

The War on Doctors, and the Pain Crisis in America - Eighty Years of Naked Emperors

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[Shortened version of my 2004: "The War on Drugs, the War on Doctors, and the Pain Crisis in America" available at: <http://www.doctordeluca.com/Library/WOD/WOD-PCA060404cWeb.htm>]

Introduction

There is a Pain Crisis in America. Its primary manifestation is the routine and widespread under-treatment of pain, especially chronic, non-cancer pain. Other manifestations include a severe and growing shortage of physicians willing to prescribe morphine and related opioid analgesics, the widespread use of more toxic and less efficacious classes of medications in an effort to avoid opioids, and the profound distortion of medical education and of the doctor-patient relationship.

How large a problem is under-treated pain in America? In a 2001 article in the *Journal of the American Medical Society (JAMA)*, at a National Institute on Drug Abuse (NIDA) symposium in April 2001, Brown and colleagues stated that there was widespread acknowledgment that both acute and chronic pain are undertreated. Brown estimated that more than 17% of Americans have serious chronic pain and that many go untreated and many more are undertreated. [Vastag, 2001] This is the pain crisis in America.

These researchers developed a survey that measured the prescribing practices by different groups of physicians in response to variations of a single presented case. The physicians' prescribing decisions were then compared with recommendations from a panel of pain management experts. The findings were stark:

While the expert panel recommended that virtually all patients with [common idiopathic back pain] who do not respond to other treatments be given an opioid analgesic, only 20% of physicians said they would actually write that prescription... "It suggests there's a lot of unnecessary suffering," said Brown. To combat the problem, he called for increasing the amount of medical school education devoted to pain management... [Vastag, 2001]

None of this is new. For decades, researchers have noted this discrepancy between how chronic pain should be treated and the dismal state of the art as practiced in the U.S., and they commonly call for more and better education of physicians. But is the pain crisis in America simply a problem of the acquisition and application of medical knowledge? And if so, why have the impressive and consistent educational campaigns directed at this problem in recent decades failed to yield the expected changes in medical practice in the U.S.?

The historical record strongly suggests a deeper and far more disturbing root cause of our current pain management predicament. In the years after passage of the Harrison Narcotics Act in 1914, the Narcotics Division of the Treasury Department, progenitor of today's Drug Enforcement Agency (DEA), brought a series of test cases against physicians to the Courts to define their powers under the Act. Through the courts, drug prohibitionists achieved the criminalization of drug users and of the doctors who would treat them as patients and as human beings worthy of the same individualized medical care as any other sufferer in a free society. This wide scope of law enforcement responsibility was far beyond that legislated by Congress when it passed what appeared to be a tax act in 1914. [\[King, 1953\]](#)

This historical period marks the invention of a perpetual national drug crisis which has ever since been claimed as the special national interest justifying the regulation of opioid analgesic medications and other 'dangerous drugs' by a federal law enforcement agency. In so doing, this agency has usurped the right constitutionally reserved to the states to otherwise license and regulate medical practice in that most fundamental, archetypal, and timeless of all the medical arts: the relief of human pain and suffering.

While opium and its derivatives are among the most ancient and well understood and safest pharmaceuticals mankind has ever developed, problematic use has been a source of personal tragedy in the lives of individuals throughout recorded history. However, before about 1920, there was no domestic 'drug subculture,' no 'drug problem,' no criminal black market, no drug cartels, no state-sponsored hounding and jailing of drug users and pain patients and of their physicians, no public outcry for the politicians of the day to "get tough on drugs." In fact, there is no credible record of a domestic drug problem prior to the perversion of the Harrison Act in the courts in the years after 1914 although there were many more opioid dependent people, both in absolute numbers and as a percentage of the population, than there are today. It has been estimated that in the 1880s some 4 per cent of the population of the United States used some kind of opiate for nonmedicinal purposes. [\[King, 1972a\]](#) For a sense of perspective, consider that modern heroin use *peaked* in the late 1980's at approximately 326,000 (past month) users, or about 0.1 percent of the population, according to National Household Survey data. It is notable that, in the decades around the end of the nineteenth century, America supported large and powerful popular social movements against alcohol and tobacco use which were widely (and correctly) perceived as true national public health scourges. There is no record of any anti-opioid movement or opioid prohibition movement of similar significance because opioids were not viewed (again correctly) to be a social scourge or significant public health menace. [\[Brecher, 1972a\]](#)

The root cause of the widespread undertreatment of pain can be traced directly to the systematic, nationally coordinated, relentless harassment, arrest, and prosecution of thousands of American physicians, many of whom had been engaged in nothing other than the standard care of pain and addiction of the day. This pogrom has continued, unabated, for almost ninety years.

The proximate cause of the pain crisis arises from what is known as the “chilling effect,” a phrase which describes the grotesque distortion of the norms of medical practice and the violation of the doctor-patient relationship that results from the withdrawal of physicians from the appropriate treatment of pain due to fear of litigation, loss of livelihood, and incarceration.

Criminal prosecutions of physicians increased under Attorney General John Ashcroft. Examples of recent important cases include those of Dr. William Hurwitz, a pioneer in the field of pain management in Virginia; Dr. Jeri Hassman, who had the largest pain practice in Tucson, and is being threatened with a 28-year prison term apparently because a small fraction of her patients used the prescriptions in unauthorized way; Dr. Robert Weitzel of Utah, who was convicted of negligent homicide and manslaughter but then acquitted in a new trial after the prosecutor was found to have concealed exculpatory evidence, and Dr. Deborah Bordeaux of South Carolina, who was convicted under a "drug kingpin" statute carrying a mandatory minimum sentence of 20 years, after working a mere two months in a locum tenens position at a clinic treating chronic pain among other ailments.

In a 2003 press release entitled “The Myth of the Chilling Effect,” the DEA denied the possibility that its actions against physicians could have such an effect, arguing that DEA only brings actions against a miniscule proportion of doctors, therefore actions against doctors for violations of the Controlled Substances Act (CSA) cannot be causing other doctors to seek to avoid such actions by failing to use opioid analgesics appropriately or by refusing to prescribe them at all. [\[DEA, 2003\]](#) We will analyze this document very carefully later in this paper and reveal it to be so much dissembling gibberish.

What each of us as members of a free and democratic society, governed by our own consent under the Constitution and the Bill of Rights, with an understanding of the meaning of federalism, States rights, the Fourth Amendment right to privacy, and the separation of powers, has to decide is:

1. Was there ever, or is there now, a national problem caused by domestic licit and illicit drug use of such dire import and magnitude that it might justify placing medical doctors and researchers under the direct regulatory control of adversarial federal law enforcement officers with no medical training? Should the DEA, a federal law enforcement agency with a Fiscal Year 2004 Office of Management and Budget (OMB) rating of *ZERO* [\[OMB, 2003\]](#), have the power to prescribe and proscribe the medical behavior of individual physicians, down to the level of judging individual patient medication regimens, and to grossly distort the norms of medical practice in entire specialties of medicine?
2. If there is a national drug problem that does warrant eighty years of a war on drugs / war on doctors and the systematic state sanctioned abuse of pain patients, drug users, and their families, what exactly is the nature of the problem and how severe is it? Compared to what?

3. Where do we go from here? Does the DEA have a legitimate role in making policy on issues which are considered to be medical and public health matters by the vast majority of the nations of the world? Is negotiating towards achieving consensus with such people possible? Is it strategically, morally and ethically advisable? There have been several 'Pain Summits' over the years and grand 'consensus documents' and 'clinical guidelines' have been proclaimed, and yet the war on doctors continues unabated. So we ask, does the DEA negotiate in good faith?

Historical Antecedents

A Tax Act Gone Terribly Wrong

The Food and Drug Act of 1906 was a basically good public health measure that required medicines containing opiates and certain other drugs must say so on their labels. Later amendments to the act also required that the quantity of each drug be truly stated on the label, and that the drugs meet official standards of identity and purity. The Harrison Act effectively withdrew the protection of the Food and Drug Act from the users of these drugs and precipitated the public health debacle that is the real drug crisis in America.

Matters of international diplomacy and international trade significantly impacted the development of U.S. domestic drug policy. In 1906, in response to domestic opposition to continued British opium sales to China and to America's own foreign opium problem in the Philippines, President Theodore Roosevelt called for an international opium conference to foster the development of international rather than just national controls. The Hague Convention of 1912, which focused mainly on the opium problems of the Far East, followed. Secretary of State William Jennings Bryan, a man famous and infamous in American history for his prohibitionist convictions, was the Harrison Act's primary proponent and he urged passage as a matter of international treaty obligation.

[[Brecher, 1972b](#)]

The Harrison Narcotics Act was a tax act: "An Act To provide for the registration of, with collectors of internal revenue, and to impose a special tax on all persons who produce, import, manufacture, compound, deal in, dispense, sell, distribute, or give away opium or coca leaves, their salts, derivatives, or preparations, and for other purposes."

[[Harrison Act, 1914](#)] The Act contained provisions for the licensure of physicians and pharmacists as well as manufactures and importers and set a modest excise tax of one cent per ounce on opium, coca leaves and their derivatives. Its passage was encouraged with some appeal to the early stirrings of the media-inspired hysteria with racist and xenophobic overtones that are a leitmotif in America's war on drugs and a driving force behind it. However, the Harrison Act was not a prohibition measure at the time of its enactment nor was fear of an impending domestic addiction problem its primary focus. [[King, 1972a](#)]

The Act was intended to measure and get a handle on what was an entirely unregulated and chaotic market. Physicians and patients in a doctor-patient relationship were specifically exempted with this language: "Nothing contained in this section shall apply .

. . . to the dispensing or distribution of any of the aforesaid drugs to a patient by a physician, dentist, or veterinary surgeon registered under this Act in the course of his professional practice only.” [\[Harrison Act, 1914\]](#) The only burden placed on doctors was that they register for a fee and keep records of medications dispensed or prescribed.

Had the Harrison Act been left unchanged as initially passed by Congress, we might today be discussing it along with the Food and Drug Act of 1906 as examples of the United States’ early and laudable public health efforts at addressing a small but potentially significant domestic substance abuse problem. Instead, the Harrison Act is instead best remembered as a tax act gone terribly wrong, marking the beginning of drug prohibition as national policy. The very first cases brought to the Courts to test the Act and hone it through legal challenge were cases against practicing physicians, and so the Harrison Act marks the beginning of America’s war on doctors making them the Acts first, and at the time only, targets. For a brief time, pain patients and drug users would have to wait their turn.

In the Course of His Professional Practice Only...

How did everything change, so abruptly and violently, in the wake of the Harrison Act? Enforcement was the responsibility of the Narcotics Division of the Treasury Department. The Division was merged into the Prohibition Unit of the Treasury Department when that was established in 1920 after passage of the Volstead Act in 1919, and later became the Federal Narcotics Bureau in 1930 as the era of alcohol prohibition was drawing to a close. The Division, seeking clarification and establishment of the scope of their powers under Harrison, brought a series of clever prosecutions to the court against the exemption for the doctor patient relationship. This was critical, for as long as doctors were taking care of addicts as they heretofore had, there was in fact no problem for our G-men-in-waiting to attack. Further, as long as doctors and patients were shielded by the exemption from the Harrison Act, there could be no sizable market for illicit drugs and no way for law enforcement to get at addicts who turned to the medical profession for help. Quoting Rufus B. King from his 1953 Harvard Law Review article entitled, “The Harrison Narcotics Act - Jailing the Healers and the Sick”:

Our grievous error was in allowing the narcotics addict to be pushed out of society and relegated to the criminal community. He isn't a criminal. He never has been. And nobody looked on him as such until the furious blitzkrieg launched around 1918 in connection with the enforcement of the Harrison Act... Narcotics-users were "sufferers" or "patients" in those days; they could and did get relief from any reputable medical practitioner, and there is not the slightest suggestion that Congress intended to change this -- beyond cutting off the disreputable "pushers" who were thriving outside the medical profession and along its peripheries. [\[King, 1953\]](#)

I will not review in great depth here the details of the three core cases through which the Bureau changed a benign tax act into a nightmare prohibition act. Interested readers are referred to detailed accounts by both King, in his 1953 Yale Law Review article [\[King, 1953\]](#) and in Chapters 3 and 6 of his 1972 book, *The Drug Hang-Up, America’s Fifty-*

Year Folly [King, 1972b] and by Brecher in Chapters 8 and 9 of his classic *Licit and Illicit Drugs* [Brecher, 1972c], also published in 1972. The three key cases are *Webb* (1919), *Moy* (1920), and *Behrman* (1921). Rufus King portrays all three litigants as ne'er-do-wells. Dr. Webb “simply sold prescriptions by the thousands, indiscriminately, to all comers, for fifty cents apiece,” Dr Moy was “an out and out peddler [who] prescribed morphine to strangers... 10 grams at a time for \$1.00 a gram” and Behrman was “likewise a flagrant violator.”

In *Webb*, the Attorney General posed a certified question to the Court:

If a practicing and registered physician issues an order for morphine to an habitual user thereof, the order not being issued by him in the course of professional treatment in the attempted cure of the habit, but being issued for the purpose of providing the user with morphine sufficient to keep him comfortable by maintaining his custom use, is such order a physician's prescription under exception (b) of s.2? [King, 1953]

The Court, offended by the facts of the Dr. Webb’s outright peddling responded: “to call such order for the use of morphine a physician’s prescription would be so plain a perversion of meaning that no discussion of the subject is required.” The problem here is that the phrase, “sufficient to keep him comfortable by maintaining his customary use” is not a merely a description of the egregious facts of *Webb* but also encompasses the dispensing of opioids for the relief and prevention of withdrawal that is clearly bona-fide medical treatment of opioid dependence.

The wedge between “the appropriate bounds of medical practice” and the bona-fide medical treatment of opioid dependence was widened in *Moy* in which the Court rendered the opinion:

Manifestly the phrases “to a patient” and “in the course of his professional practice only” are intended to confine the immunity of a registered physician, in dispensing the narcotic drugs mentioned in the act, strictly within the appropriate bounds of a physician's professional practice, and not to extend it to include a sale to a dealer or a distribution intended to cater to the appetite or satisfy the craving of one addicted to the use of the drug. [King, 1972c]

Which brings us to *Behrman*, a name made infamous in succeeding years when medical doctors were rounded up in large numbers by means of what came to be known as the “Behrman indictment.” [King, 1972c] Behrman was arrested for prescribing at one time 150 grains of heroin, 360 grains of morphine and 210 grains of cocaine. [See also “[Flash Trash](#)” in Appendix Two for an analysis of this dosing regimen.] The trick here is that the indictment was not drawn as an accusation that Behrman’s prescriptions were not “in the course of his professional practice only,” but “instead alleging that, in effect, the drugs were given in a good faith attempt to cure the addict.” [King, 1953] This is the birth of what we might call the “doctor’s dilemma,” that it is a federal offense to administer

opioids to an opioid addict for the purposes of treating their opioid addiction though to administer opioids to an opioid addict in pain for the purposes of analgesia is OK. Now, if only the distinction between the two could be reliably made...

The Doctor's Dilemma

While opioid medications are relatively safe and effective, there can be complications. Doctors commonly bring both legitimate medical concerns and well-founded fear of regulation to the table. An aura of unease surrounds medical training in the use of opioid analgesia. Physicians are taught that morphine and its relatives are dangerous, difficult to use substances; that they are highly addictive and can easily cause respiratory depression and death. But even when the safety and efficacy of opioid therapy is recognized and taught, the reality of the DEA war on doctors need not be taught; it is on the news and in the trade journals and happening all the time around physicians in communities across America.

In 2002, then DEA Director Asa Hutchinson, in an address to the American Pain Society, attempted to reassure the medical community:

I'm here to tell you that we trust your judgment... The DEA does not intend to play the role of doctor... We will not prevent practitioners acting in the usual course of their medical practice from prescribing OxyContin for patients with legitimate medical needs. We never want to deny deserving patients access to drugs that relieve suffering and improve the quality of life. [\[Orient, 2003\]](#)

Soothing words perhaps, but the medical community can be forgiven for paying more attention to the escalation of the war on doctors this agency has undertaken under Bush / Ashcroft. The unfortunate reality is that it is impossible on clinical grounds to reliably distinguish the “deserving” chronic pain patient from the presumably undeserving drug addict who is not otherwise in pain. The pain management physician employs functional criteria to monitor the course of chronic opioid therapy. That is, the patient is regularly assessed in the areas of his ability to perform “activities of daily living” and to meet family obligations and social norms, and the patient who meets expectations in these areas is presumed to be a chronic pain patient rather than an addict. However, any opioid dependent person on an adequate regular dosage regimen, for example, a successful methadone maintenance patient, is physiologically and socially indistinguishable from a chronic pain patient whose pain is controlled by chronic opioid therapy, or indeed, from a well person.

We have reviewed the Harrison Act and its aftermath as the historical crux of the war on drugs and the war on doctors, from which the pain crisis in America directly stems. In short, the drug prohibitionists succeeded in creating, through deceptive legal challenges, a very broad scope of power criminalizing doctors and drug users as well as drug importers and peddlers, instead of the very small scope that Congress had intended (the smuggler and the peddler) when it exempted the doctor-patient relationship under Harrison. [\[King, 1953\]](#) Millions of law-abiding American opioid users became criminals by legislative fiat while at the same time being cut off from legal supply of the medication they needed to

function in society and with no effective public health measures employed to mitigate the predictable physical, emotional and spiritual sickness and suffering unleashed across the nation.

Big Lies and Bullies Trump Research in the War on Drugs

In a scientific society we might expect that good epidemiological and medical research would, over time, dissolve myths and prejudices and generate basic scientific answers on which rational policy might be based. It is a sad, recurrent theme in the war on drugs that law enforcement repeatedly tried to limit what research is undertaken by denying permits to possess and use drugs for studies, and by vilifying and threatening the professional lives of those courageous researchers who do the necessary work despite the obstacles. What research is accomplished is manipulated and spun by various governmental agencies to suit predetermined national drug policy.

The Dissembling DEA and the “Chilling Effect”

A 2003 Drug Enforcement Agency DEA press release entitled "The Myth of the Chilling Effect" [[DEA, 2003](#)] is a very interesting document. It is brief, a mere 182 words in seven sentences formed into four paragraphs, and contains a table and six pie charts. Every sentence is entirely true, and the text as a whole is odd only in that the content of the first three paragraphs make no particular point regarding the "chilling effect" the document purports to debunk. The overall message is: "DEA only brings actions against a miniscule proportion of doctors, therefore actions against doctors for violations of the Controlled Substances Act (CSA) cannot be causing other doctors to seek to avoid such actions by failing to use opioid analgesics appropriately or by refusing to prescribe them at all."

Let's start with the title. What is a "chilling effect"? Let me propose the following working definition of a "chilling effect" that is consistent with what the DEA is addressing in its press release: ***The “chilling effect” is the withdrawal, for fear of litigation, by physicians from the appropriate treatment of pain.***

It is important to note that much of the public health damage here is caused not by the doctors accused of wrongdoing, rather it is caused by doctors-in-good-standing who, faced with a patient in pain and therefore at risk of being targeted by the DEA, modify their treatment in an attempt to avoid regulatory attention. This distortion of the doctor-patient relationship is complex and can be gross or subtle. Examples include a blanket refusal to prescribe controlled substances even when clearly indicated, or selecting less effective and more toxic non-controlled medications when a trial of opioid analgesics would be in the best interests of a particular patient. At the very least, some degree of suspicion and mistrust will surely arise in any medical relationship involving controlled substances.

There is very little a well-intentioned physician can do to mitigate this risk, to correct these distortions in medical values, ethics, and in the doctor-patient relationship that

always arise in the course of treatment for pain and/or substance abuse problems. Even experts in the medical treatment of addiction and pain cannot make the crucial distinction, the identification of the 'legitimate pain patient,' with confidence. [PAIN_CHEM_DEP listServ, 2003] Quite simply, the core presumption, that the states-of-being: 'legitimate pain patient,' 'drug abuser,' 'diverter,' 'frequent flyer,' etc., are mutually exclusive and dichotomous is, medically, false.

The legal punishment for mistaking a drug abuser for a pain patient can be extremely severe; doctors are being threatened with 28-year prison terms (Dr. Hasman), have been likened to "crack dealers" (Dr. Hurwitz) and tried as "drug kingpins" (Dr. Bordeaux).

[Orient, 2003];[White & Kaufman, 2003] On the other hand, mistaking a pain patient for a drug addict, and thereby committing the error of failure to appropriately treat pain, is highly unlikely to have any legal consequences at all. This set of legal and psychological imperatives with their attendant severe punishments has created a near ideal environment for manifestation of a "chilling effect" which inexorably leads to the under-treatment and non-treatment of pain in America.

The Controlled Substances Act (CSA) of 1972, which supersedes and replaces the Harrison Act and all intervening federal drug legislation, makes it a federal offence to prescribe controlled substances to a drug addict for the purposes of treating or maintaining their addiction, except where the physician holds a separate DEA license to provide methadone maintenance. This is what defines the "bounds of accepted medical practice" referred to in the subtitle of the DEA press release under consideration. Defining the medical treatment of addiction as 'outside the bounds of accepted medical practice' is a legacy of the Harrison Narcotics Tax Act of 1914 as discussed earlier in this paper.

The one table contains the only comprehensible data in the DEA press release and makes, somewhat obliquely, the point as stated in the beginning of this analysis. Here is the table which presents partial Fiscal Year (FY) 2003 data:

<u>Total registrants</u> = 963,385	<u>Number</u>	<u>% Total Registrants</u>
Investigations Initiated:	557	0.06
Actions Against MDs:	441	0.05
Arrests of MDs:	34	0.01

The table is presented without caption or discussion except what is contained in paragraph four:

Since FY 1999 the DEA registrant population has continually increased reaching almost 1 million doctors (as of June 30, 2003). During this same time, DEA has pursued sanctions on less than one tenth of one percent of the registered doctors..." [DEA, 2003]

We are talking about risk here and the appropriate statistic is a rate. The **Numbers** in the table above can correctly be used as numerators to compute this statistic, however, **Total registrants** is *not* the appropriate denominator because the denominator used must include only physicians who could possibly come to DEA attention. I call this misleading use of an incorrectly computed rate *Denominator Abuse*.

Having a DEA license is necessary but not sufficient to put a physician at risk of investigation, loss of license and arrest. The other requirement for being a physician-at-risk, thereby earning a rightful place in the denominator, is prescribing controlled substances in regimens that DEA finds questionable, and this number is far, far smaller. It should be noted in this regard, that DEA licensure is commonly required for hospital employment or privileges regardless of whether a physician ever intends to prescribe controlled substances or even possesses the special prescription pad necessary to do so.

Exactly how much smaller is the appropriate denominator? The answer is open to interpretation and affected by assumptions; only the DEA could provide the precise number and they do not publish this datum. For example, using the full year's numbers from the same 2002 data set, 622 physicians were investigated, charges were brought against 586, and in 426 cases medical licenses were revoked "for cause." [Hoffman, 2003] Dr. Hochman, a pain specialist and the Executive Director of the National Foundation of the Treatment of Pain, estimates that the number of physicians practicing "chronic opioid therapy" was 5000 in 2002. This estimate is somewhat close to the "3000 pain specialists" estimated by Dr. Eric Chevlen. [Chevlen, 2001] If we use Hochman's "5000 doctors practicing chronic opioid therapy" number to compute the rate statistic (and assuming that all in the numerator are also members of the denominator): $622/5000 = 0.1244$ = a DEA investigation-or-action rate of 12.44 percent, *orders of magnitude higher than the incorrectly computed DEA rate statistic* of "less than one tenth of one percent of the registered doctors." The comparable rate using Chevlen's "3000 pain specialists in the U.S." is 20.73 percent of at-risk physicians had DEA action initiated against them in 2002.

If reasonably derived, either Hochman's or Chevlen's estimate could be a statistically appropriate denominator to compute a risk statistic. On the other hand, the DEA's choice for the denominator is most certainly wrong. I am trying here to give a sense of how important it is to be explicit about one's assumptions in these matters and of how difficult it is, given the available DEA data, to construct even simple rates that are more enlightening than misleading. Regardless of how the rate statistic is computed, a "chilling effect," as operationally defined in this paper, is not a solely a function of risk as defined by an appropriate rate; severity of risk, highly publicized trials of prominent physicians, and the perceived rationality or irrationality of the DEA criteria used to set the "bounds of accepted medical practice" also play a significant role in how physicians react to the fear of litigation.

Finally, as Dr. William Hurwitz pointed out in a December 7, 2003 message to the PAIN_CHEM_DEP listServ, the DEA presents statistics relating only to their actions against doctors and not the consequent distortion of medical practice that is the 'chilling

effect' they are claiming to examine. “The same purportedly low rate of disciplinary action cannot logically serve as an index of both cause and effect. How can one determine if there has been a chilling effect without looking at what doctors really do? There has been no attempt by the DEA to do so.” [Hurwitz, 2003] I call this misleading confusion of outcome and index event, "[Outcome Obfuscation](#)." (See Appendix Two)

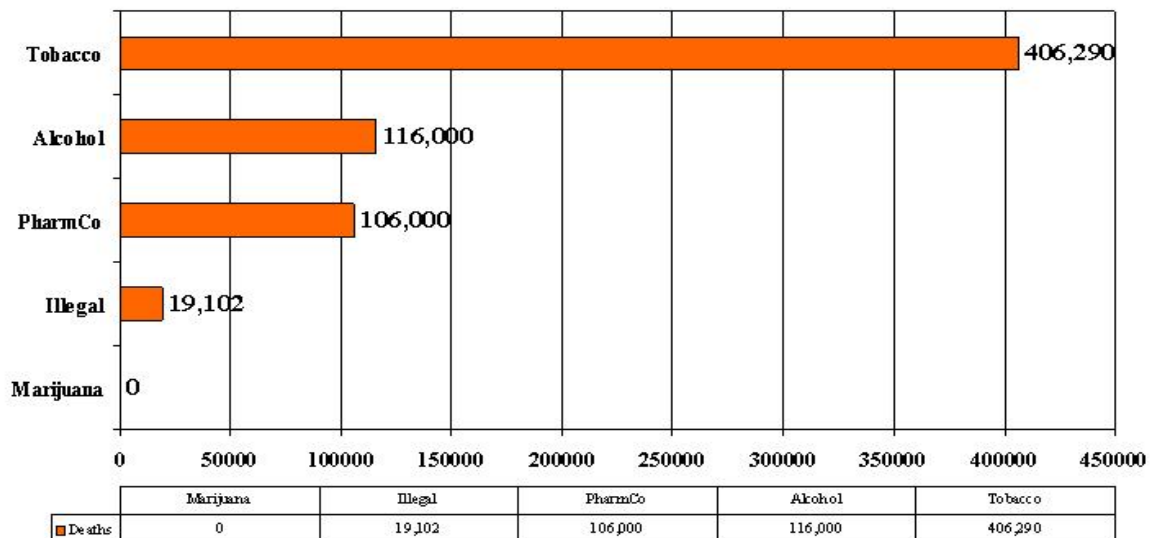
One can only conclude that *The Myth of the Chilling Effect* DEA press release is grossly and purposefully misleading, and statistically childish.

Drugs are Bad. Compared to What?

America does have a large substance-related public health problem, but it is very difficult to make a serious case that the substances we should be most concerned about are the illicit drugs and licit prescription controlled substances. Figure 1 compares deaths related to the “recreational” use of tobacco, alcohol, illicit drugs, and cannabis to deaths related to fatal adverse drug reactions (ADRs) which are captioned “PharmCo.” Note that deaths related to illicit drugs are an order of magnitude lower than deaths related to the legal recreational substances tobacco and alcohol. Note also that deaths related to cannabis use are zero. Consider Figure 1 [From: <http://bbsnews.net/drug-deaths.html>]:

US Recreational Drugs Deaths

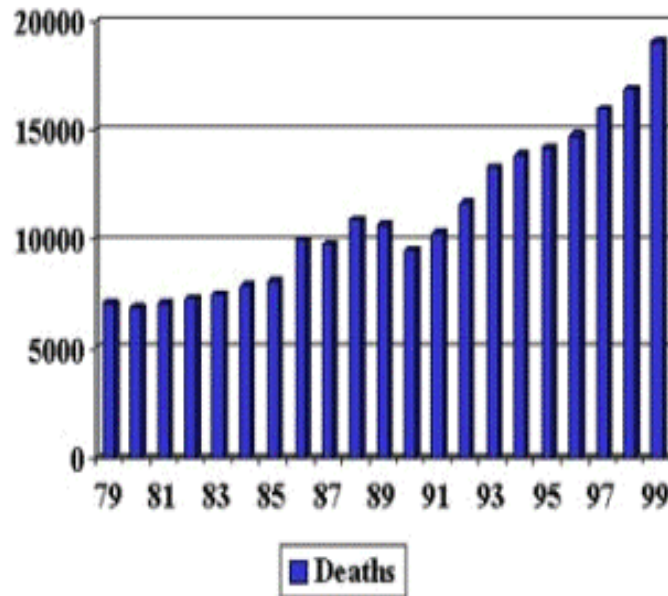
Special New Release of BBSNews Faqlet #1 (98) July 2002



America’s problem with ADRs is truly startling in that it is a far more common cause of morbidity and mortality than illicit drugs and occurs under direct medical auspices. Lazarou et. al., in their 1998 meta-analysis of prospective studies, published in

Figure 3 shows that over the same period of time that current drug use is essentially unchanged, deaths related to illicit drug use climbed continuously and dramatically. **This is the opposite of a sane public health policy of harm reduction: our national prohibition policy creates conditions under which an increasing proportion of drug users get sick and die.**

Figure 3 [[Scherlen & Robinson, 2003](#)]



Source: Sourcebook on Criminal Justice Statistics (2003)

The Pain Crisis in America

On October 2, 2003, the Association of American Physicians and Surgeons (AAPS) issued a statement entitled, “Doctors say U.S. drug policy forces pain patients to extreme measures, turns doctors into criminals.” [[Serkes, 2003](#)] In a country where there is no shortage of physicians qualified to prescribe opiate analgesics, which are relatively safer

than alternative classes of medications commonly used in the treatment of chronic pain (antidepressants, NSAIDs, and anticonvulsants), they noted that the 48 million odd people suffering from chronic pain in the U.S. were having difficulty finding doctors to treat them, and that this was the result of a tragically misguided, politically driven national drug policy, defacto law enforcement regulation of medical practice, and overzealous federal prosecutors. “The ‘war on drugs’ has turned into a war on doctors and [on] the legal drugs they prescribe and the suffering patients who need the drugs to attempt anything approaching a normal life,” said Kathryn Serkes, public affairs counsel for the AAPS. Referring to an review of thirty recent cases of prosecutions against physicians [[AAPS, 2004](#)] involving physician loss of livelihood, loss of license, and imprisonment and the abandonment of literally thousands of their patients, Serkes issued this stark and frightening statement to AAPS members:

If you’re thinking about getting into pain management using opioids as appropriate -- DON’T. Forget what you learned in medical school -- drug agents now set medical standards. [[Serkes, 2003](#)]

Magnitude and Nature of the Problem

How big a problem is pain in America? Stewart et al., in a 2003 cross-sectional study using 2001 – 2002 data from the American Productivity Audit on 28,902 working adults, revealed that thirteen percent experienced a loss in productive time during a 2-week period due to a common pain condition. (Most, 76.6 percent, of the lost productive time was explained by reduced performance while at work and not work absence). Lost productive time was estimated to cost \$61.2 billion per year. They concluded that pain “is an inordinately common and disabling condition in the US workforce...” [[Stewart et. al, 2003](#)]

Reports and statements from government, regulatory and academic bodies attesting to a massive problem of untreated and undertreated pain abound. In 2004 Robert Meyer, Director of the FDA’s Center for Drug Evaluation and Research, in testimony to the House Subcommittee on Criminal Justice, Drug Policy and Human Resources reminded legislators of a Consensus Statement from the National Cancer Institute Workshop on Cancer Pain over a decade earlier (1990) which indicated that the “undertreatment of pain... is a serious and neglected public health problem.” [[Meyer, 2004](#)] The Agency for Healthcare Research and Quality reported in 1992 that, “half of all patients given conventional therapy for their pain... do not get adequate relief.” [[Carr, 1992](#)] In 1999 the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) issued a press release noting that unrelieved pain had huge physical and psychological effects on patients and increased health care costs. JCAHO at that time officially declared pain to be the “fifth vital sign,” henceforth regarding the evaluation of pain a routine requirement of proper patient care as important and basic as the assessment and management of temperature, blood pressure, respiratory rate, and pulse rate. [[JCAHO, 1999](#)]

What is the impact of chronic pain on quality of life? Are there barriers and stigma related to pain treatment and especially to mainstay opioid medications? Most importantly, do those afflicted with chronic pain in fact have their pain under control?

Does treatment go far enough particularly in more difficult cases where first line therapies have failed? These questions about the effect of chronic pain on individual sufferers and about their experiences seeking relief were investigated in a study commissioned by the American Pain Society (APS), the American Academy of Pain Medicine (AAPM) and Janssen Pharmaceutical and conducted by Roper Starch Worldwide, which was published in 1999 as, “Chronic Pain in America: Roadblocks to Relief.” [\[Roper Starch Worldwide, 1999\]](#) Of a mail panel of over 500,000 households representative of all households in the U.S., a total of 35,000 screening questionnaires were sent to a random cross-section and 805 individuals with moderate to severe non-cancer pain were interviewed. The findings are thus representative of all such sufferers in the U.S.:

- An estimated 9% of the U.S. adult population suffers from moderate to severe non-cancer related pain.
- Approximately one third describe their pain as being almost the worst pain one could possibly imagine and two thirds have been living with it for over five years.
- Just over one-half say their pain is pretty much under control, however, the majority with the most severe pain do not have it under control and of those who do, it took most over a year to reach that state.
- Uncontrolled pain has a significant impact on quality of life, affecting the ability to concentrate, work, socialize, sleep, exercise, and engage in sexual activity.
- Controlled pain is associated with significant improvement in function and mood, however, those with severe pain still have a significantly lower quality of life and emotional well being compared to moderate pain sufferers.
- Overall 40 percent are not currently seeing a physician for pain relief believing that there is nothing more a doctor can do and that they can deal with it. Of severe chronic pain sufferers, 70 percent are under current medical treatment and are significantly more likely to require emergency room visits, hospitalization, and psychological therapy in pursuit of adequate pain relief.
- Difficulty finding a doctor willing and competent to treat pain is the rule and not the exception. Approximately one half of the entire sample have changed physicians since the onset of the pain condition and over one fourth have made at least three changes because doctors did not take their pain seriously enough, or were unwilling to treat it aggressively, or seemed to lack knowledge about pain.
- Among the subset with severe pain, the level of frustration with the availability of adequate medical care was truly disturbing. The majority had

changed doctors and almost one third had made three or more changes primarily because of persistent intolerable pain despite treatment.

- Opiate analgesics are rated significantly more effective than non-opiate pain relievers among those who had ever tried them, though fears about addiction and side effects limited wider usage. A small percentage had turned to alcohol at one time or another for relief, and this was most common in those middle aged and in men.

Etiology of the Undertreatment of Chronic Pain in America

In 1929 Alexander Fleming published his discovery of penicillin, the first antibiotic. Prior to this time, all the way back to ancient Greece, physicians could be relied on for little else beyond the skillful administration of opium preparations and later morphine, which was isolated by German pharmacists at the turn of the century, towards the effective relief of pain. Just as there is no historical record of a national drug abuse problem in the first decade of the 20th century, a pervasive problem of the undertreatment of pain was likewise unheard of. Indeed, especially after the invention of a practical hypodermic syringe by Alexander Wood in 1845, rampant undertreatment of pain such as we are experiencing in the early 21st century would probably have been unimaginable to medical practitioners in the early decades of the 20th century.

Recognizing the efficacy of opioids in relieving pain and in improving the mood and functioning of the majority of chronic pain patients many experts have urged that such medications not be denied to sufferers. Portenoy, among others, has thoroughly studied and reviewed chronic opioid therapy and the consensus is clearly that long-term opioid treatment is safe, efficacious, and is widely perceived to improve functioning and quality of life. [[Portenoy, 1996](#)] ; [[Portenoy & Foley, 1986](#)]

How then can we explain the shortage of American physicians willing to prescribe appropriately potent opioids in appropriate doses on an ongoing basis to achieve such results? One reason is a persistent belief in the medical community that opioids are dangerous and difficult to use and that in high doses commonly cause respiratory depression and death. In fact, respiratory depression is often seen in studies when opiate-naïve subjects who are not in pain are given acute doses in the range commonly used to treat pain. The same doses given to opiate-naïve patients in pain do not cause respiratory depression. An explanation is that painful stimuli affect the respiratory center of the brain counteracting the respiratory depressant potential of the opioid. This is why opioids can and should be titrated to effect against pain. [[McQuay, 1999](#)] Further, respiratory depression and death from overdose are so rarely seen in pain populations receiving chronic opioid therapy because while tolerance to the analgesic effect of the drugs develops very slowly if at all, tolerance to the respiratory depressant and euphoric effects develops relatively rapidly.

A second persistent erroneous belief is that addiction is a common outcome of chronic opioid therapy. There is no research evidence of any quality that chronic opioid therapy is

associated with any significant level of addiction outcomes. This is consistent finding over decades.

- In 1981, Medina and Diamond reviewed their experience with 2,369 patients treated in the 1970's at the Diamond Headache Clinic in Chicago for a NIDA Research Monograph: only two of 2,369 patients showed signs of psychological dependence (addiction) consequent to their receiving opioid or other pharmacotherapy. [Medina & Diamond, 1981];[Medina & Diamond, 1977]
- Moulin et. al. (1996) employed a randomized double-blind crossover study design to investigate whether oral morphine effectively relieved pain and improved quality of life in a group of chronic pain patients who had failed other therapies. Their findings: “[The] morphine group showed a reduction in pain intensity relative to placebo in period I (p=0.01) and this group also fared better in a crossover analysis of the sum of pain intensity differences from baseline (p=0.02). *No other significant differences [including psychological symptoms, functional status, and cognition] were detected.*” [Moulin et. al., 1996] (emphasis mine)
- In a 2003 review article in the *New England Journal of Medicine*, Ballantyne and Mao thoroughly examined the literature on opioid therapy. In none of the 37 articles reviewed by these authors was addiction as a consequence of opioid therapy found to be a major, or even significant, problem. [Ballantyne & Mao, 2003]

A corollary of the belief that opioid therapy commonly causes addiction is that modern potent opioid formulations favored by expert practitioners, for example sufentanil and Oxycontin, are especially dangerous in this regard. This is entirely incorrect and suggests a failure to understand the basic pharmacology of opioids and of substance abuse. Sufentanil is 1000 times more potent than morphine but its therapeutic index, the ratio of the dose necessary stop breathing to the dose necessary to stop pain, is similar to that of morphine. The addictiveness of a substance, more accurately how neurophysiologically reinforcing a substance is, depends on a complex interaction of host factors, substance, dose, rapidity of onset of action, duration of effective blood levels after ingestion, and pattern of ingestion (daily regimen). Transdermal fentanyl and Oxycontin were designed in part to decrease abuse liability by producing a gradual onset of effects and prolonged steady state blood levels. This is distinctly different from the “drugs of choice” of substance users and abusers which are uniformly rapid in onset and of short duration, for example, caffeine, alcohol, amphetamine, methylphenidate, cocaine, short and intermediate acting barbiturates, alprazolam (Xanax), heroin, morphine, and short-acting oxycodone.

The third persistent erroneous belief widely held by the American medical community is that opioid drugs should be avoided because increasing medical use will lead to a corresponding rise in diversion to illicit recreational use. It is this “problem” that is the “drug crisis” that is the target of America’s peculiarly intense regulation of controlled substances. Joranson et. al., in an important 2000 *JAMA* article, measured the proportion of opioid abuse (as opposed to mere non-medical use or emergency room “mentions” of

opioid use) as well as overall trends in the medical use and abuse as a result of medicinal opioid therapy for severe pain. The results:

Conventional wisdom suggests that the abuse potential of opioid analgesics is such that increases in medical use of these drugs will lead inevitably to increases in their abuse. The data from this study with respect to the opioids in the class of morphine provide no support for this hypothesis. The present trend of increasing medical use of opioid analgesics to treat pain does not appear to be contributing to increases in the health consequences of opioid analgesic abuse. [[Joranson, 2000](#)]

The Distortion of Medical Practice

The persistence and power of these beliefs, which are quite simply wrong, over the medical community is remarkable. This, I believe, is a consequence of basing national drug policy on the given that opioids are bad because the policeman says they are and are therefore dangerous for physicians who would prescribe them - but that is an uncomfortable thing for the medical community to admit. So we hold on to half truths and false beliefs which more acceptably bolster the legislatively encouraged behavior which is the avoidance, fear and loathing of opioid therapy. Jacob Sullum refers to this as *opiophobia*:

Torture, despair, agony, and death are the symptoms of “opiophobia,” a well-documented medical syndrome fed by fear, superstition, and the war on drugs. Doctors suffer the syndrome. Patients suffer the consequences. [[Sullum, 1997](#)]

Society sanctions these beliefs and doctors are punished for acting otherwise by regulatory structure and function. The authority lays in state health practice acts and in the federal CSA and at both of these levels the war on drugs, war on doctors is unquestioned policy. It is this authority so directed that informs “the standard of medical practice” by which physicians are then judged, at least as much as the current state of medical understanding does. The various guidelines produced by clinicians in negotiation with various state and federal the boards and agencies also incorporate these erroneous beliefs and in fact reinforce and legitimize them. Often referred to as embodying the “principle of balance,” in fact such activities are examples of the pitfalls and consequences of negotiating with DEA whose mission and values rest on a belief that addicts are criminals who belong in jail, and in drugs with the power to render citizens soulless, amoral, ghouls.

Even authors who ably explain the power relationships underlying the pain crisis in America conclude by calling for more physician education or for the inclusion of more clinical expertise in consensus building with law enforcement. They are wrong.

If the problem were one of physician knowledge or of the dissemination of clinical expertise, and not state and federal regulatory behavior guided by a war on drugs policy and mentality, then we would expect that medical knowledge and the current state of the

practice of pain management would be substantially the same in countries where the regulatory balance struck is far less determined by anti-diversionary law enforcement. Let us consider two recent studies of doctors' medical knowledge and attitudes about basic aspects of pain management and about the deficiencies in the treatment of patients suffering from chronic non-malignant pain.

Rothstein et. al. 1998, using a questionnaire to investigate a sample of Germany physicians, found that the “[treatment] of pain with strong opioid analgesics was seen as beneficial for the patients [and the] use of strong opioids for long-term treatment was recommended, and psychological addiction was regarded as non-existent.” [Rothstein et. al., 1998] The results of a similar survey administered to a group of Texas physicians in 2000 by Weinstein et. al. are starkly different. “Overall, a significant number of physicians in this survey revealed opiophobia (prejudice against the use of opioid analgesics), displayed lack of knowledge about pain and its treatment, and had negative views about patients with chronic pain.” [Weinstein et. al, 2000]

Conclusion

In 1918, a mere four years after initial passage of the Harrison Tax/Prohibition Act, a high level commission was appointed by the Secretary of the Treasury to examine the drug problem. It reported that an illegal black market approximately equal to the legitimate medical trade in these substances had come into existence. It also noted that some twenty cities including San Francisco and New York were reporting increasing addict populations, suggesting migration and the beginnings of a drug subculture. [Brecher, 1972b] And so in 1918 the Treasury Department documented the birth of “the drug problem” in America. The committee noted that “the wrongful use of narcotic drugs had increased” since Harrison, but it is also simply and tragically true that the Narcotics Division of the Treasury Department in their legal challenging of Harrison and highly aggressive police actions directly brought these problems into being. Before prohibition there were no “wrongful users,” no “illegal black market,” no migration of addicts to form an incipient drug subculture and black market in major cities. We made these problems.

The committee's recommendation? Stricter law enforcement and the passage of State legislation patterned on the Harrison Act to stem the apparently rising tide of drug abuse. [Brecher, 1972b] And so the pattern was set. The perpetual drug crisis was brought into existence between 1914 and 1918. We have compounded the problem with decades of criminalization and imprisonment of drug users, collateral damage to generations of pain patients, and over eighty years of ongoing harassment of caring physicians and distortion of medical ethics and practice, and of the constitutional right reserved to the States to regulate medicine. The emperor has no clothes.

The Solution...

Is Not More Education of Physicians

As we have noted, calls for more and better education for physicians have been frequently offered as the solution to the pain crisis, and at one level, who could be against education? Educational campaigns regarding modern techniques of optimizing chronic opioid therapy in the treatment of non-cancer chronic pain, are in fact highly successful in countries where the chilling effect does not hold sway, but they are not effective in addressing the chilling effect itself, which is the problem in the United States. The point of the comparison between physician education in Germany vs. the U.S. (above) is not that German physicians better learned chronic opioid therapy, but that the U.S. doctors have also been taught an opiophobic worldview that places them squarely in a therapeutic double bind.

Is Not More “Research” in Thrall to Governmental Policy

The American taxpayer deserves a lot more for the money they spend on supposedly “scientific” federally supported research from the likes of the Substance Abuse and Mental Health Administration, the Centers for Substance Abuse Treatment and indeed from the Congress of the United States. What we get is the endless spinning of data to suit drug war policy objectives and, as we have discussed in this paper, the knowing incorporation of nonsense and bad science into Congressional legislation such as the Drug Free Workplace Act of 1998. [DeLuca, 2002] If there is a real drug problem in this country let physicians and public health researchers rigorously define it and propose rational solutions instead of decade after decade of crisis declaration, denominator abuse, flash trash and shock schlock (see [Appendix Two](#)).

Is Not More Negotiation with Law Enforcement

Appeasement is a strategy that groups of clinicians and policy-makers have used in an attempt to work with the DEA to agree on common guidelines for prescribing for pain patients, for example. Appeasement is also a strategy or understanding employed by individual clinicians and policy makers as they justify their actions to themselves and others. For example, the clinician who declines to treat a patient for pain because that patient might be considered an "addict" by regulatory and law enforcement bodies is practicing appeasement.

What is common and what defines appeasement is a tacit agreement with the DEA core belief in magic substances that turn some users into criminal addicts requiring long term incarceration to be distinguished from deserving pain patients who may morph into criminal drug addicts at any moment. This is gibberish and nonsense, of course, promulgated by the very same police forces that invented and that perpetuate the real drug problem in America.

Law enforcement *does not* deserve a place at the table where scientists and clinicians and politicians of good faith should meet to honestly assess the harm that has been done to criminalized drug users, pain patients and physicians and earnestly seek ways to undue the public health crisis stemming from our disastrous drug war juggernaut.

Is to Let Doctors Treat Pain, Let Doctors Treat Substance Use Disorders

The solution to this awful societal dilemma is to once again allow doctors treat patients respectfully, as whole and complex human beings. Some of these patients have simple medical problems; others complex conditions involving overlapping emotional problems and substance use disorders. Let doctors freely treat pain and addiction just as they do the other chronic public health problems of major importance and consequence in our society, such as alcoholism, asthma and chronic obstructive pulmonary disease, HIV, chronic liver disease, and hepatitis C. These are medical and public health matters, and are treated primarily as such by all Western nations except the U.S.

Dr. Jerome H. Jaffe, a psychiatrist who became head of President Nixon's drug programs and established a network of methadone treatment centers for heroin addicts, remarked in the 1965 edition of Goodman and Gilman's textbook, *The Basis of Therapeutics*:

Much of the ill health, crime, degeneracy, and low standard of living are the result not of drug effects, but of the social structure that makes it a criminal act to obtain or to use opiates for their subjective effects... It seems reasonable to wonder if providing addicts with a legitimate source of drugs might not be worthwhile, even if it did not make them our most productive citizens and did not completely eliminate the illicit market but resulted merely in a marked reduction in crime, disease, social degradation, and human misery. [Jaffe, 1965]

The Real Enemy is the Big Lie

In 1962 the United States Supreme Court described the addict as "one of the walking dead," and one could no doubt find isolated persons superficially fitting this description among addicts living under modern prohibition-caused conditions of high opiate prices, vigorous law enforcement, draconian penalties, and ostracism. The court erred, both in presenting its ghoulish description as the norm and by attributing this "addict" state of being to the drugs themselves rather than to the laws and to the social conditions which largely determine the how modern addicts live.

The US tries, through its drug policy, to keep drugs out of the hands of addicts; most countries, like the UK, Denmark, and the Netherlands, put their resources into trying to keep drugs out of the hands of the as-of-yet unaddicted. Addicts are treated, with various forms of opiate maintenance including methadone, heroin, and buprenorphine, *by community physicians*, individually. In the European model a drug subculture is less likely to form and less likely to be strong. In the American model, we interfere with the community treatment of problematic substance use, instead segregating sufferers into 'treatment centers' including drug-free inpatient, drug-free outpatient, methadone maintenance, and jail. Under conditions of prohibition this breeds subculture and crime-culture which is then misleadingly called "a drug problem." Accurately, these are drug prohibition problems.

It is argued here that prescription drug abuse is a trivial problem compared to under-treated chronic pain in this society, and one that would largely disappear were doctors

permitted to freely treat addiction and pain. Instead, American physicians daily face the demoralizing and futile task of distinguishing between chronic pain and addiction, to the satisfaction not of the patient or medical peers, but of federal policemen who have the power to crush their livelihoods and jail them as drug dealers or murderers.

The myths of the criminal addict, of the perpetual drug crisis, and of a significant prescription drug problem caused by venal pill-pushing physicians in the guise of pain doctors are deeply intertwined in our national law, social values, prejudices about pain, poverty, and race, and have severely distorted our public health research systems and medical practice. This genie will not be put back in the bottle in anything like the four years (1914 – 1918) it took to unleash it. Administration after administration, Congress after Congress, generation after generation of physicians, and an entrenched and often reactionary substance abuse research and treatment industry, have all bought into and amplified the Big Lie.

Let honest and independent public health research and enlightened citizens groups and political leaders finally lead the way towards championing expert pain management for all, compassionate medical care for the sick and disabled among us, and universal respect for every individual as a human being who potentially suffers.

Appendix One - Fooling most of the people all of the time

Declare a perpetual crisis...

The historical existence of a “drug abuse crisis” that justifies the extreme financial and social expenditures of a decades long “war on drugs,” and the bizarre result that the practice of medicine is defacto regulated by federal law enforcement, is an article of faith among the drug warriors and one that has been so often repeated that it shocks many to hear that evidence for the existence of a problem for which the war on drugs is the solution is very scarce while evidence of the awful cost of the war itself abounds.

History aside, it is extremely difficult, I think, to make a rational argument that there exists a continuing drug abuse crisis complete with periodically declared “epidemics.” Nonetheless, the relentless dirge and dire warnings of the drug warriors continues into the present. [[Leshner, 2001](#)]; [[Vastag, 2001](#)] It is crucial that one thoroughly grasp the most robust trend in addiction epidemiology: drug use has dramatically declined over thirty years. Past month use rates are literally half of what they were in the 1970’s, and there has been virtually no change in past-month drug use for over a decade. The declining trend was clearly established for a decade before workplace drug testing became routine. [[Maltby, 1999](#)] In 2000, Quest Diagnostics reported that positive urine drug tests were at historic lows, down some 66 percent in eleven years. [[Quest, 1999](#)] In that report, 62% of the positives were for marijuana - a group particularly *unlikely* to cause workplace problems. [[DeLuca, 2002](#)]

It's Orwellian: thirty years of steady decline in national drug use but drug abuse somehow remains a "crisis" and an "epidemic" justifying a brutal war on doctors and pain patients.

Appendix Two - Statistical Tricks of the Drug Warriors

Outcome Obfuscation

A sort of statistical sleight of hand, *Outcome Obfuscation* is a misleading confusion of outcome and index event. For example, in their 2003 press release "The Myth of the 'Chilling Effect'" the DEA (see "[The Dissembling DEA and the 'Chilling Effect'](#)" above) the index event is the rate of actions against physicians, which they incorrectly calculate. The outcome would be some measure of effect on physician behavior resulting from the index prosecutions, which the DEA ignores.

Outcome Obfuscation commonly turns up in statements like the following, in which drug use is correctly identified as an index event, but is also incorrectly identified as the (problem) outcome.

- "In 2001 it is estimated that 94 million people had used an illegal drug at some point in their lives. Today, some 16 million people are using illicit drugs at least once a month -- about seven percent of the population."
- "The National Household Survey on Drug Abuse reports a significant increase in "past month, non-medical use" of pain relievers among those age 18-25 when comparing 2001 data with that for 2000."

The misleading message is: use = abuse = problem = national crisis demanding federal action. More accurately and honestly we might say, for example, that a teenage alcohol use rate of X (index event) resulted in Y motor vehicle accidents (outcome).

Denominator Abuse

Denominator Abuse is the misleading use of an incorrectly computed rate statistic.

(See "[The Dissembling DEA and the 'Chilling Effect'](#)" above.)

Flash Trash

The use of suggestive or provocative numbers or statistics, usually presented as true *prima facie*, which when analyzed using algebra, do not in fact support the implied conclusion.

A famous example of *Flash Trash* is contained in the *Behrman* case discussed in the "[Historical Antecedents](#)" section of this paper. Behrman was arrested for prescribing at one time 150 grains of heroin, 360 grains of morphine and 210 grains of cocaine. These amounts are not as outrageous as they might seem. Just to put the dosing in perspective, and considering for the moment only the morphine component of the medication

regimen, 360 grains represents near ideal outpatient maintenance dosing for an opiate dependent person based on a *modern* understanding of methadone dose-effectiveness research.

- 1 grain = 64.8 milligrams (mg).
- Outcomes for MMTP (methadone is equipotent with morphine) are best in the dose range of 100-200 mg a day; chronic pain patients sometimes require doses in the *grams* /day range.
- $360 \text{ grains} \times 64.8 \text{ mg / grain} = 19,440 \text{ mg} / 150 \text{ mg/day} = 129.6 \text{ days} =$ approximately 4 months supply = a script for one month with 3 refills with a little left over = medically appropriate ambulatory treatment of opiate dependence.

I have no knowledge of Dr. Behrman other than what is written about him in the document by Rufus King in his “The Narcotics Bureau and the Harrison Act: Jailing the Healers and the Sick” article [King, 1953] and 1972 book, *The Drug Hang-Up, America’s Fifty Year Folly* [King, 1972b] and in Brecher’s 1972 *Licit and Illicit Drugs*, [Brecher, 1972c] and I do not know what his intentions were. Assuming for the sake of argument that he was acting as a legitimate physician, we could hypothesize that the morphine / heroin / cocaine regimen was part of a detoxification-to-abstinence regimen starting with morphine at, say, 200 mg /day decreasing the dose on a weekly basis, faster at first slower towards the end, switching at some point to heroin (believed at the time to be an effective 'cure' for morphine dependence) and ultimately tapering to abstinence using the cocaine, in the accepted manner of the day, to mitigate the depression and ennui known to accompany detoxification from opiates. This detoxification regimen could be accomplished, given the amounts of the medications involved, in six to twelve months depending of the patients’ progress.

For another example of *Flash Trash*, consider the following sentence from a DEA document entitled, “A Closer Look At State Prescription Monitoring Programs” in the “Scope of the Problem” section by Susan Peine, DEA Program Analyst: “In the last five years of her life, Renee obtained at least 469 prescriptions—11,684 doses of pills—from 43 Treasure Valley pharmacies under the names of 110 doctors.” [Peine, 2003] (Presumable there were many forgeries or did she see two docs a month for 5 yrs?)

- $5 \text{ years} \times 365 \text{ days} = 1825 \text{ days}$
- $11,684 \text{ "doses of pills"} / 1825 \text{ days} = 6.4 \text{ doses / day}$ as in the very commonly written, “Take 1 dose every 4-6 hours as needed for pain.” This would be a pharmacologically correct script for the low potency, combination-opiate formulations such as Tylenol #3, Vicodin 7.5/325, Percocet, etc, etc.

If the patient were taking such most commonly prescribed opiates, the number of pills she had to work incredibly hard to obtain is the amount of medication, daily, commonly prescribed for toothache.

Shock Schlock

Shock Schlock is the presentation of lurid or otherwise shocking anecdotes in lieu of meaningful data and sober statistical analysis.

Consider again the “Scope of the Problem” section of the DEA’s “A Closer Look At State Prescription Monitoring Programs” [Peine, 2003] which, after all, was written by a DEA ‘Program Analyst:’

Kentucky is a hotbed of prescription drug abuse. The reasons are many— drug seeking patients, pill-pushing doctors, no-questions-asked pharmacists, and lax oversight and enforcement." Two examples cited: During a 15-month period, a woman visited 10 doctors a total of 45 times, went to three hospitals’ emergency rooms at total of 43 times, visited four dentists, had 30 prescribers of medicine, filled 159 prescriptions in 103 visits to eight drugstores. Cost to the state \$14,508; after she was restricted, her treatment for one year dropped to \$3,091. During a 15-month period, a man visited five doctors a total of 56 times, went to two hospitals’ emergency rooms a total of 18 times, had 224 prescriptions filled in 114 visits to 15 drugstores. Cost to the state \$32,130; after he was restricted, his care for one year dropped to \$5,604." [Peine, 2003]

One might expect to find data and analysis demonstrating, minimally, a mastery of the real situation and a reasonable plan of action and a plausible connection between the two. Instead, the taxpayer is treated to anecdotes worthy of tabloid journalism.

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