

Prosecution of Physicians for Prescribing Opioids to Patients

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Many patients in pain receive inadequate doses of opioids. Fear of government action against prescribing doctors is one cause of this inadequate treatment. The purpose of the study was to assess criminal prosecutions by reviewing press reports of indictments or trials of doctors for opioid offenses during 2 years. Forty-seven cases were reported involving 53 doctors. Fifteen cases were for offenses unrelated to medical practice. In 32 cases, the charge was based on determining the prescriptions for opioids were outside the bounds of proper medical practice. Only two of these cases were evaluated by a state medical board before indictment. Five doctors were indicted for murder related to drug overdose deaths. None were found guilty of murder. Prosecutorial excesses and hyperbole were common. The state medical board's review of appropriateness of prescribing opioids when a doctor-patient relationship is presumed to exist could decrease inappropriate criminal indictments and reduce this component of fear of prescribing adequate opioid therapy for patients in pain.

Studies have found that many patients with pain are given inadequate doses of opioid medications to relieve their pain.¹⁻⁵ Multiple barriers to the adequate treatment of pain have been identified.⁶⁻¹⁵ One of these barriers is fear of government action against a physician who prescribes opioids for patients in pain. We have addressed the issue of whether the reality of this risk of government action is as great as physicians' perception of it. We have reviewed Medical State Board actions¹⁶ and information from the Drug Enforcement Administration about indictments and revocations of registration.¹⁷ We have found that the risk of a physician being punished by either group for prescribing opioids for a patient in pain with adequate medical record documentation is very small.

Ziegler and Lovrich¹⁸ surveyed chief prosecutors in four states with hypothetical cases of doctor-patient encounters in which opioids were prescribed. The investigators asked prosecutors if they would investigate the physicians in each of the cases. Some prosecutors said yes for some of the cases. We then thought a review of actual state and federal prosecutions for opioid offenses was needed. We reviewed newspaper accounts of indictments and trials of doctors to determine if these, and the publicity attendant to them, contribute to physicians' reluctance to prescribe adequate doses of opioid analgesics for patients in pain.

Our method was to use ProQuest and Lexis Nexis Academic Universe electronic journals, news, and periodicals databases. These were searched for all available publications about criminal cases against physicians treating chronic pain patients. Search terms entered were physicians, doctors, prescription medications, pain killers, opioids, controlled substances, pain medications, prescription drugs, trial, court, investigations, and drug trafficking, with each term being used alone and in combination. Additional sources of information were found on web sites, including <http://www.cpmmission.com/politics> and <http://www.cpmmission.com/main/charged.html>. The accuracy of information published on these web sites was always confirmed by a second source from the press. These confirming sources were found by entering the physician's name in Google and Ask.com search engines. Numerous second-source articles and publications from nationwide newspapers and journals were reviewed as well. Detailed and thorough review was limited to only those cases published in the years 2004 and 2005, and the published press reports were the sources of the primary facts cited.

Information about 47 cases involving 53 doctors was obtained. Twenty-one cases were state and 26 were federal. Seventeen were reports of convictions, two were reports of acquittals, 27 were reports of indictments, and one decision

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was pending. Fifteen cases were for activities unrelated to the practice of medicine such as stealing opioids from a hospital supply. In 32 of the 47 cases, the charge was based on determining that the prescriptions of the opioids were outside the bounds of proper medical practice. In only two of these cases was it declared that a state medical board reviewed the case before indictment.

A total of 13 cases involved deaths in which prescribed opioids were initially considered the cause of death and often initiated criminal investigation.

In 17 cases, the articles reviewed included information about the duration of the investigation of the doctors before an action was taken. For some, specific dates were given. For others, the time was given in years. Using 12 months for each year of investigation, the mean duration of investigation was 22 months with a median of 24 months and a range of 1–48 months. The investigations took longer than 2 years in one-third of the cases.

A total of five doctors out of the 32 cases with charges related to medical practice were charged with murder in association with drug overdose deaths along with other offenses. In two of the cases, the charges were withdrawn. In the other three, juries found the doctors not guilty of the murder charges. No doctor was found guilty of murder.

One of the doctors convicted of manslaughter was sentenced to 25 years in jail. The sentence for manslaughter was withdrawn after it was revealed by the prosecution that the patients who died of drug overdoses were not this doctor's patients.¹⁹ A doctor charged with murder in the death of two patients had the charges dropped when the deaths could not be linked to the prescribed medications.²⁰ One doctor, found not guilty of all charges including murder,^{21–22} has written a detailed account of his experience with the criminal justice system.²² He described an unwillingness on the part of the state to admit its errors and correct them. Another doctor, convicted of offenses other than murder, claimed that evidence produced after the trial showed a witness-committed perjury in the trial.²³

Judges and prosecutors are quoted in some of these articles as intending to “send a message” to doctors. Examples of this are as follows:

After conviction and obtaining a 19-year sentence for a 74-year-old physician who claimed he was treating patients in pain and who was defended by a court-appointed public defender, an assistant US attorney said: “I believe and I hope that this case has sent a clear message to the medical community that they need to be sure the controlled substances they prescribe are medically necessary. If doctors have a doubt if they could get in trouble, this case should answer that.”¹⁹

After obtaining a conviction, prosecutors said the doctor's “practice amounted to a criminal enterprise” because he charged for his service and should have known that some of his patients were faking or exaggerating their pain.²⁴

In a third case, following indictment for murder related to prescribed drugs, the District Attorney is described as saying:

“a jury would have to decide whether the medications Green allegedly prescribed illegally were excessive, or whether the individuals should have been getting the medications at all.”²⁵

In summary, we found 47 cases of media accounts published in 2004 and 2005 involving 53 doctors indicted or convicted of criminal activities related to opioids. In 32 cases, the criminal charges were based on allegations of prescribing opioids outside the bounds of normal medical practice. In only two of these cases did a state medical board make a judgment before criminal action. In many cases, witnesses were undercover investigators taught to deceive doctors or they were drug-abusing people who deceived doctors. Some of the news accounts indicated that the doctors thought these people were real patients in pain.

Many people have been trained to behave like patients with a wide variety of diseases. These people are used to teach medical examination skills in medical schools and in the testing of medical students for promotions and physicians for licenses. They are called “standardized patients” and are also used for continuing medical education evaluations. Standardized patients have fooled experienced doctors.²⁶ It is not surprising that trained undercover agents or clever drug abusers can also fool experienced doctors.

Our method of an internet search for news articles about doctors indicted or tried for offenses with respect to opioids has limitations. It may underestimate the true number of cases brought during the 2-years period under study. A second limitation is the small amount of factual information in most of the articles. This has limited our ability to do a more comprehensive review of the actions taken and of the motivations of the parties involved. Nevertheless, it is clear from some of the quotations in the articles and from the fact that all five doctors indicted for murder were not guilty, that prosecutorial excesses and hyperbole appeared to be routine. The dire consequences to one physician and his patients of unsubstantiated charges of murder and other drug-related offenses have been described.²¹ The consequences for the patients were the loss of their doctor and loss of pain control with resultant disability and depression. The consequences for the doctor were time spent in jail, loss of income and savings, loss of medical practice, the ability to practice during the time the case was pending, and concern about the possible outcome of the criminal proceeding.²¹ These consequences probably occurred to other indicted physicians and their patients as well.

A physician apparently risks being charged with murder only when a patient takes more than the prescribed dose of a “controlled substance.” If patients take overdoses of antidepressants or other medications not on the list of controlled substances and die as a result, prescribing doctors do not appear to have been criminally charged with murdering their patients. This risk of being called a murderer if one prescribes opioids to patients in pain who subsequently die, contributes to the present climate of opinion that inhibits many doctors from treating people in pain with adequate doses of opioids. A finding that is used to indict some doctors for murder

relates to the misinterpretation of forensic drug level measurements. Some chronic-pain patients on appropriately large doses of opioids die under circumstances in which they become medical examiners' cases. Some medical examiners interpret forensic opioid levels from these patients as causing their deaths. This is because they apply criteria for an opioid concentration that may be fatal in a drug-naive patient to a chronic-pain patient who is tolerant to opioids.^{27,28} Functioning pain patients, receiving appropriate doses of opioids chronically, can have drug levels in the range that can kill people intolerant of opioids. Pain patients who died of unrelated causes have been erroneously declared to have died of opioid overdose by medical examiners who have interpreted the drug levels inappropriately.²⁷ This has led to unwarranted criminal charges against the prescribing physicians.²⁷

Publicity about doctors being arrested and tried for their prescriptions given to patients who deceived them and the hyperbolic public denunciations of these doctors by prosecutors sends "a clear message to the medical community."¹⁹ It contributes to physicians' fear of prescribing opioids. More importantly, it makes doctors suspect patients claiming to be in severe pain. This suspicion interferes with a proper doctor-patient relationship and prevents adequate therapy for patients genuinely in pain.

When the alleged controlled substance offense occurs outside of a doctor-patient relationship, a jury trial is the appropriate way to determine guilt or innocence. The statement by a prosecutor that a lay jury is the proper body to decide if a specific prescription is within or outside the bounds of acceptable medical practice²⁵ should not be correct. When prescriptions are written in a doctor's office and a doctor-patient relationship is presumed to exist, the state medical board is the governing body responsible for evaluating the evidence and determining if an action is within or outside the bounds of acceptable medical practice. This occurred only twice in the 32 cases in which a doctor-patient relationship was presumed to exist. Our review failed to identify the reason why medical board review before indictment was consistently avoided by prosecutors.

The intended purpose of these criminal prosecutions is to stop the diversion of controlled substances away from legitimate medical use. The average delay between initiating an investigation and bringing criminal action appeared to be 2 years. In one-third of the cases, it was longer. Certainly, a state medical board can take action by stopping a physician from prescribing opioids faster than the time needed for a criminal investigation, trial, and conviction. A more effective and rapid way to stop diversion of physician-prescribed opioids is to promptly refer the cases of physicians reasonably suspected of supplying opioids to diverters to their state medical boards rather than the criminal justice system. The boards can then take any appropriate actions including referring the case of the physician to the criminal justice system for prosecution. Such actions as convicting a 74-year-old physician and giving him a 19-year jail sentence when he

claimed to be innocent and treated people in pain¹⁹ is far from the best way to stop diversion. It is an excellent way to make physicians reluctant to prescribe adequate doses of opioids to patients with chronic pain who need strong analgesia.

CONCLUSION

There are physicians who abuse their privileges and knowingly arrange for opioids to be taken by people who are not in pain. There are other physicians who appear to have a doctor-patient relationship with people who deceive the doctors into treating them as patients in pain. And there are many doctors who treat patients in pain appropriately with high doses of opioids. Any of these doctors may be investigated and risks prosecution with a lay jury to decide if the prescriptions are within or outside the bounds of medical practice. This inhibits doctors from prescribing appropriately high doses of opioids to patients who need them. In addition, when doctors must continually be suspicious of patients claiming to be in pain because being deceived can lead to criminal prosecution, their willingness to treat patients in pain with opioids diminishes. This harms patients in pain by increasing their suffering and by diminishing their ability to work and to function independently and in society. State medical boards rather than lay juries should be used to determine if doctors are prescribing opioids for patients inappropriately. If the prescriptions are determined to be within the bounds of medical practice, the case should end immediately. If the doctors are intentionally prescribing opioids for non-medical uses, they should be referred to the criminal justice system. If the doctor is intending to treat patients in pain, but prescribing excessively, the state medical board can and should take appropriate action. This would be a far more efficient and effective way to diminish this aspect of drug diversion than current criminal prosecution. It could eliminate prosecutions for prescriptions given within the bounds of medical practice. This would help diminish the fear of government punishment for prescribing opioids and lower this barrier to the adequate treatment of pain.

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CONFLICT OF INTEREST

The authors declared no conflict of interest.

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