

Conviction without a Crime: a True Story

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The Drug Enforcement Administration (DEA) is accusing doctors, especially pain management specialists, of being “drug dealers.” In any medical practice, especially one treating chronic pain, it is a statistical likelihood that a small number of patients may prove to be selling their pain medications. Most often, they obtain the drugs for a legitimate purpose, but then sell a portion of them. Then there are times when they obtain drugs fraudulently, by deceiving the physician, expressly for the purpose of diversion. Often, these patients “doctor shop” to obtain pain medications, which can be sold at enormous profits.

Drug War Targets Doctors: the Modus Operandi

The typical scenario: A patient presents to a doctor complaining of severe, intractable pain that has been unresponsive to conventional treatment. Before the patient’s first appointment, a copy of the medical or surgical records is obtained from the referring physician(s) for review. Most often, these records consist of prior diagnoses, surgeries, treatment plans, nerve conduction studies, and imaging studies. After a review of the medical records and consultation with the patient, a focused or comprehensive physical examination is conducted to confirm or reassess the patient’s complaint.

The following are some common conditions for which patients consult a pain-management specialist: chronic severe headaches, cervical or lumbar radiculopathies, complex regional pain syndrome (CRPS), diabetic peripheral neuropathy, fibromyalgia, severe arthralgia, and a variety of neuromuscular pathologies secondary to trauma.

Sometimes bona fide patients “doctor shop.” They visit several doctors in the same month, in an attempt to ease their chronic and severe pain. Often, this is a manifestation of *pseudoaddiction*—an attempt to acquire enough medication to reduce intractable pain, from doctors who undermedicate them, usually because of fear of causing addiction or fear of arrest by overzealous law enforcement agents.

It is completely appropriate for the pain specialist, after careful evaluation of the medical records and a physical examination, to institute a treatment plan that includes the closely monitored use of long-acting opioids. For centuries, opioids have been recognized as the most effective pain relief available. Fortunately, opioids do not have the toxic effects on the liver, stomach, or kidneys commonly experienced with other pain-relief agents, such as acetaminophen and nonsteroidal antiinflammatories.

Although the nonmedical use of opioids has been outlawed in the United States since the early 20th century, their medical use is entirely legal. That legal use, however, has collided with a “War on Drugs.” It should be noted that pain is a subjective feeling, which may not be seen nor measured by laboratory or imaging studies. Therefore, physicians sometimes can’t tell whether patients are lying or exaggerating the severity of their pain in order to secure opioids for diversion purposes. It should also be noted that from medical school through residency, physicians are taught to believe patients’ complaints of pain despite the lack of hard objective findings. The assumption that patients are lying can destroy the patient-physician relationship.

Unfortunately, many Americans take drugs, prescribed opioids or others, for nonmedical reasons; obviously, it is safer to take prescription drugs than those bought from a street dealer. The temptation to divert some of their supply for sale may be overwhelming, especially for people of low income or earning capacity.

When such patients sell their medications, police or the DEA may arrest them. Largely unknown to the general public, these agencies have a profit motive. Asset seizure laws allow them to enrich their agencies, while concurrently providing evidence that they are “doing something” to justify their essentially unproductive war. Prosecutors also have a perverse incentive. They wield enormous power, which they can use with virtual impunity to aggrandize their careers.

There is little profit or glory, however, in arresting a patient who is diverting drugs—and there is considerable danger in targeting street dealers and members of a drug cartel. The potential payoff comes from arresting the physician “kingpin” who prescribes the drugs. The government can immediately confiscate all his assets, even *before* he is indicted. The charges usually include mail fraud (related to billing), money laundering, racketeering, and/or conspiracy; the last requires little proof of motive or guilt. These charges, plus enhancements allowed by law, add years to prison sentences. It is said that career advancement to prosecutors is often based on the number of convictions and the number of years sentenced.

A prosecutor who lacks integrity and has no concern for justice does not care about the physician’s legitimate motive to relieve suffering. Nor does he care about punishing the drug-dealing patients. Typically, the patients who are arrested are intimidated with threats of long prison terms. This is primarily a tactic to get them to “cooperate” by “testilying” against the doctor who tried to help them.

The prosecutor does not need to have any evidence that the physician profited in any way from the sale of the prescriptions he

wrote in good faith. In an aggressive, well-orchestrated front-page media blitz, the prosecution portrays the physician as a common drug dealer preying on his patients. In one case, prosecutors trumpeted that the accused physician was no better than “the Taliban.” In reality, they themselves are no better than Josef Stalin, whose false trials live in infamy. This reprehensible practice fits neatly into the recent breakdown of common decency and the rule of law in the United States.

One Doctor’s Story

My own story is one of many similar examples. I am a 62-year-old black American, born in Bronx, New York. When I was 10 years old, my family moved to the dreary Brownsville public housing “projects” of Brooklyn, New York. My parents, neither of whom finished high school, told my sister and me that the only way out of the ghetto was through education. With their constant support and by the grace of God, I was accepted into college at the age of 16. However, my education was interrupted by the Vietnam conflict; I served in the Air Force. That was followed by several years of employment at various menial jobs, e.g. recycling plant laborer, service station attendant, and production line worker. I returned to college at the age of 29, and over the next 13 years, I earned two college degrees with honors in chemistry and biology, and my doctorate in medicine. During that time I also worked full time in a factory and helped my wife raise our children.

In January 1998, I received a telephone call from Jackson and Coker, a physician recruitment agency. They presented two employment opportunities with similar salary and benefit packages. One opportunity was in Florence, S.C., and the other was in Myrtle Beach, S.C. The choice was easy; Myrtle Beach provided the added incentive of a two-year training program to qualify for certification in the relatively new specialty of pain management. At the time, I was keeping a daily journal, and every day from the date of my interview, I thanked God for the “opportunity of a lifetime.” I began my training on Apr 15, 1998, and passed my certification examination two years later, in February 2000. I then returned to Alabama to rejoin my wife and children and begin practicing pain management.

However, in April 2000, Pinnacle Healthcare Services offered me the position of executive medical director. They hired me for one year to head up a brand new pain management/primary care center back in Myrtle Beach. Then the plan was to return to Alabama to open a second clinic there with a limited partnership and buyout option. Before the new clinic opened, the DEA approved a change of registration to practice at the new location, and I began practicing on May 1, 2000.

In June 2001, I received a telephone call from the DEA in South Carolina, requesting that I help them determine which of some prescriptions that they had in their possession were signed by me, and which had been forged. I met with them to clear up the matter, and after a two-hour session, they first thanked me, and then proceeded to inform me that they were revoking my DEA registration, alleging

that I had been dealing drugs out of my office from April 1998, to March 2000. They told me that the practice had been under investigation since 1996—although they had never had warned me that I was in harm’s way, and could be judged guilty by association. Nor did they warn the other physicians hired to practice there.

It turns out that a small number of patients were selling their medications, wholly without the knowledge of the treating physicians. As a consequence of the illegal actions of those patients, eight physicians were arrested on completely trumped-up charges, and then railroaded through the “justice” system. We were convicted by a confused jury of our “peers” and sentenced to long prison terms without the possibility of parole! (There is no parole in the federal system.)

As my assets were “unavailable”—having been seized by the government, I qualified for representation by the public defender at trial. He did no meaningful cross examination of the prosecution’s witnesses and withheld possibly exculpatory evidence that I provided. I was told that the information would be presented “at the right time”—but it never was. Former patients under plea-bargain agreements testified against me, untruthfully. One mouthed “I’m sorry” as she passed me on her way down from the witness stand. For the conspiracy charges, hearsay “evidence” was all that was needed.

Given the unchallenged “evidence” that was presented, and the instructions to the jury, I would have voted for conviction also, had I been on the jury. I do not believe the jury understood the concept of chronic pain management and the standard treatment protocol involving long-term use of sustained-release opioids, nor was it explained to them. Also, I believe they were not made aware of the concept that it is entirely legal to prescribe controlled substances in good faith during “the course of professional practice.”

A year after my conviction, I was given a sentence of 292 months (24 years and 4 months); however, it was dramatically reduced to 30 months, largely because of a U.S. Supreme Court decision holding that the maximum sentence that a judge may impose must be based on facts submitted to the jury or admitted by the defendant (*Blakely v Washington*).¹ In the consolidated cases of *United States v. Booker*² and *United States v. Fanfan*,³ the U.S. Supreme Court held that *Blakely* applied to federal sentencing guidelines. Thus, I could not be sentenced on the basis of an allegation of manslaughter—of two patients *I had never even seen!* Also my initial sentence was calculated on the baseless accusation that I was in possession of 12 weapons, including an Uzi, a sawed-off shotgun, an AK-47, and 7,000 rounds of ammunition. And then there was the phantom 217,000 kilos of marijuana. When all of these totally fabricated “enhancements” were dropped, my sentence of more than 24 years was reduced to 2.5 years.

Of special note, upon reduction of my sentence, my prosecutor was enraged. I guess he lost a lot of promotion points. In any event, the system was able to get back at me. My sentence called for incarceration in a federal prison camp, but a malicious “mistake” was made, and I was sent to a maximum security prison, where I feared being assaulted, raped, or even killed. It took months of “lost

paperwork” to correct the “error.” Currently, I am serving a 3-year probationary period that began on my release from prison on May 30, 2008. During this time period, I’ll be subject to random drug testing and unable to travel more than 75 miles from home without permission. These and other restrictions may be enforced until 2011.

After release, life does not go back to normal. I have as yet been unable to get my medical license reinstated. Moreover, a felony conviction for drug dealing makes it virtually impossible to obtain employment of any kind. My job prospects would be better as a high-school dropout. In addition, I have lost several low-level jobs because of apparently deliberate efforts by persons I believe to be federal officials to intimidate or mislead my employers, by faxes and phone calls. Rehabilitation is evidently not the object of the federal “correctional” process: destruction of life and livelihood appears to be the intention.

It is not just the convict himself who suffers from imprisonment; my wife and children were devastated. As Richard Henry Dana wrote in *Two Years Before the Mast*, “When a convict is confined to prison, the distress consequent to his inability to earn a livelihood falls upon a poor wife and helpless children or an infirm parent.” The distress of impoverishment for me and my family, while waiting on appeal, was by no means the only hardship. We also had to endure social stigma, rejection, and isolation.

Motiveless Crime?

Notably, in the Myrtle Beach cases the average age of the physicians supposedly beginning “new careers” as drug dealers was 53 years. Not one of us had a prior criminal record. Had I wished to become a drug dealer, I could have stayed in the ghetto and made “Big Money.” Why would my wife of 23 years and I have made such sacrifices to undertake the grueling years of medical training at a much more advanced age than most (I was 42 when I graduated from medical school), and then become a drug kingpin? Why take a long and onerous detour as a certified pain practitioner, chief of staff of a hospital, and colonel in the Alabama Army National Guard—and then suddenly get involved in drug dealing by writing very traceable prescriptions worth \$60,000 a day (\$300,000 a week), with my cut being a mere 95 cents a day (\$4.95 a week)—before taxes?

Here’s the math: There were 10 alleged illegal patient visits per month at \$50 per visit, for \$500 total per month, to be divided among 25 staff persons including physicians. This amount would be further divided by 4.2 weeks per month and 5 days per week yielding *\$0.95 per day per “conspirator”!*

The DEA and federal prosecutors do not claim that any person who was not totally insane would engage in such a scheme. They just say, “It doesn’t matter.”

What profile model could the government have used to track such criminals?

In answer to the question of what conceivable motive we could have had to write illegal prescriptions, a representative of the U.S.

Attorney’s office responded: “According to conspiracy laws, *it doesn’t matter*; we do not have to *prove* you had a motive!” A crime with no mens rea is foreign to our traditions, but that is how the conspiracy laws are interpreted.

One must also ask: How can one conspire without communication, co-conspirators, or knowledge? According to the interpretation of conspiracy laws, none of these things matter! Since we paid taxes on our alleged drug money, the government, if one were to apply the same logic, would be a co-conspirator.

While engaging in the conscientious, legal practice of my profession, I was the *victim* of a crime perpetrated by dishonest patients without my knowledge or consent. How can being a crime victim be turned into a crime? Yet the DEA and the U.S. Department of Justice, with no compunctions or embarrassment, told Americans that I was a drug dealer, rather than a physician treating patients in good faith, even though I had no control over the fact that some of my patients were selling the medications I prescribed for them. Where are common sense and logic, never mind decency?

Conclusion

Physicians are increasingly scapegoats for societal problems, such as the failed War on Drugs, huge hospital bills, and the ever increasing costs of medications and health-insurance plans.

Reassuring statements may be made by law enforcement agencies that one has nothing to fear if one is practicing good medicine and has signed pain contracts. Nothing could be further from the truth. I had these protections in place, but they did not matter. There is no guarantee that you will be safe from the government agencies that are persecuting the very people they are sworn to protect.

There are 37 different pain management associations, not one of which attempted to help me or my colleagues. They are as reassuring as the AMA, which sent a “letter of concern” to Congress 7 years ago but has done nothing since.

There are many stories like mine. Physicians are increasingly afraid to prescribe effective doses of pain medications. Every year, more than 50 million patients suffer relentless, incurable, severe pain. Unless and until the public demands reform of the Controlled Substances Act and modification of the conspiracy laws, political leaders will not take action to end this travesty of justice. And patients will continue to be at risk of undertreatment of intractable pain—or worse yet, no treatment at all.

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REFERENCES

- ¹ *Blakely v. Washington* (02-1632) 542 U.S. 296 (2004).
- ² *United States v. Booker* (04-104) 543 U.S. 220 (2005).
- ³ *United States v. Fanfan* (04-105) 543 U.S. 220 (2005).