The Myth of Available Pain Care

BY FRANK B. FISHER

America is in the midst of an ongoing epidemic of undertreated chronic pain. This fact is confirmed by surveys such as "Chronic Pain in America: Roadblocks to Relief," which is posted on the American Pain Society website (www.ampainsoc.org/whatsnew/toc_road.htm). The economic cost of this epidemic can be estimated, in terms of lost productivity, at about $100 billion per year. The human costs are more difficult to quantify. These include unnecessary suffering and lives ruined through inability to work. To physicians facing unwarranted criminal charges of drug dealing, the consequences of such an accusation range from damage to reputation to life imprisonment. In cases in Florida and Virginia, prosecutors have even contemplated seeking the death penalty against pain-treating physicians.

Opioid analgesics are a class of medications, which includes morphine and oxycodone. In lay terms they are recognized as endorphins. After centuries of successful use they remain the cornerstone in the treatment of chronic pain. They are natural substances that the body itself uses in the regulation of pain. When used as directed by a physician, opioids are categorically safe, and addiction is a vanishingly rare side effect.

The failure of physicians to prescribe opioid medications in quantities sufficient to control chronic pain is the immediate cause of the epidemic. The deeper causes are attributable to social forces, the most significant of which is the intrusion of the war on drugs into the medical profession and the relationship between the physician and his patient.

Most people believe that if they develop chronic pain, their physician will take care of them. They are sadly mistaken. Both scientific and anecdotal evidence inform us that chronic pain is ineffectively treated. The previously mentioned "Roadblocks" survey reveals, alarmingly, that the more severe a patient's pain is, the less likely the sufferer will be to obtain relief. This experience is described by patients all around the country who can't find a physician willing to risk prescribing the amounts of opioids necessary to bring their disease under control.

The behavior of the medical profession in its approach to the treatment of chronic pain extends far beyond neglect. Many physicians accept patients suffering from severe chronic pain into their practices. But they rarely treat these patients with dosages of medications that will allow them to return to productive lives. Instead, these unfortunate souls are subjected to a series of abuses that systematically violate their basic human rights.

This seems shocking and unbelievable. Here's how it works. Physicians are actually trained to scrutinize patients for signs of impending drug addiction. This is accomplished through the use of a set of "aberrant drug-related behaviors." These behaviors are essentially measures of compliance. Apart from pain management, compliance with medical treatment is generally thought to be in the patient's best interest and is voluntary. This is consistent with the principles of informed consent and patient autonomy, which are pillars of ethical practice. Around the issue of pain management, however, compliance takes a strange twist. It becomes, as we will see, a prerequisite for further treatment. It also becomes less than voluntary.

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The classic examples of "aberrant" behavior occur when a patient uses up his pain medications and either calls in "early" for a refill or asks his physician for a larger prescription. The list of "aberrant" behaviors for which physicians are trained to be vigilant extends to a number of other supposed transgressions, such as a request by a patient for a specific medication that the patient knows from past experience will work. Physicians are trained to regard these sorts of reasonable conduct as a sign of addiction or possibly even of illegal diversion of pharmaceuticals to the black market.

Physicians are both trained and required to react to these behaviors by imposing structure and sanctions. Structure may take the form of more frequent visits to receive smaller amounts of medication and intrusions into patient privacy that may include unannounced pill counts and mandatory drug testing. Many physicians keep a log of transgressions and employ a "three strikes and you're out policy," terminating opioid treatment after three supposed transgressions.

All of this places the pain sufferer in a terrible bind. If he can't obtain the medications he needs in sufficient quantity, he can't live a normal life. On the other hand, he isn't allowed to ask for it. If he makes his needs known, he runs the risk of being accused of addiction and criminality, and of being cut off from treatment entirely. As a result, undertreated patients suffering from chronic pain who need to ask for increased dosages are truly damned if they do and damned if they don't. Under these circumstances, it is not surprising that surveys reveal widespread undertreatment of this disease, particularly among those most severely afflicted.

This conduct is required of physicians by guidelines set out by academic pain specialists and their organizations. It is an abomination that systematically violates the central ethical obligations of the physician to his patient. These obligations include putting the patient's interests first and controlling pain. Informed consent and patient autonomy, the pillars on which ethical medicine is based, are abrogated as compliance is replaced by coercion.

Among pain victims, this results in bewilderment, increased pain, progressive disability, and general deterioration of health.

One may reasonably conclude that pain management, as it is currently practiced, is a sham. Patients who approach their physicians expecting they will receive pain control are instead subjected to an abusive program of drug control that systematically violates their basic human rights. Chronic pain sufferers are accurately characterized, along with their well-intentioned but nevertheless abusive physicians, as noncombatant casualties in the war on drugs.

The Root of the Problem

The Controlled Substances Act of 1970 assigned the criminal justice system the responsibility of regulating controlled substances. In so doing, law enforcement was inadvertently established in its current role as the regulator of medical practice. Legislative intent was to leave the practice of medicine unmolested. Instead, the law of unintended consequences, which apparently accompanies all drug-war–related endeavors, prevailed. Here's how it happened.

A *safe harbor* provision for the medical use of opioids was inserted into the act. The provision states that physicians may prescribe these medications in the usual course of their professional practice. That sounds pretty good on the surface, but that is only before one comes to understand the consequences. This provision implicitly, but unavoidably, requires that law enforcement distinguish between medical practice and drug dealing. Regardless of what one might choose to call this, the result is that law enforcement regulates the practice of medicine. Naturally, law enforcement carries out this task through the use of criminal prosecutions against physicians. It couldn't be otherwise. When society assigns law enforcement to regulate an issue, criminal prosecutions necessarily result.

The unfortunate truth underlying the pain crisis is the fact that it is impossible to regulate medicines without also regulating the practice of medicine.

Every doctor who contemplates treating chronic pain with opioid analgesics must answer the following question to his own satisfaction: By engaging in this practice, might he be misperceived by medical regulators, in this case law enforcement, as a criminal? By prescribing opioids, is he risking his career, his livelihood, his freedom, and perhaps even his life? The

answer comes down to one issue. Is the safe harbor promised by the Controlled Substances Act really safe? Can law enforcement be counted on to regulate the practice of medicine correctly? Is this even a reasonable expectation?

Physicians are good at assessing risk. This is a large part of the work they do in their professional lives. As a group, physicians seem to understand that their risk of unwarranted prosecution is real and unacceptable. They demonstrate this through their prescribing behavior or, in the case of pain management, their failure to prescribe. Many physicians may not say that this is why they undertreat chronic pain or even admit that they undertreat the disease at all, but their collective inaction speaks louder than words. The facts revealed by the surveys of pain victims are as irrefutable as the stories of abuse and undertreatment told by the individual victims of this deadly disease.

Lack of Social Conscience

While most think of medicine as an institution that can be expected to respect human rights, this is a misconception. Medicine as an institution is not possessed of a social conscience. Instead, it reacts to existing social forces, and in this sense the behavior of physicians is best understood as a reflection of the core values of society. Unfortunately, society currently places its highest value on the control of drugs including opioids, which are incorrectly regarded as dangerous and highly addictive.

The medical profession has unfortunately, but predictably, taken on the value system of society in general and of those who regulate it. Social forces do not currently allow for ethical conduct within the realm of pain management. As a result, the professional conduct of individual physicians and the behavior of the institution of medicine as a whole are neither ethical nor humane. The following explanation will clarify why this is so.

The underlying problem is that no bright line exists between what is legal and what isn't concerning the prescribing of controlled substances. In fact, many of the expected characteristics of a medical practice where chronic pain is treated effectively are viewed by law enforcement as red flags indicating criminality. This conundrum is best understood through an examination of what transpires as the criminal-justice system targets, investigates, and prosecutes a physician suspected of abusing his prescribing privileges, a physician who becomes in the minds of law-enforcement officials nothing more than a drug pusher in a white coat.

Every prosecution begins with a targeting phase. Something must occur to cause law enforcement to scrutinize a particular physician in the first place. Law enforcement regards pharmacists as their eyes and ears in the community for the purpose of assisting in targeting drug-dealing doctors. As a result, a complaint from a pharmacist who suspects a physician is prescribing too much medication, or is doing so for the wrong people, is commonly the triggering event. Typically, the pharmacist believes, as do his counterparts in law enforcement, that outrageous quantities of dangerous addictive medications are being prescribed to drug addicts posing as pain patients. These patients are assumed to have become drug addicts as a result of the accused physician's criminal prescribing habits.

Such concerns belong to a category of evidence recognized as red flags. Just as physicians are trained to recognize "aberrant" drug-related behaviors, police and pharmacists learn, while attending educational conferences, to recognize red flags. These are the basis of a system of standards developed by law enforcement to identify illegal prescribing.

Having not been validated in any systematic manner, these red-flag standards are not included within the realm of medical science. In fact, many red flags actually describe the characteristics one would expect to be associated with medical practices where chronic pain is effectively treated. This is precisely why there exists no bright line between drug dealing and legitimate medical prescribing. In fact there is no line at all. Any such line that might have existed was unavoidably crossed when the Controlled Substances Act effectively assigned law enforcement, a nonmedical institution, to regulate the practice of pain management. This fundamental error in social policy is the very root of the pain crisis.

The following serve as examples of the problem.

The biggest red flag is high-volume opioid prescribing. Common sense dictates that significant volumes

of opioids are necessary to treat chronic pain effectively. In the context of drug-war ideology, this necessary medical practice resembles drug dealing. When substantial amounts of drugs and money change hands, what else is a cop to think? This is why, when law enforcement regulates pain management, a head-on collision between necessary medical practices and the war on drugs inevitably occurs.

The appearance of poverty is another red flag. All it takes for a doctor to be targeted is a pharmacist who becomes uneasy with the looks of a patient and responds by lodging a complaint. Then the game is on. Police respond by conducting surveillance. Patients with a shabby appearance are observed and are assumed to be drug addicts intent on scoring a fix. Here, again, the drug war collides with medical reality. Chronic pain is a disease, which predictably reduces its victims to poverty and a poor appearance. It accomplishes this by limiting or removing the ability to engage in gainful employment or even to care for oneself properly. As a result, patients suffering from this disease often just don't look good. Physicians are arrested over this sort of "evidence."

Another red flag is a dosage of medication out of line with what a pharmacist or law-enforcement official believes the patient should require. This red flag conflicts with medical reality. A fundamental principle underlying the treatment of chronic pain is the individualization of treatment. There exists an enormous range within which appropriate opioid dosages may vary from one patient to the next. The correct amount of medication is whatever works to return a patient to functionality, not the amount some cop or prosecutor thinks it should take.

The Sting Operation and the Myth of Legitimate Prosecution

Rational people assume that if accusations of drug dealing go to trial, the government will be obligated to produce convincing evidence to prove that the physician stepped across a clearly defined line into the realm of criminal misconduct. We assume that unless the physician has done something like prescribing drugs to an undercover agent who asks for them but gives no medical reason, he will be left undisturbed. Our assumptions are mistaken.

The following testimony from a preliminary hearing in my own case, in which all charges, including even murder, were eventually dismissed, illustrates this point (see sidebar):

> *Mr. Hallinan:* [Y]ou were told that numerous agents were sent into Dr. Fisher's office to try to con him into giving them narcotics without any medical reason; right?
>
> *Agent Weatherford:* I believe that's the reason.
>
> Q: And none of them got them; did they?
>
> A: I don't believe so.

Regardless of how the sting operation turns out, physicians suspected of drug dealing are routinely prosecuted. After the targeting process, which is based on red flags, is completed, the presumption of guilt is apparently so firmly established in the minds of law-enforcement officials that evidence to the contrary is overlooked. The physician's fate is all but sealed. It is difficult to imagine the rationale employed by law enforcement in prosecuting a case under these circumstances, but it is known from bitter experience how they go about it.

After the sting operation fails to produce evidence of illegal prescribing, instead of re-evaluating the legitimacy of their case, prosecutors intent on obtaining a conviction go to plan B. They have failed to prove that the targeted physician's *behavior* was illegal, so it becomes necessary to prove that, while maintaining the appearance of the practice of medicine, the accused physician actually *intended* to deal drugs. To this end, a "records case" is constructed.

To generate evidence of criminal intent, "experts" in the fields of pain management and addiction medicine are hired to review the accused physician's medical records. These "experts" then take the witness stand and deliver what amount to sermons regarding the dangerous, addictive, and even lethal qualities of opioid analgesics. Typically, they refer to these substances as narcotics. This language inflames the pre-existing biases of jurors, who are usually unfamiliar with the science pertaining to these beneficial substances. The "experts" then proceed to offer a litany of examples purporting to show that, *in their opinion*, the accused doctor deviated from acceptable medical prac-

tice. If what the accused physician had done was clearly not medicine, there would be no need for expert testimony. This "evidence," based on an interpretation of the standard of care, is presented as if it had something to do with drug dealing. The resulting legal affairs are best characterized as morality plays.

The role of academic physicians in the pain crisis is particularly troubling. They have turned away, as a group, from their ethical obligations to control pain. Instead, they teach the aforementioned system of "aberrant" drug-related behaviors, ensconcing them into textbooks and professional journal articles. Academics also turn with regularity against their colleagues who have attempted in good faith to treat chronic pain. By doing so, they increase both their professional standing and their personal wealth.

Witch-Hunts

To understand the pain crisis, it is useful to know a little bit about the history and general characteristics of witch-hunts. A look into the situation that developed in Salem, Massachusetts, during the late 1600s is instructive. It exposes two outstanding features that pertain to witch-hunts in general. The first is that anyone can be targeted and the triggers are social. The second is that the evidence employed to get convictions, when examined rationally, is tenuous. A category of evidence known as spectral evidence was employed in Salem. This consisted of the supposed victim's accusing the suspected witch of appearing before her in a dream.

The circumstantial evidence of criminal intent provided by government witnesses is the modern-day equivalent of spectral evidence.

Another Victim of the Drug War

BY RADLEY BALKO

It's not pleasant to hear Dr. Frank Fisher speak. I first heard him several months ago at a briefing on the Drug Enforcement Administration's war on prescription painkillers in Washington, D.C. His eyes tend to glass over through much of his speech, seemingly on the verge of tears. Above them rests a sweeping coif of white hair; below, a thick, well-manicured white beard. He speaks softly, with jaws and temples tensed, projecting a labored voice that moves from sentence to sentence. As he talks, you get the impression that a sneeze might shatter him into a thousand pieces.

There's a reason Fisher projects the image of a broken man. He is one. Fisher—a Harvard-trained physician—once specialized in the treatment of chronic pain. He served a predominantly rural and poor population in California. About 5–10 percent of his 3,000 clients were pain patients—victims of cancer, multiple sclerosis, steep falls, botched surgeries, or car accidents.

A little more than five years ago, California Attorney General Bill Lockyer initiated a high-profile campaign against pain doctors who prescribe large doses of opioids—drugs such as OxyContin, Vicodin, and codeine. He wasn't alone. Several other attorneys general across the country had or were in the process of implementing similar campaigns. At about the same time, the DEA was launching its own plan to combat what is called a nationwide epidemic of OxyContin abuse.

Lockyer made Frank Fisher his example, his trophy. He dispatched a squad of heavily armed agents to Fisher's community health center. The cops detained the center's employees while they raided the facilities for incriminating evidence. Soon after the raid Lockyer put out a press release. Fisher, Lockyer said, was party to a sophisticated drug ring. He and other California prosecutors likened Fisher to a crack dealer. Then to a mass murderer. Fisher was charged with multiple counts of drug distribution, fraud, and most sensationally, several counts of murder. The state seized his assets. His bail was set at $15 million, and he faced a possible life sentence.

Over the next five years, every one of the charges against Fisher slowly fell away. A Superior Court

Long before the witch trial of an accused physician begins, he is burned at the stake in the media. He is portrayed as a greedy Dr. Feelgood who represents a menace to society. The following are among the remarks that may appear in the local newspaper concerning the accused physician and his practice: "We are shutting down suppliers of a highly addictive drug that has been improperly allowed to saturate the community." "I think he'll turn out just like Kevorkian. These are highly toxic drugs. We're not even allowed to flush them down the toilet, for fear we'll contaminate the drinking water."

Prosecuting pain-treating physicians as drug dealers relies on the myth that there are bad doctors eager to prostitute their medical licenses. This myth is driven by media hysteria around opioids because stories about drug panics sell newspapers. As a group, physicians avoid risk whenever possible. It is unlikely that physicians who commit a dozen years of their lives to achieving an educational and professional status that guarantees them a generous living would choose to risk it all by dealing drugs. That is why pain is undertreated in the first place. The risks associated even with necessary prescribing are deemed unacceptable by the vast majority of physicians.

It is generally understood that people get the government they deserve. It also appears that because medical practices reflect social values, we also get the medicine we deserve. It is therefore incumbent on society to transform its core value of drug control to one that gives pain control priority. This will undoubtedly occur as people become aware of the implications of the medical and human-rights disaster that currently passes itself off as the management of chronic pain.

judge immediately threw out the murder charges in a preliminary hearing. Four years later, another judge threw out the other felony charges—manslaughter and fraud. Last May a jury considered the remaining misdemeanor charges against Fisher and acquitted him on every count. One juror said Fisher had been the victim of a "witch-hunt."

The state of California of course has done nothing to address Fisher's wrongful persecution. He spent five months in prison and paid hundreds of thousands of dollars in legal fees. He has yet to get his assets back, faces several civil lawsuits spurred by his arrest, and still awaits hearings on the status of his medical license—which means he still can't earn a living.

Not only was Fisher the farthest thing from a drug dealer, he wasn't even an effective "dupe"— a doctor that dealers can easily fool into thinking they're pain patients. Fisher's clinic ejected more than 400 patients from treatment for, as his website describes, "lying, diverting medications or ingesting non-therapeutic doses." He also sent away numerous undercover agents posing as pain patients in an attempt to collect evidence against him.

There are about a hundred cases like Fisher's. Most recently, Virginia doctor and pioneer in pain management Dr. William Hurwitz was convicted on 50 counts related to prescription-painkiller distribution. After a trial rife with miscarriages of justice and shifting evidentiary standards, Hurwitz now faces a possible life sentence.

After his own acquittal Fisher drew attention to the often unmentioned but most tragic aspect of the persecution of a pain specialist: the status of his patients. "The part of this story that's always missing is the suffering of the patients I was treating," Fisher told the *San Francisco Chronicle*. "For my patients, my arrest was an unmitigated disaster. Many of them survived, but many of them not well. A lot of them look like they've aged 20 years."

Fisher looks old for his 50 years too. But then, five months in jail, the loss of one's assets, wrongful homicide charges, and the loss of reputation and livelihood might have that effect. Add Dr. Frank Fisher to the roll of victims wronged by America's endless war on illicit drugs.

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