Casualties in the War on Drugs include an increasing number of doctors whose philosophy on the role of painkillers is at odds with law enforcement.

Incidental casualties — patients suffering from chronic pain — are mounting as well. A Decatur physician, Sayed Pardazi, lost his license in February for failure to properly document his patients' need for painkillers. A Gadsden doctor, Pascual Herrera Jr., met the same fate last year.

Nationwide, the list of doctors charged for prescribing painkillers is a long one. The U.S. Drug Enforcement Administration has investigated 557 doctors this year, and disciplined 441 of them. Combined state and local law enforcement agencies target many more doctors than DEA.

Some of the doctors face charges of murder or manslaughter. All face the risk of losing their medical license. Most of the prosecutions involve allegations that doctors prescribed too many opioids — painkillers with an active ingredient related to a chemical found in opium poppy — to their patients, or failed to document why their patients needed the painkillers.

Murder charges result when one of the patients — almost always in violation of their doctors' orders — overdose on the prescribed medication. In many of the cases, the overdose occurred after a patient left his doctor's care. The prosecutions' argument in those cases is that the doctor contributed to an addiction that he knew might ultimately be fatal.

Doctors almost always lose their battles with DEA, and are increasingly hostile. As a New Mexico emergency room doctor — and the husband of a chronic pain patient — Dr. Gregory Walter put it, "Apparently the DEA has decided that prosecuting drug lords is hard and dangerous work. Prosecuting innocent physicians is like shooting ducks in a barrel."

OxyContin triggers the most charges in part because it is most easily abused and, consequently, results in the most deaths. Abusers can bypass the time-release formula of the opioid oxycodone by chewing the tablets, or by crushing them and snorting or injecting the potent result. Most other prescription oxycodone pills are mixed with Tylenol or other analgesics that would be fatal if taken in the large quantities needed for a heroin-like high.
Attention on OxyContin also results from its popularity. In 2002, OxyContin was the most-prescribed Schedule II drug with 9.6 million prescriptions in the United States. According to the DEA, OxyContin accounted for 18,409 emergency room visits in 2001 and 464 deaths nationwide in 2000 and 2001.

464 deaths in two years
This last statistic — 464 deaths during two years — may account for some of the friction between DEA and health providers. By comparison, acetaminophen — the active ingredient in Tylenol — accounts for 56,000 emergency room visits and 100 deaths per year, according to the Food and Drug Administration. Critics claim Tylenol and other nonsteroidal anti-inflammatory drugs account for as many as 16,500 deaths a year, most from liver or kidney failure and bleeding from the stomach.

One Houston-based pain-management specialist, Dr. John Hochman, felt the impact of prosecutions when the DEA arrested one of his pain-management colleagues for OxyContin prescriptions.

"You talk about a chilling effect," he said at the time. "I waited all last night for them to kick my door down."

Rogene Waite, a spokeswoman for DEA headquarters in Arlington, Va., said any chilling effect results from doctors' inaccurate perception of DEA investigations.

"The doctors should have absolutely no concern when in the course of a normal medical practice they have a doctor-patient relationship and establish that OxyContin is an appropriate pain medication for the patient," Waite said. "We would have no interest whatsoever in interfering with that relationship."

She said the number of DEA investigations of doctors decreased during the past four years.

But combined federal, state and local prosecutions have increased 800 percent during the past three years, according to Siobhan Reynolds, executive director of the Pain Relief Network.

Estimates of pain-related deaths are inexact because pain generally exacerbates some other condition, such as cancer or heart disease. Pain-management surveys suggest as many as 50 million people receive inadequate pain medication, a number that many doctors believe outweighs the relatively low rate of deaths from prescription narcotics. "OxyContin is headlines now. It will be old news in a few years and a new drug will be 'the worst epidemic to hit our streets,' " said Walter.

According to one expert, the clash between physicians and law enforcement on painkillers results from an unnecessarily adversarial enforcement system.
According to David B. Brushwood, a lawyer and pharmaceutical professor at the University of Florida, the friction between doctors and law enforcement is a recent phenomenon.

"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.

Physicians try to weed out abusers during office visits, but they will not bat 1,000 in identifying illicit users, Brushwood said. Law enforcement is better able to identify the illicit user because it contacts them — or their customers — on the street.

**Prevent abuse**

Brushwood's point: Doctors want to prevent abuse of opioids. If that is also the goal of law enforcement agents, they should assist doctors by identifying illicit patients, rather than engaging in costly enforcement actions aimed not at the fraudulent patient, but at the hoodwinked doctor.

In Brushwood's view, targeting the doctor is usually counterproductive.

"(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.

The DEA's Waite is cool to the early consult idea. She said DEA handles prescription painkillers the same way it handles other cases. "We just use normal investigative techniques."

The adversarial relationship that exists between doctors and law enforcement is disastrous for chronic pain patients, says Brushwood. For every one medical career destroyed by the DEA or local law enforcement agents, hundreds of other doctors decide prescribing opioids to chronic pain patients is not worth the risk.

One subject of a DEA enforcement action, Dr. Frank Fisher, agrees.

Fisher said he knows all about overzealous prosecution. In 1999, California law enforcement officers arrested Fisher, charged him with murder for deaths alleged to have resulted from misuse of prescribed OxyContin, seized his assets and shut down his practice. Four years later a judge dismissed the charges on the first day of trial. By that time, Fisher said, several of his patients had died — one by lying down in front of a moving train — and his practice was ruined.
Since 1999, when he was charged with murder, California has the lowest rate of OxyContin prescriptions in the nation. Fisher's interpretation is that patients are undermedicated in the state because doctors are scared of becoming the next DEA casualty.

The disconnect between doctors and law enforcement is in part attributable to ambiguous "red flags" that cause law enforcement to begin investigating doctors, according to Brushwood.

"I do this exercise with my students. I have them write on the blackboard what they would consider to be a red flag of inappropriate prescribing by a doctor. So they write, 'high volume,' 'high doses,' 'patients coming from miles around.' All that stuff," Brushwood said.

"Then I tell them to look at each of the factors and describe how, from a different perspective, each one of them actually indicates a high-quality pain management practice. And we can always do that.

"The moral is you have to look beneath the surface. Law enforcement needs to go in and ask, 'What are you doing, doctor?' Most of the time, they'll find they are looking at a high quality practice. Occasionally they will discover a dishonest doctor, and he should be put out of business," Brushwood said.

Aware that the DEA was targeting him for the second time in five years, a Virginia doctor who is a friend of Fisher's, William Hurwitz, sent a farewell letter to his patients. "I have discovered that neither the honesty nor the competence of the physician is any substantial protection against prosecution, as the investigating and prosecuting officials neither know or care about the accepted principles of treatment for chronic intractable pain," Hurwitz wrote.

Fisher said overzealous prosecutions of doctors who prescribe opioids have exacerbated a much more serious problem: Chronic pain sufferers who must resort to dangerous street drugs or suicide to obtain relief. Even if they spurn those options, Fisher said, many die prematurely of heart conditions or cancer because the pain saps their recuperative powers.

Fisher said law enforcement needs to back off.

"Chronic pain is the largest public health problem in America," Fisher said. "When treated correctly, it is very manageable. Just take the law enforcement pressure off the doctors, and we will resolve it."

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