Perceived "War on Doctors" Nearing 100 years: PART I (1914 - 2000)

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Doctors are concerned that prescribing opioid analgesics in chronic pain treatment is accompanied by an unacceptable risk of unwarranted prosecution. Doctors are fearful of the standards through which physicians are targeted and prosecuted. Some medical professionals regard criminalization of medical practice as a consequence of Prohibition law which represents an error in social policy that distorts medical standards.

This article (Part I) depicts the perception of the *War on Doctors* in the 20th century, the treatment of doctors as drug dealers and the drug enforcement administration's war on prescription painkillers".[2] PART II summarizes the 21st century initiatives, policies and developing national guidelines from numerous organizations pertaining to appropriate pain management.

QUESTIONS

What evidence is there that the U.S. government has been waging a war on doctors who prescribe controlled substances? How many pain doctors have been prosecuted over the past almost 100 years? Have the prosecutions turned public opinion against physicians, painting them as suppliers of narcotics to degenerate addicts? What are Congress and law enforcement officials doing to battle the problem of diversion, combat the theft of the drugs from warehouses, manufacturing facilities, and trucks en route to pharmacies? Do registered pain doctors present an easy target to the Drug Enforcement Administration (DEA)? Finally, are doctors so frightened of prescribing pain management that patients are suffering from under-treatment of pain?

PRE-PROHIBITION ERA – PRIOR TO 1914

In the 19th and early 20th centuries, prior to 1914, narcotics were widely available in the United States and they were not regulated.[3] Drug addiction was largely accidental. Opiates were as readily available in drug stores and grocery stores as aspirin, serving many of the same functions that alcohol, tranquilizers, and antidepressants serve today. Morphine was the most popular albeit highly addictive drug of the time, but the public was ignorant of its habit-forming properties. It was used for medical operations, convalescence, and every day potions and elixirs. Morphine was commonly regarded as a universal panacea. It was used to treat about fifty-four diseases, including insanity, diarrhea, dysentery, menstrual and menopausal pain, and even nymphomania. That perception was drastically altered after the use of opium was criminalized in 1914.[4]

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THE HARRISON NARCOTICS ACT[5]

In 1914, the federal Harrison Narcotics Act was signed into law. *The Act outlawed the nonmedical use of opium, morphine, and cocaine, and made it illegal for any physician or druggist (pharmacist) to prescribe narcotics to an addict.*

The Harrison Act was the first federal law to criminalize the nonmedical use of narcotic drugs. Upon its passage, the Harrison Act adversely affected one-quarter of a million drug addicted citizens and their doctors as potential criminals.[6] The Act was supported by advocates of Prohibition,[7] including Secretary of State William Jennings Bryan, Captain Richmond Pearson Hobson, and (3) Harry J. Anslinger, who held office as the Assistant Prohibition Commissioner in the Bureau of Prohibition, before being appointed as the first Commissioner of the Treasury Department's Federal Bureau of Narcotics (FBN) on August 12, 1930.[8]

By 1916, 124,000 physicians; 47,000 druggists; 37,000 dentists; 11,000 veterinarians; and 1,600 manufacturers, wholesalers, and importers had registered with the Treasury Department, as required by the Harrison Act.[9]

Between 1914 and 1970, the U.S. government pursued both physicians and addicted patients. Hundreds of doctors were arrested and prosecuted for prescribing narcotics to so-called "addicted" patients.

Between 1914 and 1938, U.S. attorneys prosecuted more than 77,000 people. They included approximately 25,000 doctors who were arrested under the terms of the Harrison Act for giving narcotic prescriptions to addicts.[10] Many doctors were eventually put on trial, and most of them lost their reputations, careers, or life savings. By 1928, the average sentence for violation of the Harrison Act was one year and ten months in prison.[11] During that period, Rufus King noted in his book entitled, "The Drug Hang-Up: America's Fifty-Year Folly", that more than 19 percent of all federal prisoners were incarcerated for narcotics offenses.[12] Clinics closed down, and physicians had little choice but to abandon thousands of so-called "addicted" patients. Some of them were probably pain patients who were not addicted but instead might have been physically dependent on the opiates. And as a consequence of abandoning the allegedly "addicted" patients, a black market for narcotics arose.

COMPREHENSIVE DRUG ABUSE PREVENTION AND CONTROL ACT (DAPCA)[13]

In 1970, **the Harrison Act** was repealed. It was replaced by the **Comprehensive Drug Abuse Prevention and Control Act of 1970 (DAPCA)** which required the pharmaceutical industry to maintain physical security and strict record keeping for certain types of drugs.

CONTROLLED SUBSTANCES ACT (CSA)[14]

Title II of DAPCA is called the federal **Controlled Substances Act (CSA)**. It is the legal foundation of the government's fight against the abuse of drugs and other substances. The CSA is a consolidation of numerous laws regulating the manufacture and distribution of narcotics, stimulants, depressants, hallucinogens, anabolic steroids, and chemicals used in the illicit production of controlled substances.

DRUG ENFORCEMENT ADMINISTRATION (DEA)[15]

In 1973, the **Drug Enforcement Administration (DEA)** was established by President Richard M. Nixon, as part of the Justice Department. It united a number of federal drug agencies that had often worked at cross-purposes. The mission of the DEA was to "enforce the controlled substances laws and regulations of the United States and bring to the criminal and civil justice system those organizations and principal members of organizations who are involved in the growing, manufacture, or distribution of controlled substances in the United States".

DEFINITION OF ADDICT BY DEA[16]

The DEA defines an addict as ***"any individual who habitually uses any narcotic drug so as to endanger the public morals, health, safety, or welfare, or who is so far addicted to the use of narcotic drugs as to have lost the power of self-control with reference to his addiction"***. The DEA's conception of an addict includes what pain specialists call ***"pseudo-addicts"***. These are pain patients who require opiates to lead a normal life. By classifying pain patients as addicts, the agency justifies its pursuit of certain doctors who might be regarded as potentially illicit "distributors."

DEA STANDARDS FOR PROSECUTION

The prosecution of any given doctor, according to the DEA, is based on two standards:

1. Whether a "legitimate medical purpose" exists for a prescription that the physician has written, or
2. Whether the prescribed drug is "beyond the bounds of medical practice."

The DEA appears to have no specific guidelines or procedures to evaluate either of those standards. The government's aim is to produce probable cause[17] that a doctor intentionally wrote a narcotics prescription for patients without legitimate medical needs or that he or she knew the patients who were getting the prescriptions were addicts or knew the patients getting the prescriptions were selling the drugs.[18] Any of these grounds suffices for an arrest of a doctor.

UNITED STATES V. MOORE (423 U.S. 122, 124 [1975])

Can a State-licensed physician be federally prosecuted under § 841 by virtue of his status as a DEA-registrant? In *United States v. Moore* (1975), a licensed physician who was registered under the Controlled Substances Act (CSA) was convicted of knowing and unlawful distribution and dispensation of methadone (a controlled substance or addictive drug used in the treatment of heroin addicts) in violation of § 841 of the CSA. The evidence disclosed that the physician prescribed large quantities of methadone for patients without giving them adequate physical examinations or specific instructions for its use and charged fees according to the quantity of methadone prescribed, rather than fees for medical services rendered. The U.S. Supreme Court reversed the Court of Appeals and held that DEA-registered physicians can be prosecuted when their ***activities fall outside the usual course of professional practice***. And, a doctor may be criminally charged with unlawfully prescribing (or "diverting") highly addictive narcotic drugs that the Drug Enforcement Agency (DEA) classifies as Schedule II "controlled substances."

LEGISLATION FROM 1988-2006[19]

The following are pertinent federal drug laws that were enacted since 1988:

- In 1988, the Anti-Drug Abuse Act was established with the goal of creating a drug-free America.
- In 1994, the Violent Crime Control and Law Enforcement Act established specific reporting requirements in the areas of drug use, availability, consequences, and treatment.
- In 1993 and 1996, by Executive Orders, the Office of National Drug Control Policy (ONDCP) chartered the President's Drug Policy Council and established the ONDCP director as the president's chief spokesman for drug control.
- In 1993, the Diversion Control Fund was created by Congress.
- In 1997, the Drug Free Communities Act authorized the ONDCP to carry out a national initiative that awards federal grants directly to community coalitions in the United States.
- In 1998, the Media Campaign Act directed ONDCP to conduct a national media campaign for the purpose of reducing and preventing drug abuse among young people in the United States.
- Also in 1998, the Reauthorization Act of the Office of National Drug Control Policy expanded ONDCP's mandate and authority. It set forth a long list of additional reporting requirements and expectations.
- In 2006, the second Reauthorization Act of the Office of National Drug Control Policy reauthorized ONDCP through FY 2010, contained several reporting requirements, and expanded the mandate of the agency.

CRITICISM OF DEA

The Controlled Substances Act empowered the DEA to regulate all pharmaceutical drugs. However, from 1973 until the 1990's, the DEA focused its resources primarily on illegal drugs, such as heroin, cocaine, crack cocaine, ecstasy, and marijuana, sold on the black market in urban areas.

In 1999, Congress[20] and in 2001-2002 the Department of Justice[21] criticized the DEA on the grounds that no "measurable proof' existed to show that it had reduced the country's illegal drug supply, and that its goals were not consistent with the president's federal **National Drug Control Strategy**. Also in 2002, Glen A. Fine, the inspector general of the Department of Justice, asked why the DEA was not doing more to combat prescription-drug abuse when it was "a problem equal to cocaine".[22]

THE OXYCONTIN ACTION PLAN[23]

In 2001, the DEA announced a major new antidrug campaign, the **OxyContin Action Plan**. It contacted 775 medical examiners from the National Association of Medical Examiners and instructed them to report "OxyContin-related deaths" for

2000 and 2001.[24] Based on those reports, the DEA subsequently announced that there had been 464 "OxyContin-related deaths" over those two years.

The conclusions the DEA were reviewed and found to be flawed.

1. The DEA regarded the finding of an OxyContin tablet in the decedent's gastrointestinal tract to be indicative of an "OxyContin-verified death," regardless of other circumstances.
2. If investigators found OxyContin pills or prescriptions at a crime scene or if a family member or witness merely mentioned the presence of OxyContin, the death was also confirmed as "OxyContin-verified".
3. Overdose victims tended to have multiple drugs in their bodies, including . Valium-like drugs, other opiates (Vicodan, Lortab or Lorcet), Prozac, cocaine and over-the-counter antihistamines or cold medications.
4. The DEA's claims of an OxyContin epidemic were also criticized as representing the agency's inflated estimate of risk of death. In 2003, Cone et al found that of the 919 deaths related to oxycodone in 23 states over a three-year period, only 12 showed confirmed evidence of the presence of oxycodone alone in the system of the deceased. Approximately 70 percent of the deaths were attributable to "multiple drug poisoning". Thus many of the deaths attributed to OxyContin by government officials were not the result of pain patients unknowingly becoming addicted to OxyContin and then overdosing, but of habitual drug users taking that drug with any number of other substances, any one of which might have contributed to overdose and death.

The OxyContin plan appeared to elevate a licit prescription drug to the status of cocaine and other Schedule I substances. Thus, pain doctors became susceptible to investigation as conventional drug dealers. For example, in September 2003, when Virginia doctor, William Hurwitz, was indicted on 69 counts, U.S. attorney Mark Lytle claimed that:

- Dr. Hurwitz was complicit in the deaths of three patients;
- He was comparable to a "street-corner crack dealer," and
- He posed such a threat to the community that he should be denied bail.[26]

The OxyContin Action Plan bore resemblance to the Harrison Act. It enabled the federal government to prosecute physicians who prescribed an otherwise legal narcotic drug. The nonmedical use of OxyContin was described as a deadly new drug epidemic, and fears of it being a "dope menace" were sweeping the country.

The DEA began combating the illegal diversion of a legal medication by targeting practicing physicians who represented a pool of registered, licensed, and generally cooperative targets who were obligated to keep medical and billing records, and a variety of forms.

From October 1999 through March 2002, the DEA investigated what it considered 247 OxyContin diversion cases, leading to 328 arrests.[27] In 2001, the DEA conducted a total of 3,097 drug diversion investigations, including 861 investigations of doctors.[28] In 2003, the DEA investigated 732 doctors, sanctioned 584, and arrested 50.[29] These figures do not include physicians investigated and arrested by the 207 DEA-deputized state and local task forces throughout the country.

As a consequence of decades of war and prosecutions, doctors became afraid of prescribing pain medications, to the detriment of patients who were undertreated for pain.

END OF PART I ARTICLE

PART II will present the 21st century constructive initiatives, policies and developing national guidelines aimed at alleviating unrelieved pain of suffering patients.

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14. http://www.justice.gov/dea/pubs/csa.html
15. http://www.justice.gov/dea/index.htm
16. 21 USC, Section 802, Definitions [1]
17. Probable cause is a level of reasonable belief, based on facts that can be articulated, that is required to sue a person in civil court or to arrest and prosecute a person in criminal court. Before a person can be sued or arrested and prosecuted, the civil plaintiff or police and prosecutor must possess enough facts that would lead a reasonable person to believe that the claim or charge is true. http://legal-dictionary.thefreedictionary.com/Probable+cause
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