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.

Radley Balko (rbalko@cato.org) is a policy analyst at the Cato Institute.