Drug Cops and Doctors

How has the prosecution of the War on Drugs affected the medical community? On September 9, the Cato Institute hosted a conference, "Drug Cops and Doctors: Is the DEA Hampering the Treatment of Chronic Pain?" Dr. Linda Paey, whose husband Richard is currently serving a 25-year sentence for drug trafficking, asked why the medical community must look at pain patients as potential drug abusers first and suffering human beings only second. Professor Ronald T. Libby of the University of North Florida exposed the DEA's manipulation of statistics to cover up its persecution of pain doctors. Drew Edmondson, attorney general of Oklahoma, discussed necessary reforms on the law enforcement side.

Linda Paey: My husband Richard is a World War II buff, and he loves stories about its heroes. He has given a lot of thought to the way he would behave in war, believing that someday he would face a crisis. In 1985 he was hit by a car and badly injured his back. He had two surgeries, one with metal implants. Those surgeries started a crisis of pain, a cycle that, at the time, we were totally unaware would continue. In fact, the doctors never told us of the possibility that he might not improve.

Richard was convinced, I think like many Americans, that with determination and strong will, he could conquer the pain. He sought out the doctors. He went through every treatment and modality that they suggested, and yet he failed over and over again.

Richard, like most pain patients, endured the degrading experience of visiting medical practitioners, emergency rooms, nurses, and doctors who, when we gave them information about his medical condition, didn't believe us. We tried to tell them what medicines he was on and how he was feeling, but instead of being perceived as a suffering patient, Richard was judged on the basis of a checklist of suspicious behavior. The suspicion of addiction and diversion is so strong that medical professionals don't hear the pain. They are listening only for signs that he might be an addict. He was hurt in 1985. This is not something new. I have been shocked to hear that so many other patients have the same experiences.

We rarely got care in emergency rooms. My three small children and I would sit in the emergency room in the middle of the night for hours with my husband. Pain is not triaged very highly. I think it is a common belief in the medical community that a patient who takes high doses of medication for a long time must be addicted. But a chronic pain patient who has been suffering needs that medication.

I want the medical community to be more truthful. I visited many websites and pain treatment centers, and they all talk about multimodality treatment for pain. Combining different types of pain medication with physical therapy and other treatments sounds great, but doctors must acknowledge the place that opioids have. Patients do not seek them out, but sometimes, as with Richard, they are the only thing that works. The doctors told him that he couldn't have more back surgery, and other treatments didn't relieve his pain. He didn't choose opioid therapy; it chose him.

Linda Paey: "DEA officers put my husband Richard under surveillance, looking to see if he was diverting drugs. They found that he was not, but they pressed charges anyway."

Richard was determined to be productive. He could not sit for the bar exam in either New Jersey or Florida because he was taking Percocet. He has never been able to practice law. He tried to work twice but was unable to because of his pain.

We moved to Florida in 1994, and when Richard went to fill his prescriptions at the pharmacy, the local police and the DEA diversion officers decided that he was taking more than a normal amount of medication. They never talked to a specialist or a doctor or anybody about what they felt was ordinary or above normal. They put Richard under surveillance, looking to see if he was diverting drugs.

They found, after three months, that he was not, but they pressed charges anyway. They charged him with trafficking. In Florida, the state does not need to show that he distributed the drugs. It had only to show that he had obtained them fraudulently.

The police told Richard's doctor that they had discovered a crime. They threatened him with a 25-year mandatory minimum sentence, warning him that if they couldn't convict Richard, they would come after him. The doctor then said that the 166 prescriptions he had written for Richard were fraudulent, despite the fact that the pharmacist had confirmed the doctor's authorization by phone before filling the prescriptions. And yet the doctor said he did not write any of them, so the police charged my husband.

Richard felt he owed it to himself and to other pain patients to fight the charges. He felt that if he didn't stand up for his rights no one else would be able to stand up for him, and he felt certain that he would be acquitted. It took seven years and three trials before they convicted him and sent him to prison.

What has happened to Richard in this country, in my eyes, is shameful. The police and the DEA are picking on the most vulnerable citizens. They are spinning the facts in the courtroom. They called my husband a drug abuser, a drug addict, a drug pusher, and he has never been called any of those by any medical facility or any doctor.

When encountering a person taking large doses of painkillers, I hope that everyone, especially doctors, will err on the side of assuming the person is suffering rather than label him a drug addict. I believe that relieving pain should be prioritized over curbing diversion of drugs. It is not for anyone but the patient and his doctor to decide whether opioids are friend or foe.

Ronald Libby: For 20 years I have done research on a variety of topics, but nothing has personally affected me the way my scholarly research on pain has. All of us are per-

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sonally affected by the persecution of doctors and sick patients. Everybody I know is personally affected by this.

One thing that has driven me in the research is the personal contacts I have had with desperate physicians. I have had calls at one or two o'clock in the morning from doctors pleading with me to explain what is happening to them, not understanding. One doctor, Ben Moore, called me many times, frantic, and in the end he committed suicide. I think most of us probably are aware of cases like that, and although objectivity and balance are important in scholarly study, such personal stories are too compelling to ignore.

The DEA frequently claims that doctors have nothing to fear from law enforcement, and I cannot understand why the media do not investigate those claims. The DEA released a press release in October 2003 titled "The Myth of the 'Chilling Effect': Doctors Operating within Bounds of Accepted Medical Practice Have Nothing to Fear from DEA." The release says that, during the first 10 months of 2003, the DEA sanctioned—by which they mean arrested—fewer than one-tenth of 1 percent of registered doctors. On April 14, 2005, the DEA administrator Karen Tandy repeated that number, and DEA officials have continued to repeat it in the press. They basically say that the million doctors who legitimately prescribe narcotics to relieve patients' pain have nothing to fear. She was speaking after Dr. William Hurwitz was sentenced to 25 years in prison for prescribing high doses of pain medication to patients who, without his knowledge, misused the drugs.

Is it true that the DEA targets only one-tenth of 1 percent of physicians? In 2003 the DEA arrested 34 doctors. There are 963,385 doctors licensed by the DEA, and about 800,000 of those are practicing. However, that number is misleading for two reasons. First, only a tiny fraction of doctors is willing to prescribe high levels of opioids for the relief of pain. Dr. David Haddox, vice president of health policy at Purdue Pharma, which produces OxyContin, estimates that only four or five thousand doctors in the country are prepared to write prescriptions for 150 milligrams or more of OxyContin a day.

Conservative estimates say that there are 30 million to 50 million sufferers of chronic pain, which is one doctor for every 6,000 pain patients. The average pain doctor has maybe 300 patients. Pain patients are very difficult to manage and require intensive attention, so there are not nearly enough pain doctors to handle the workload.

What few doctors there are tend to be concentrated in major cities. In Oklahoma there are 60 pain doctors listed, but 70 percent of them live in the two largest cities. If you do not live in Oklahoma City or Tulsa and need treatment, you may have to travel hundreds of miles to find a doctor who will treat you. Traveling a long distance to find a doctor to prescribe a controlled substance is one of the red flags that law enforcement uses to decide whether patients are addicts and whether doctors are drug dealers.

Ronald Libby: "The DEA carries out direct criminal investigations of between 15 and 20 percent of all pain management doctors, resulting in needless suffering of thousands of chronic pain sufferers."

The second reason the one-tenth of 1 percent estimate is flawed is that criminal investigations, not arrests, are the best proxy to use to evaluate the DEA's actions. The DEA's prescription drug diversion investigators do not have police powers and therefore cannot make arrests; they can only investigate cases of diversion and refer them to law enforcement agents who can make arrests. Doctors may have their assets seized, their practices shut down, and their reputations ruined by DEA investigations that do not ultimately result in arrest and prosecution. In 2001 there were 861 criminal investigations of physicians. If we assume that there are 5,000 pain doctors who are prepared to use opioid treatment—and 5,000 is a generous estimate—861 of 5,000 is 17 percent. According to the DEA's own data, 17 percent of physicians who prescribe opiates were investigated in 2001.

But even the 17 percent figure understates the full impact of the DEA's actions. DEA diversion investigators work very closely with 217 local drug task forces. They provide financing and technical support, as well as records from the drug companies of prescribing physicians and pharmacies. The drug companies tell them which doctors are writing prescriptions for which drugs.

DEA information says that 56 percent of all criminal investigations of doctors are carried out by local and state law enforcement agents. Only 35 percent of doctors indicted between 1999 and 2005 were indicted by the federal government. The majority of those doctors were indicted by state and local authorities working in cooperation with the DEA.

The DEA's insistence that it has a negligible impact on the prescription of pain medicine is a myth. The DEA carries out direct criminal investigations of between 15 and 20 percent of all pain management doctors. Still more doctors are implicated in investigations carried out by local and state task forces in cooperation with the DEA.

The effect of targeting physicians is to put pain medicine in the deep freeze, resulting in the unjust prosecution of doctors and needless suffering of thousands of chronic pain sufferers.

Drew Edmondson: Most people know how they would like their lives to end. They would prefer to die at home, free from pain, in the company of family and friends. Unfortunately, some 80 percent of us will in fact die in a hospital or nursing facility. We will die in pain that could be managed and is not being managed, and we will die isolated from family and friends.

As the attorney general of Oklahoma, I began to ask why that gap between patients'

Continued on page 14

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POLICY FORUM *Continued from page* 13

wishes and medical practice exists. What are the barriers between what people envision for their end-of-life care and what is actually happening? We are all consumers of health care and, as consumers, we have the right to ask why our wishes are not being honored.

The 30 million Americans who are suffering from pain on an ongoing basis are spread throughout the 50 states. They are our constituents. They are all consumers of health care. They are in pain. That pain needs to be treated.

More than 40 percent of nursing home residents are constantly in pain that has been reported and is not being adequately treated. They are consumers of health care and have the right to demand treatment for their pain.

In 2001 a group of 21 health care organizations had been, in concert with the DEA, attempting to formulate a policy that balanced the necessity of combating diversion of controlled drugs with the necessity of adequately treating pain. The director of the DEA at the time, Asa Hutchinson, embraced the effort and joined in the public statement promoting the critical balancing act between pain relief and preventing abuse of pain medications. The DEA seemed prepared to assure doctors that writing a large number of prescriptions for high doses of medication would not by itself trigger an investigation.

In 2003 the National Association of Attorneys General adopted a resolution endorsing that balance between pain management and combating diversion. Forty-eight state attorneys general signed the resolution, agreeing to a uniform policy to balance combating diversion with effective pain management.

We were distressed, therefore, when the DEA appeared to change direction during the prosecution of Dr. William Hurwitz in Virginia. During that trial, the DEA withdrew from its website a series of frequently asked questions that explained to doctors how to comply with the rules enacted under the 2001 agreement. Suddenly, there was no guarantee that prescribing high doses of pain medication to multiple patients wouldn't spark an inquiry from the DEA.

The DEA issued an interim policy statement informing the medical profession that the agency could start an investigation based on just about any criteria it chose. As a matter of law, the DEA can use any criteria it wants to decide what warrants an investigation, but it seemed to believe that the withdrawal of the 2001 guidelines and the issuance of that interim policy statement would not change the way doctors cared for their patients.

Doctors prescribe conservatively. If doctors have two treatment options, and one is more likely than the other to bring them under the scrutiny of law enforcement, they will take the route that is less likely to get them in trouble. Every hurdle that you add to the process of monitoring medical care will make getting treatment more difficult for some patients. When you have to write prescriptions in triplicate, patient care is affected. Doctors are less likely to prescribe a drug that requires additional effort than some other drug that does not; that influences patient care. Doctors are making decisions based not on their best medical judgment but on the policy of a law enforcement agency in Washington, D.C., or Oklahoma City.

Drew Edmondson: "The undertreatment of pain is as much a departure from the standards of medical practice as the overtreatment."

In January 2005 more than 30 state attorneys general wrote a letter to DEA administrator Karen Tandy stating their support for the balance between combating diversion and effective pain management and expressing concern about the changes in policy after the Hurwitz trial. We requested a meeting with her during our March conference in Washington, D.C., to discuss the formulation of a permanent policy statement. Administrator Tandy could not meet with us because she was presenting testimony to Congress to justify the budget of the DEA. In the remarks that she made to Congress about the DEA's work in the previous year, she spoke only of indicting members of international drug cartels and breaking up distribution rings of drugs such as LSD. Nowhere did she mention the 42 doctors that DEA prosecuted in 2004. When we met with her in April, she was unable to assure us that the new policy would address our concerns.

In a press statement about the sentencing of Dr. Hurwitz, Tandy did reiterate her commitment to balance and say that ethical doctors should not have to worry about being prosecuted. Unfortunately, two days before, the DEA had issued a press release about the indictment of four people in Florida on charges related to pain medication. The press release trumpeted the $5 million worth of assets the DEA seized, but there was no mention of balance. The medical community received no information about why that was an egregious case and why the rest of the doctors do not have to worry.

The message to pain management doctors is to be afraid. Be careful if you prescribe an opioid, because we are watching. Be afraid, because we will indict you. And that is, while sometimes necessary, the wrong message to send to the medical community if we care about the 30 million Americans who are in pain.

It is my opinion that the DEA should leave the regulation of physicians to the states. The states, in turn, should rely primarily on licensure boards to refer doctors, when necessary, for criminal prosecution instead of the other way around. Licensure boards should make better progress toward adopting the pain guidelines that were proposed in 2004, which state very clearly that the undertreatment of pain is as much a departure from the standards of medical practice as the overtreatment and that those two should be viewed as equally problematic by licensure boards reviewing the conduct of doctors.

I made a speech recently about pain management at a Washington, D.C., meeting of the American Medical Association. I told those doctors that I had been blessed in my life not to have suffered from major illnesses. But I know that the time may come when I will need serious medical treatment, and that I may well be in pain. And when that day comes, the last thing I want is to see a DEA agent standing between me and my doctors. ■