DEA guide did not carry the force of law and therefore was not admissible (Kaufman 2004a).

The DEA later explained that it disavowed the pamphlet because of language at odds with the agency’s insistence that in commencing an investigation it is not bound by any evidentiary standard, not even by the well-established principle in federal law that enforcement of the Controlled Substances Act should in no way interfere with 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” (DEA 2004b, 3). 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 and marking it for later dispensing, and using “street slang” rather than medical terminology when discussing pain medication with patients (DEA 2004b). The DEA’s original pamphlet had dismissed all these criteria, incidentally, 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” (Kaufman 2004c).

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 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 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.²⁴

The end result of these proceedings is that investigators and prosecutors without medical training are now in the position of interpreting whether 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 NADDI conference in July 2003, investigators were told what practices—or red flags—might indicate criminal behavior: 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 twenty-five minutes; licenses to practice in more than one state; and dispensation of large amounts of narcotics from one office (Cichon 2003).

One of the many problems with the red-flag system is that investigative bodies use invasive procedures to uncover them. NADDI, for example, instructs cops to conduct video surveillance of doctors’ offices as if they were “crack houses” (Luken 2003). 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 (Luken 2003; see also Faria 1998; Hurwitz 1998; Scott 1998).

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

24. National Association of Attorneys General, letter to DEA administrator Karen P. Tandy, January 19, 2005.

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 disavowal of its guidelines pamphlet. Doctors and patients are then forced to play a game. Patients must negotiate their way through a narrow straits, indicating enough pain to their doctors to warrant the prescription of more medication but avoiding the appearance of desperation—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 (Brownlee et al. 1997). One study published in the *Journal of Clinical Oncology* found that when asked to match their patients' pain intensity on a scale of one to ten, 35 percent of physicians failed to match their patients' descriptions within two points (Au et al. 1994). It is now not at all clear to doctors at what point they are 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" (Fleischer 2003b). 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 are not bringing in someone else's urine—all to ensure that the patients are not lying to them and to protect the doctors from prosecution down the line (Glueck and Cihak 2003). "I have to be a detective," a Tennessee doctor told the *Wall Street Journal* (Spencer 2004). One of Dr. Hurwitz's patients told the *Washington Post* that Hurwitz's treatment saved his life, and he was worried about what he would 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" (Kaufman 2003a).

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 (DEA 2004a). Common sense suggests that people posing as pain patients to divert narcotics illegally or pain patients getting excessive pain medication prescribed to them are *least* likely to report their doctors to the DEA. Conversely, it is not 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 happens. Undercover agents tend to be female because investigators believe that women are perceived to be less threatening and less suspicious, and that they are more likely to illicit 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 tells a pain patient where he can get his prescriptions filled; a physician who asks his patients which drugs they prefer and which dosage works best for them; and doctors who prescribe the same drug in the same dosage to many patients, including to more than one member of the same family (Luken 2003).

These aggressive procedures have not 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 (qtd. in Fleischer 2003b).

Brushwood also noted that investigators will often 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 (Fleischer 2003b).

Because doctors are now being prosecuted for not adequately discerning their patients' motives and intentions, pain patients know that doctors will be looking them over for signs of abuse, so many strategically 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 from diverting drugs to the black market, but because the patient may be an undercover cop. Under threat of arrest, even longtime patients can be duped by police into turning in their doctors.

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 (Faria 1998; Luken 2003).

Dr. Hurwitz's case is again an excellent example. 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" (White 2003). He was arrested at his home by twenty armed agents in the presence of his two young daughters. Investigators seized his assets, including his retirement account, and jailed him without bond (Hochman 2003). Hurwitz was eventually convicted, essentially of being unknowingly duped by pain patients who later diverted his prescriptions (Markon 2004b). 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 him of "conspiracy to distribute controlled substances and trafficking resulting in death and serious injury" (Markon 2004a). In April 2005, Hurwitz was sentenced to twenty-five years in prison and fined \$1 million (DEA 2005).

The DEA now insists that in order to secure a conviction prosecutors do not have to prove a doctor's malicious intent or desire to profit from narcotics diversion (DEA 2004b). In fact, it is 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 (DEA 2004b).

Perhaps no case illustrates the injustice of aggressive law enforcement tactics better than that of Dr. Frank Fisher (Hall 2004). Fisher was a Harvard-trained physician whose California practice served about three thousand patients, most of them rural and poor. Approximately 5–10 percent of his patients were pain patients. In 1999, the police arrested Fisher and charged him with multiple counts of fraud and drug diversion. More notably, he was originally charged with several counts of murder. State prosecutors attempted to make the case that Fisher's overprescription of narcotics made him criminally culpable for the deaths of a pain patient who died in an unrelated automobile accident, of a man who received narcotics after they had been stolen from the home of one of Fisher's patients, and of a patient who died *after* her prescription ran out and Fisher had already been arrested and imprisoned. Fisher was further besmirched in the press. Prosecutors described him as a "mass murderer" and a common drug pusher who addicted thousands of Californians to prescription painkillers.

Upon his arrest, all of Fisher's assets were seized, and he was held on \$15 million bond. It took just a twenty-one-day preliminary hearing for a judge to dismiss the murder charges and lower the bail, releasing Fisher from prison. It took another four years to gain dismissal of the remaining felony charges, including fraud and manslaughter. Finally, in May 2004, a jury acquitted Fisher of the remaining misdemeanor charges. One juror described the state's 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 felony for physicians to prescribe narcotics to addicts. In the early twentieth century, the news media highly publicized these prosecutions and turned public opinion against physicians, painting them not as healers of the sick but as suppliers of narcotics to degenerate addicts and thus as threats to the nation's health and security.

Since 2001, the federal government has similarly accelerated its pursuit of physicians it alleges 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, it has made physicians scapegoats for its own failed drug war. Because pain physicians are in general legitimate, well-meaning professionals who keep accurate records, they present a better target than 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 reduce the domestic drug supply measurably. Even worse, the DEA's renewed war on pain doctors has also 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 is not pursuing “good” doctors, it is not difficult to see how law enforcement officials' rhetoric might make doctors think otherwise. Hurwitz's prosecutor, for example, promised to root out bad doctors “like the Taliban” (White 2002). Another assistant U.S. attorney said that upon the sentencing of one doctor to eight years in prison for having worked for fifty-seven 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 implored doctors to err on the side of undertreatment (Association for American Physicians and Surgeons 2005).

It is easy to see how all of this legal fury makes 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” (Owen 2003). One doctor flatly told the *Wall Street Journal*, “I will not treat pain patients ever again” (Spencer 2004). 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” (qtd. in Spencer 2004). The *Voice* also reported 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” (qtd. in Spencer 2004).

The most obvious (though least likely) course of action to deal with these problems would be for Congress to end the costly, regrettable war on drugs. Barring that

course, 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 trucks en route to pharmacies. More important, the DEA, the Department of Justice, Congress, and state and local authorities should end the senseless persecution of doctors and allow them to pursue the treatment options they believe are in the best interests of their patients, free from the watchful eye of law enforcement.

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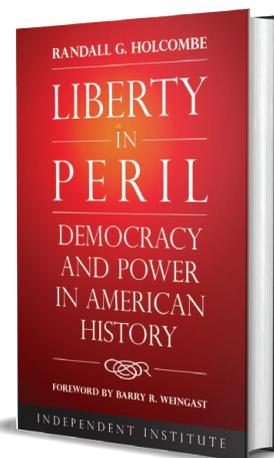
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