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ESSAY

## Doctors Behind Bars: Treating Pain Is Now Risky Business

By SALLY SATEL, M.D.

**I**n February 1999, Dr. Frank Fisher, a general practitioner in Shasta County, Calif., was arrested by agents from the California state attorney general's office and charged with drug trafficking and murder.

The arrest was based on records indicating that Dr. Fisher had been prescribing high doses of narcotic pain relievers to his patients, five of whom died. He lost his home and his medical practice and served five months in jail before it was discovered that the patients had died from accidents or from medical illnesses, not from the narcotics he prescribed.

All charges were dropped last year, and Dr. Fisher now has his medical license back. Yet his ordeal lingers as a cautionary tale of what can happen to doctors who treat pain aggressively.

Over the last decade or so, pain specialists and patient advocates have diligently educated doctors about the undertreatment of persistent and debilitating pain. But as physicians have expanded their use of opiate painkillers like oxycodone and hydrocone, the abuse and diversion of the drugs has also increased. This, in turn, has led the Drug Enforcement Administration to intensify its scrutiny of physicians.

The result is a clash of imperatives: The doctor's job is to treat pain; the drug agency's is to stop the diversion of prescription drugs for illicit use. And resolving this conflict has become a pressing matter for doctors, pharmacists, law enforcement officials and patient advocates alike.

"Pain management has become a crime story when it really should be a health care story," said David Joranson, director of the Pain and Policy Studies Group at the University of Wisconsin.

No one questions that abuse of opiate painkillers is a problem. But federal and state law enforcement agents, who wield considerable power in deciding whether to initiate investigations, as well as the prosecutors and jurors who determine a doctor's fate if the case goes to trial, are often misled by obsolete ideas about the practice of pain medicine and the effects of opiate drugs.

Pain treatment itself is an area ripe for misinterpretation. Many patients who seek doctors' help have already tried nonsteroid anti-inflammatory drugs, conventional opiates like codeine and even surgery, yet they are still in severe pain from cancer, degenerative arthritis, nerve damage or other conditions. Large doses of medicines like hydrocodone (Vicodin), oxycodone (OxyContin), morphine or methadone may be required.

Consider the clinical experience of a colleague, a neurologist who ran a pain service at a university medical center. He treated a young woman who developed a number of painful disorders including complex regional pain syndrome, psoriatic arthritis and diabetic neuropathy. She was in so much agony that she could get around only in a motorized wheelchair and could barely move her arms to feed herself.

Disuse led to the stiffening of her arm muscles, and surgery was needed to release the tendons. Still, the pain was so excruciating that her doctor had to increase her dose to a staggering 3 grams of oxycodone per day, 90 grams per month - easily 30 to 60 times the standard dose for a person with, say, a painful degenerative disk disease. At this level of pain medication, she was able to get out of bed and use her wheelchair.

It is not known how many patients need long-term treatment with opioids, particularly at high doses. Dr. Russell K. Portenoy, chairman of pain medicine and palliative care at the Beth Israel Medical Center in New York, cites surveys estimating that as many as 6 to 10 percent of Americans suffer from chronic, disabling pain. He speculates that maybe 1 in 10 of them could benefit from long-term, high dose treatment.

This small group, however, is probably responsible for a large portion of all the narcotic painkillers prescribed. Dr. Fisher, for example, told Reason magazine that almost half of all the highest strength OxyContin pills prescribed for patients enrolled in California's MediCal program in 1998 had been consumed by 24 of his patients.

The red flags that rightly alert regulators to potential misconduct by doctors are, paradoxically, the very features that can also mark responsible care for intractable pain. These include prescribing high volumes of narcotic painkillers for extended periods, prescribing potentially lethal doses or prescribing several different drugs. In some regions, patients use several different pharmacies, at their doctor's instruction, because some pharmacists are reluctant to dispense large quantities of the medications.

To complicate matters further, doctor shopping can also be a sign of what is called pseudo-addiction: the efforts to obtain drugs look on the surface like drug addiction, but in fact represent the patient's attempt to attain an adequate level of pain control. Once that is achieved, the patient no longer presses for more narcotics.

Also confusing is the distinction between addiction and physical dependence. Physical dependence occurs in almost everyone who takes narcotic medication regularly for at least two weeks. Addiction - a craving for the drug and its compulsive use to regulate one's mood - does not.

With dependence, the body adapts physiologically to the drug, and if it is stopped abruptly, withdrawal symptoms occur. Tapering medications prevents the nausea, vomiting, diarrhea and cramping of withdrawal. Tolerance may develop such that higher doses of the medication are needed for relief. Tolerance and physical dependence are normal and reflect the pharmacologic properties of opiates.

People who are addicted to narcotics are generally dependent and tolerant, but dependence and tolerance only sometimes indicate addiction. In fact, when you scratch the surface of someone who is addicted to painkillers, you usually find a seasoned drug abuser with a previous habit involving pills, alcohol, heroin or cocaine.

Take as an example OxyContin, a high dose, slow-release oxycodone drug intended for patients with chronic moderate to severe pain. When the pill is crushed or chewed, destroying the slow-release feature, the contents can be snorted or injected for a rush similar to that of heroin.

Contrary to media portrayals, the typical OxyContin addict does not start out as a pain patient who fell unwittingly into a drug habit. In 2003, The Journal of Analytical Toxicology reported on deaths related to oxycodone in 23 states over 29 months. In less than 2 percent of the 919 oxycodone-related deaths was OxyContin the only drug - licit or illicit - found at the autopsy. In 2002, the National Household Survey on Drug Abuse found that among nonmedical OxyContin users, 98 percent had also used other addictive pain relievers for nonmedical purposes and more than a fourth had used heroin.

Last August, the D.E.A. publicly acknowledged the need for a "principle of balance" to address the necessity of access to pain medications and the approaches to containing abuse, addiction and diversion. It published "Prescription Pain Medications: Frequently Asked Questions and Answers for Health Care Professionals and Law Enforcement Personnel," which thoughtfully explained the concepts, and offered clear descriptions of the circumstances under which the D.E.A. may prosecute a doctor. Mysteriously, however, in early October the agency pulled the document from the Web site, saying it had "misstatements."

The D.E.A. declined to elaborate on its reasons for pulling the document. Some people have speculated that the agency was worried that the information could be used to help clear physicians charged with trafficking. Indeed, a lawyer for Dr. William Hurwitz, a pain management specialist whose trial on drug trafficking charges is to start Nov. 3, had already submitted the drug agency's document to the Federal District Court in Alexandria, Va., as evidence in Dr. Hurwitz's defense.

Certainly there are some doctors who abuse their power to prescribe and deserve prosecution. But overzealous law enforcement takes a toll.

"We are unable to refer patients to doctors who will treat pain, if only because once a name gets out there, patients understandably flock, and then the doctor is targeted," said Siobhan Reynolds of Pain Relief Network, a patient advocacy group based in New York. The Association of American Physicians and Surgeons, based in Tucson and dedicated to the concerns of private practitioners, has gone so far as to warn doctors against managing chronic pain, lest they face years of harassment and legal fees, even prison. "If you do," the association enjoins, "first discuss the risks with your family."

Scattered evidence confirms these impressions. A 1998 survey of more than 1,300 physicians by the New York State Medical

Society found that 60 percent were moderately or very concerned about the possibility of being investigated by regulatory authorities for prescribing opiates for noncancer pain.

A third said they prescribed lower quantities of pills and lower dosages "frequently" because of the possibility of eliciting an investigation. When asked how often they avoided prescribing a preferred drug for noncancer pain, because doing so required triplicate forms, half said "frequently."

But progress is being made. In 1998 the Federation of State Medical Boards, which represents American licensing boards, published "Model Guidelines for the Use of Controlled Substances for the Treatment of Pain" to assure physicians that appropriate prescribing of opiate painkillers would not lead to action against their licenses. Kansas was among the first states to adopt the guidelines. Now, 22 of 70 American medical licensing authorities have done so.

Recently, the California Legislature passed a bill called "The Medical Crimes: Investigations and Prosecutions." It requires that the state's district attorneys association collaborate with "interested parties" on protocols to investigate physicians.

Other states should follow suit. Better yet, they should require that prosecutors first obtain declarations from qualified medical experts as to the good faith of the physician in question before charges are filed. It would go a long way toward making pain medicine what it should be: a health care story, not a crime story.

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