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**AAPS Correspondence with DEA:  
Patients cannot expect to have adequate pain relief available when physicians are  
afraid to prescribe it.**

by Jane M. Orient, M.D., F.A.C.P.; Executive Director, Association of American Physicians and Surgeons, Inc.; April 23, 2003. Originally posted: 8/23/2004;

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April 23, 2003

The Honorable John B. Brown III  
Acting Administrator, Drug Enforcement Administration  
Mailstop: AXS; 2401 Jefferson Highway; Arlington, VA 22301

Dear Mr. Brown:

This letter is on behalf of all physicians who treat pain, especially chronic pain; their patients who suffer from it; and several real physicians whose lives are being destroyed by your agency. These physicians courageously treat very difficult patients with controlled substances, according to the best of their medical judgment and their understanding of applicable law. Our organization, founded in 1943, defends the practice of private and ethical medicine.

The DEA recently cancelled, at the last minute, a five-month commitment to attend a conference on pain management sponsored by the Pima County Medical Society. In the DEA's absence, physicians were advised to treat their patients like criminal suspects. We were told to use methods such as surveillance cameras, urine drug screens, frisking patients before they give the specimen, and maintaining a chain of custody for the specimen. These precautions were not talked about several years ago, but physicians fear they will be held to these standards retroactively.

Physicians are trained to care for their patients, not police them. When we become aware of illegality, we report it, though typically law enforcement has no interest in investigating or apprehending the suspect. But after bad publicity about someone overdosing on a painkiller, prosecutions of physicians take the form of a witchhunt.

A single example of prosecutorial abuse is sufficient to destroy physicians' willingness to care for chronic pain patients. What sane person would risk being sentenced to die in federal prison (the likely effect of the mandatory minimum drug-kingpin 20-year sentence for a 55-year old physician) for writing a prescription in good faith?

There is always the possibility for error in the practice of medicine. But for pain control, an error or isolated bad judgment is being treated as a federal crime entailing decades in prison. No mens rea is proven, and sentences are unconscionable.

Here are just a few examples of the prosecutorial abuse:

Dr. Robert Weitzel of Utah was convicted of negligent homicide but then acquitted in a new trial after the prosecutor was found to have concealed exculpatory evidence. The jury needed only a few hours of deliberation to find him not guilty. Nevertheless, he was sent to federal prison based on an unrelated admission of a record-keeping violation.

Dr. Deborah Bordeaux of South Carolina was convicted under a "drug kingpin" statute carrying a mandatory minimum sentence of 20 years, after working a mere two months in a locum tenens position treating chronic pain among other ailments;

The late Dr. Benjamin Moore, who had worked briefly in the same clinic, pled guilty, though convinced of his own innocence, and then committed suicide rather than testify against others; Dr. William Hurwitz of Virginia had his retirement account seized and faces potential indictment, even though his pain practices were under the careful supervision of the medical board; and

Dr. Jeri Hassman of Arizona, who had the largest pain practice in Tucson, is being threatened with a 28-year prison term, apparently because a small fraction of her patients used the prescriptions in unauthorized ways.

The policy of your agency was described by Asa Hutchinson, former DEA Director, in an address to the American Pain Society on March 14, 2002, as follows:

I'm here to tell you that we trust your judgment. You know your patients. The DEA does not intend to play the role of doctor. Only a physician has the information and knowledge necessary to decide what is appropriate for the management of pain in a particular situation. The DEA is not here to dictate that to you. We do not intend to restrict legitimate use of OxyContin or other similar drugs. We will not prevent practitioners acting in the usual course of their medical practice from prescribing OxyContin for patients with legitimate medical needs. We never want to deny deserving patients access to drugs that relieve suffering and improve the quality of life.

Mr. Hutchinson demanded that prescriptions be in the "usual course of medical practice" for "legitimate medical needs." But the physician who prescribes more than the average in order to treat patients in pain has an unusual practice. Any prescription may be used in an unauthorized, illegitimate way. Or physicians may unwittingly prescribe for an actor hired by the federal government to entrap them.

Patients cannot expect to have adequate pain relief available when physicians are afraid to prescribe it. To assure the availability of pain treatment, major reforms are needed in DEA procedures.

1. A physician's lawful prescriptions should never be second-guessed by law enforcement. No criminal investigations or proceedings against a physician should ever be contemplated without expert physician opinion that the target physician had a pattern of prescribing medications without any reasonable medical rationale. The number of prescriptions written and dosages are never in themselves a sufficient reason for criminal investigation, as accepted clinical practice requires titrating dose for effect, and judgment of effect is subjective.
2. Errors, poor judgment, and even incompetence are not criminal. The proper enforcement mechanism is civil litigation or actions by licensing boards. Moreover, administrative actions by the DEA must assure due process with opportunity to know the charges with particularity and the ability to cross-examine witnesses and otherwise present an adequate defense. Judgment must be before an unbiased tribunal that does not profit from the verdict.
3. Federal agents should not be permitted to intimidate vulnerable patients, or to knowingly make use of false testimony. Incentives to testify must be made known to juries. All encounters with potential witnesses must be videotaped with tapes made available to defendants and juries. Violations of proper procedures should carry a heavy sanction—at a minimum, loss of employment. Accountability and oversight for abusive prosecutions is badly needed.
4. Physicians who prescribe in good faith should not be criminally liable for the actions of their patients in diverting or abusing prescribed drugs.

Restoring physician trust will be difficult. Past wrongs must be righted, and a process instituted for preventing future abuses. Otherwise, the only recommendation that medical associations can make is that physicians refrain from prescribing OxyContin or other preparations disfavored by the DEA, or any narcotic in a dose higher than considered "usual," regardless of patient need.

Because physicians who follow that recommendation might find themselves in jeopardy of a malpractice action or even an action under an Elder Abuse statute, not to mention violation of their professional code of ethics, many will withdraw from any practice situations that place them in such a dilemma.

For patients, what can we suggest other than contacting their congressmen, reminding them of Drs. Weitzel, Bordeaux, Moore, Hurwitz, Hassman, and others that may come to our attention?

Sincerely yours, Jane M. Orient, M.D., F.A.C.P.; Executive Director, AAPS

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