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Dr. Feelscared

Drug warriors put the fear of prosecution in physicians who dare to treat pain.

Maia Szalavitz

On February 1, 2002, Cecil Knox was seeing patients in his Roanoke, Virginia, clinic when more than a dozen federal agents burst through the doors with guns drawn. Helmeted, shielded, and wearing bullet-proof vests, they terrified waiting patients and employees. One worker later told the Pain Relief Network, a patient advocacy group, she thought she and her husband, who was helping her in the office that day, would be shot. She looked on in horror as an agent put a gun to his head and ordered, "Get off the phone! Now!"

Knox, a pain management specialist who had been practicing medicine in Roanoke for seven years, was dragged out in handcuffs and leg irons. The local U.S. attorney's wife, a TV reporter, was among the journalists tipped about the raid in advance. She stood outside with a gaggle of other media people to announce her husband's triumph. Knox's assets were frozen and bond set at \$200,000. He and several employees soon faced a 313-count indictment, including charges of drug distribution

resulting in death or serious bodily injury, prescription of drugs without a medical purpose, conspiracy, mail fraud, and health care fraud. Prosecutors said Knox had illegally distributed millions of dollars' worth of OxyContin, a timed-release version of the narcotic painkiller oxycodone.

William Hurwitz, a McLean, Virginia, internist and prominent pain specialist, received similarly heavy-handed treatment when he was arrested last fall. Hurwitz, who is Jewish, was visiting his children on Rosh Hashanah eve when federal agents descended upon his ex-wife's house in McLean and took him away in handcuffs. As with Knox, the government froze Hurwitz's assets; his bail was set at \$2 million. He was charged with 49 felony counts, including drug trafficking resulting in death or serious injury, conspiracy, and running a criminal enterprise.

Like Knox, Hurwitz attracted attention largely because of his OxyContin prescriptions. Attorney General John Ashcroft said "the indictment and arrests in Virginia demonstrate our commitment to bring to justice all those who traffic in this very dangerous drug." Prosecutors said Hurwitz was "no better than a street corner crack dealer" who "dispenses misery and death." Assistant U.S. Attorney Gene Rossi had earlier declared that the feds would "root out" such doctors "like the Taliban."

Knox and Hurwitz are just two recent targets of an aggressive push by the Drug Enforcement Administration (DEA) and the Department of Justice (DOJ) to impose their judgments about the proper use of opioid painkillers (drugs derived from opium and synthetics that resemble them) on doctors throughout the country. In their attempt to prevent prescription drug abuse, the DEA and the DOJ in effect have taken upon themselves the authority to regulate the practice of medicine, traditionally the province of the states. Worse, they have transformed

disagreements about treatment decisions into criminal prosecutions, scaring physicians away from opioids and compounding the suffering of patients who have trouble getting the drugs they need to relieve their pain.

Drug Control vs. Pain Control

Few disagree that pain is already poorly treated in the U.S. "Even the DEA admits that 30 to 50 million people are undertreated for pain," says Ronald Libby, a professor of political science at the University of North Florida who has studied the issue. A 1999 survey of 805 chronic pain patients conducted by Roper Starch for the American Pain Society and Janssen Pharmaceutica found that roughly half of those with serious chronic pain could not find relief -- and that the more severe the pain, the less likely it was to be alleviated. Other surveys have yielded similar results. Only a tiny fraction of the nation's nearly 1 million health care professionals licensed to prescribe controlled substances are willing to consistently use opioid medications, recognized as the best drugs for severe pain. A 2003 analysis by the Ft. Lauderdale *Sun-Sentinel* found that less than 3 percent of Florida's doctors prescribed the majority of opioids for Medicaid patients there.

During the 1990s, pain experts, patient advocates, and drug makers sought to reduce exaggerated fears about opioids and increase prescribing. Research and clinical experience had shown that few patients without a prior history of serious drug abuse get hooked on narcotics during pain treatment, resulting in addiction rates no higher than those seen in the general population. In one important study, reported in the journal *Pain* in 1982, the researchers surveyed 181 staffers of 93 burn units who had seen more than 10,000 patients and worked in the field an average of six years. Most patients had been given opioids to cope with agonizing debridement treatments, but the staff could

recall no cases of addiction in anyone without a prior history of it. A study of 100 people taking opioids for chronic pain over prolonged periods, reported in the *Journal of Pain and Symptom Management* in 1992, likewise found that none became addicted. No new evidence has contradicted this research, and a study of prescribing from 1990 to 1996, published in 2000 in *The Journal of the American Medical Association*, found that massive increases in the use of particular opioids were not associated with proportional increases in misuse; in fact, as use of some medications rose, emergency room "mentions" of them dropped.

But in the minds of police and prosecutors, such reassuring findings were overwhelmed by concerns about what was dubbed the OxyContin "epidemic." Introduced by Purdue in 1995, OxyContin was designed to deliver steady pain relief over an extended period of time, avoiding the peaks and valleys of shorter-acting pills that have to be taken several times a day. It soon became a \$1 billion blockbuster. When illegal drug users figured out how to defeat its timed-release mechanism and get all the oxycodone at once, street demand -- and media coverage -- soared. (See "The Agony and the Ecstasy," April 2003.)

Most news stories neglected to mention that OxyContin abusers generally were not new addicts freshly minted from innocent patients by irresponsible doctors. Rather, they were drug aficionados who scammed physicians for the latest media-hyped high. According to data from the federal government's National Survey on Drug Use and Health, some 90 percent of illicit OxyContin users have also used cocaine, psychedelics, and other painkillers. The typical profile is a person who has abused many drugs in many combinations for many years. OxyContin poses no greater addiction risk than other opioids

when taken as directed. But the media helped teach addicts and thrill seekers how to do otherwise.

In 2002 the *Charleston Daily Mail* quoted former Surgeon General C. Everett Koop as saying "exaggerated news stories" have "hyped [OxyContin] for recreational use into being almost irresistible." In some cases, OxyContin-related pharmacy robberies followed local exposés. On February 16, 2001, less than a week after the Cleveland *Plain Dealer* reported on the OxyContin "epidemic," someone robbed a local pharmacy at gunpoint, taking only OxyContin. *The Cleveland Free Times* quoted a drug dealer who said a customer had shown him a newspaper clipping about OxyContin, asking where he could get it.

While the OxyContin panic does not seem to have deterred addicts, it has scared doctors. "Every time there is one of these trials," says Libby, "another 50 to 60 doctors drop off from prescribing." Among the doctors recently targeted by federal or state prosecutors are Frank Fisher of Anderson, California, charged with three counts of murder and 24 drug- and fraud-related charges; Jeri Hassman of Tucson, Arizona, charged with 362 counts of "drug dealing with a pen"; James Graves of Pace, Florida, convicted in 2002 of causing the deaths of four patients and sentenced to 63 years in prison; Denis Deonarine of West Palm Beach, Florida, charged with 79 felony counts, including first-degree murder, based on a patient's death from a self-administered overdose; and Deborah Bordeaux of Myrtle Beach, South Carolina, who in February was sentenced to eight years in prison for working less than two months at a pain clinic targeted by the feds as a "pill mill."

The sheer number of charges in these cases makes defending the doctors difficult because it's natural for jurors to think that with so many counts, some crime must have occurred. But this

impression is misleading. The essence of the prosecutors' cases is that ordinary events in a doctor's office become criminal when the doctor steps outside the bounds of legitimate medicine. It's easy to generate lengthy indictments by portraying the doctor's entire practice as a criminal enterprise and redefining everyday activities related to the practice as offenses.

Each prescription of a controlled substance can be made into several crimes. In addition to drug distribution, it can be described as health care fraud because charging or billing third parties for practices that aren't really medicine is illegal. If the prescription or a bill has been sent through the mail, it can also be mail fraud. Every deposit of the physician's paycheck becomes money laundering. Seeing a patient who turns out to be a drug dealer or addict can lead to a conspiracy count, as can working with one's colleagues. Most shocking of all, any death that can in any way be connected to use of the doctor's prescriptions becomes a charge of drug dispensing resulting in death or serious injury -- even if the person who died stole the drug from a legitimate patient, lied to get the drug, used it with other drugs or alcohol, or expired while suffering from a potentially fatal illness.

Physicians face these daunting indictments with their assets frozen, their bail set as if they were drug kingpins, and their livelihoods ruined by license suspensions or bail conditions. In these circumstances, mounting a defense is extremely difficult. "It makes it impossible to retain private counsel," says Virginia attorney James Hundley, who represented William Hurwitz prior to his indictment. (He is now using a public defender.) California attorney Patrick Hallinan, who has represented Frank Fisher and has advised Hurwitz, says, "They're throwing the entire penal code at them."

The tremendous pressure that such charges bring to bear is illustrated by the 2002 federal indictment of eight doctors who worked at the Comprehensive Care and Pain Management Center in Myrtle Beach, South Carolina. Threatened with hundreds of years in prison and fearful that his wife (an employee) could also be indicted, clinic owner Michael Woodward pleaded guilty and testified that he had schemed with the other doctors, including Deborah Bordeaux, to sell drugs. South Carolina is a conservative state, and Woodward had seen his clinic repeatedly attacked in the news media. The Woodwards may also have feared that their young children could lose both parents to long prison terms.

Another clinic doctor, Benjamin Moore, told Siobhan Reynolds, founder of the Pain Relief Network, that he and his colleagues had done nothing wrong. When he, too, found that he faced life in prison, he pleaded guilty in desperation. But according to his brother, he could not go through with testifying against co-workers he believed to be innocent. Instead he hanged himself from a tree in his mother's backyard.

Doctors As Dealers

In fiscal year 2003, according to the DEA, the federal government investigated 557 physicians and arrested 34. Betsy Willis, chief of the Operations Section of the DEA's Office of Diversion Control, says "the numbers of federal prosecutions have been relatively consistent for the last four years." The DEA reports 81 arrests in fiscal year 1999, 83 in fiscal year 2000, 78 in fiscal year 2001, and 68 in fiscal year 2002.

Even if the number of federal prosecutions has declined, they have received much more attention since the news media began highlighting OxyContin abuse in 2001. And the alarm about OxyContin clearly has led to increased enforcement efforts:

Last year the DEA doubled controlled substance licensing fees for health care providers to fund more investigations, and in March the Office of National Drug Control Policy unveiled "a coordinated drug strategy to confront the illegal diversion and abuse of prescription drugs."

The strategy includes closer monitoring of prescriptions, coupled with "outreach" and "education" aimed at making doctors more skeptical of patient requests for painkillers.

Until recently, investigators would approach a physician if they suspected a patient of diversion; now they try to build a case against the doctor. "This is new in my experience, and I have been doing this for 25 years," says David Brushwood, a professor of pharmacy at the University of Florida. "I've always seen drug control and health care work together....They were never really at odds until the last two years....The way it used to be was that when drug control officials saw the beginnings of a pattern of diversion, they would say to the doctor, 'It looks like a problem is developing; let's work together to fix it.' Now when they see a small problem, they conduct surveillance and wait for it to be-come big, then swoop in with a massive show of force."

Even when there is no direct evidence of diversion, investigators and prosecutors may decide a doctor is being too generous with painkillers because they are influenced by an outmoded view of addiction. According to this view, the essence of addiction is "physical dependence," changes in the body that result in withdrawal symptoms when drug use is halted. Based on this criterion, all pain patients become addicts when they take opioids long enough.

In recent decades, researchers have recognized the inadequacy of this definition. On the one hand, some drugs that don't cause

physical withdrawal symptoms (for example, cocaine) clearly can produce a potentially self-destructive desire for more. On the other hand, the vast majority of those who try even the most addictive substances don't develop lasting habits. Researchers therefore redefined addiction to emphasize craving and negative consequences rather than withdrawal symptoms. The diagnostic manual of the American Psychiatric Association now recognizes that physical dependence is neither necessary nor sufficient for addiction, which is characterized by continued use of a substance despite ongoing drug-related problems. For pain patients, of course, the drug produces fewer problems and greater functioning, rather than the reverse.

Some patient advocates say drug warriors can't accept this reality because it undermines the logic of prohibition: If most people don't get hooked when exposed to the "hardest" of all categories of drugs, if patients' lives get dramatically better and they function perfectly well on doses that are supposed to incapacitate, stupefy, and derange, why is it so important for the government to protect us from these substances? From this point of view, the DEA must fight pain control because functional patients on high doses of opioids threaten its authority.

"It completely puts the lie to the whole criminal approach because it shows that these molecules are not evil, that people can and do function well on them," says the Pain Relief Network's Siobhan Reynolds. "It undermines the whole basis for the war on drugs and makes it a strictly scientific/medical issue."

Whatever their reasons, law enforcement officials (along with most of the public and many physicians) still cling to the old-fashioned view of addiction as a biochemical process that inevitably results from extended use of certain drugs. In the

Myrtle Beach case, federal prosecutors said in court (before being forced to retract their claim due to contrary testimony) that *none* of the clinic's 3,000 patients was "legitimate"; in other words, in their view every pain patient of all eight doctors was an addict.

The DEA defines addicts as "habitual" users of narcotics who have "lost the power of self control with reference to [their] addiction" or whose use "endangers the public morals, health, safety, or welfare." From this perspective, pain patients could be considered addicts who have "lost control" in the sense of needing the drug to function.

Many prosecutors do not understand the distinction between addiction and physical dependence or recognize the growing acceptance of opioids in medicine. Says John Burke, vice president of the National Association of Drug Diversion Investigators, "Do I think some prosecutors and law enforcement officers are not well educated? Absolutely." A 2003 study published in the *Journal of Law, Medicine, and Ethics* found that nearly three-quarters of prosecutors in four states believed simply taking opiates poses a moderate or high risk of addiction. Holding that view was one of the best predictors of who would choose to prosecute physicians in a hypothetical case designed to reflect good pain practice. Just under half of prosecutors surveyed said they would recommend a police investigation merely on the basis of evidence that a physician was prescribing high doses of opioids to some patients for more than a month, something that is perfectly legitimate in cases involving severe chronic pain.

Prescriptions for Trouble

Frank Fisher seems to have been targeted based on just this sort of suspicion. At his Northern California clinic, the Harvard

Medical School graduate accepted patients on Medicaid and Medi-Cal (California's health insurance for the poor) that most other physicians refused, and he tried to treat their pain as aggressively as he would treat anyone else's. In February 1999 state law enforcement agents raided Fisher's clinic and arrested him for drug dealing, fraud, and murder. His bail was set at \$15 million. State prosecutors accused him of "creating a public health epidemic" of OxyContin abuse and death. They implied that he must be a drug dealer because he was the largest prescriber of the drug under Medi-Cal.

But in a context where fear of prosecution leads most doctors to under-prescribe, anyone who prescribes what is necessary for severe pain will be a top prescriber. Even Burke admits that prosecuting doctors has a chilling effect on their colleagues' treatment decisions. "I know from lecturing thousands of physicians that there is no question but that it does," he says. "The thing we don't want to happen is that physicians don't prescribe appropriately because of these cases, but I know that it happens. I have to be honest." Burke also recognizes that there is no ceiling on opioid doses: When patients develop tolerance, they may need massive doses that would kill someone who had never taken the drug. "Physicians should not be targeted simply on volume," he says. "That can be a huge mistake."

The DEA insists physicians aren't targeted based on volume alone. But Fisher believes he was. While patients with moderate pain can be treated effectively with low doses of opioids, he explains, severe pain requires that the dose be adjusted ("titrated") to a level that maximizes pain relief and minimizes side effects. "To get a sense," he says, "I titrated about two dozen patients, and they ended up taking almost half of the OxyContin 80-milligram pills prescribed in California in

1998. What that tells you is that nobody else titrated."

Fisher was jailed for five months, during which time the prosecution's case began to evaporate. First, the murder charges were reduced to manslaughter by the judge, who saw no proof of intent. Then the truth about these "killings" came out. One death involved a passenger who died when her spine was severed in a van accident. Fisher was charged with her "murder" because she had high levels of OxyContin in her blood. Another "victim" had taken drugs stolen from a patient, while a third died of a self-administered overdose two weeks after Fisher was incarcerated.

During cross-examination in pretrial hearings, it was revealed that seven attempts by undercover agents to get drugs from Fisher had been rebuffed. "I had a screening process for those who tried to get controlled substances," he says. "I screened out 60 percent of those, and apparently the agents were amongst them."

In January 2003, four years after Fisher's arrest, a state judge dismissed all the charges against him because prosecutors had tried repeatedly to delay the trial. But this year prosecutors decided to pursue another set of charges against him. Instead of homicide, drug dealing, and felony fraud involving \$2 million in Medi-Cal reimbursements, they charged him with eight misdemeanor counts of fraud. Prosecutors would not put a dollar value on the offenses, but Fisher said they added up to \$150. The jury agreed with Fisher's expert, who said the billings in question didn't warrant civil penalties, let alone criminal charges, and he was acquitted of all counts in May. He still faces possible disciplinary action by the state medical board as well as civil suits by patients' relatives. Fisher forwarded an e-mail message from a juror who said: "Now that I am home and can read about you on the Internet, my heart

really goes out to you...I was upset that the prosecutor wasted my time and the court's time on such a weak case. But now that I know what you have really been through I feel embarrassed and selfish to be thinking about my own time. I hope you can reopen your clinic some day and get back to practicing medicine...Thanks for doing the job most doctors won't."

Unlike Fisher, other doctors fighting prosecutions based on their opioid prescriptions so far have enjoyed only partial victories. Last fall Cecil Knox's federal trial in Virginia got off to an inauspicious start for prosecutors when their first witness, who claimed Knox had traded prescriptions for marijuana, couldn't identify him in the courtroom or from photographs. The jurors ultimately acquitted Knox of about 30 out of 69 charges. But due to a single holdout who voted guilty, they hung on the remaining charges, including the most serious. In January prosecutors refiled the case, this time with 95 charges.

Also in January 2004, federal prosecutors agreed to drop 358 of their 362 charges against Tucson pain specialist Jeri Hassman, who pleaded guilty only to four counts of failing to report patients for infractions such as taking a recently deceased relative's OxyContin. On the same day, a Florida judge rejected a first-degree murder charge against West Palm Beach physician Denis Deonarine, based on the death of a patient who succumbed to "polydrug toxicity" after a night of drinking and drug use. But in March state prosecutors filed a new murder charge under a different statute, and Deonarine also faces 79 other charges stemming from his prescription of OxyContin and other opioids.

Second Opinions

Eli Stutsman, an appeals attorney who is representing Myrtle Beach physician Deborah Bordeaux at the behest of the Pain

Relief Network, thinks he may have found a way to stop such prosecutions, at least at the federal level. Stutsman also represents the state of Oregon in its thus-far successful battle with Attorney General Ashcroft over physician-assisted suicide, a dispute that hinges on what the federal drug laws mean and how they should be enforced. A federal appeals court's decision in that case suggests the DEA is overstepping its statutory authority when it tells doctors how controlled substances should be prescribed.

In 2001 Ashcroft tried to nullify Oregon's assisted suicide law with a directive that declared the prescription of drugs for suicide a violation of the Controlled Substances Act (CSA).

Under the CSA, a prescription is "authorized" if it is "issued for a legitimate medical purpose by an individual practitioner acting in the usual course of professional practice." If a doctor writes prescriptions to order for money, trades drugs for sex, or prescribes drugs for resale, he is operating outside "the usual course of professional practice." In such cases, the CSA authorizes the DEA to revoke the registration that allows physicians to prescribe controlled substances and to pursue criminal charges.

But Stutsman concluded that in recent cases the DEA has taken the statute's language out of context, improperly reading "for a legitimate medical purpose" as a requirement separate from prescribing in "the usual course of professional practice." Instead of claiming that the accused doctors weren't sincerely trying to treat patients, federal prosecutors have argued that the defendants wrote prescriptions that weren't "medically necessary" or that had no "legitimate medical purpose." Thus the DEA claims the authority to determine what doses of which drugs a doctor may use and what medical purposes are legitimate. Those are questions about the standard of medical

care -- the sort of questions addressed in malpractice litigation and civil actions by state medical boards.

The DEA insists it is correctly interpreting the law. "We're only looking at instances where we have information [that] practices outside of the norm are taking place," says Pat Good, acting deputy director of the DEA's Division of Diversion Control. "We're not talking about avant-garde medicine where patients are doing really well. We're talking about cases where patients are selling drugs on the street, using fictitious names on prescriptions, overdosing, and getting arrested."

But in *Oregon v. Ashcroft*, the assisted suicide case, U.S. District Judge Robert Jones found Stutsman's reasoning compelling. Ashcroft had argued that the CSA gave federal prosecutors the right to decide that assisting suicide is not part of legitimate medical practice. Jones disagreed: "The CSA was never intended, and the USDOJ and the DEA were never authorized, to establish a national medical practice [standard] or act as a national medical board. To allow an attorney general -- an appointed executive whose tenure depends entirely on whatever administration occupies the White House -- to determine the legitimacy of a particular medical practice without a specific congressional grant of such authority would be unprecedented and extraordinary." Last May the U.S. Court of Appeals for the 9th Circuit affirmed Jones' decision, finding that "the attorney general's unilateral attempt to regulate general medical practices historically entrusted to state lawmakers...far exceeds the scope of his authority under federal law."

Stutsman intends to use similar reasoning in his appeal of Deborah Bordeaux's conviction. Her prescribing never exceeded manufacturers' recommendations or those of her state medical board; there was no exchange of drugs for sex or other evidence that she was not practicing real medicine. "What

makes this particularly outrageous," says Stutsman, "is their confusion of civil and criminal standards to start with. It's an excessive exercise of federal power based on a misapplication of federal law."

Suicide Is Painless

Kathryn Serkes, spokesperson for the Association of American Physicians and Surgeons (AAPS), sees these cases as part of a long-term trend toward increased prosecutorial power that includes sentencing guidelines, mandatory minimums, and forfeiture laws. The Coalition Against Prosecutorial Abuses, a group she is organizing to fight this trend, declares: "There's still one group of trial lawyers that has been left alone to go about their dirty work with few restrictions -- and all at taxpayers' expense. These are the government prosecutors."

The AAPS, along with the Pain Relief Network, has been vocal in denouncing the federal and state doctor prosecutions. The group's Web site warns: "If you're thinking about getting into pain management using opioids as appropriate: DON'T. Forget what you learned in medical school -- drug agents now set medical standards." The AAPS urges doctors inclined to ignore this advice to be aware of the risks, including "years of harassment and legal fees," loss of income and assets, and professional ostracism.

Despite increasing outrage from physicians and patient advocates, the DEA maintains that people in pain have nothing to fear from the crackdown. "A legitimate patient with legitimate medical problems should have no problem getting another doctor if their doctor has been arrested," says the DEA's Willis.

Anti-pain activists vigorously dispute that. "This is causing

doctors not to prescribe," says the Pain Relief Network's Siobhan Reynolds, "and that means patients will be in hell." Several of the prosecutions have been associated with suicides by devastated patients who couldn't get effective treatment elsewhere. Common Sense for Drug Policy reports that one of William Hurwitz's patients killed herself on March 16. Frank Fisher says one of his patients drove her car in front of a train.

In a forthcoming documentary by Reynolds, pain patient Skip Baker says, "It's a devastating health care crisis, to the point that thousands are committing suicide that nobody knows about. Most pain patients know -- everybody's planning to run into this bridge abutment or that tree or whatever to make it look like an accident." Ronald Myers, a Mississippi physician and minister who founded the American Pain Institute, observes:

"They want to talk about deaths associated with OxyContin. But no one wants to talk about these deaths. There's been an epidemic of suicide."

Laura Cooper, an attorney with multiple sclerosis and a former patient of Hurwitz, moved to Oregon when his practice was shutting down. Her new doctor "is also under the microscope," she says. "All of these guys are on their way out -- if not on their own, the government is on the way to putting them out. Anybody who would treat me the way I need to be treated is not long for American medicine. When my doctor goes down, I don't know what I'll do."

Since Cooper lives in Oregon, she notes, "by law I can get drugs to kill myself, but not to treat my pain. The doctor could say, in effect, 'I'm not trying to treat pain; I'm trying to kill her,' and that would be more acceptable. Clearly, something's a little off kilter. My medical needs are less important than their

war on drugs."

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