William Hurwitz, Prosecution, and the Undertreatment of Pain

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On Friday, April 27, 2007, pain management physician William E. Hurwitz was convicted on 16 counts of narcotics trafficking by a federal jury. The facts of the case, as well as the arguments advanced by both the prosecution and the defense, offer an important window in assessing relevant pain and drug policy, as well as some cultural attitudes towards pain and its treatment in the U.S.

Hurwitz was originally convicted in December 2004 of various crimes arising out of his pain management practice. Yet the U.S. Court of Appeals for the Fourth Circuit reversed the conviction, holding that the district court had erroneously instructed the jury that they could not consider whether Hurwitz had acted in good faith in prescribing large amount of opioids. As the Fourth Circuit correctly observed, the good faith claim is crucial to Hurwitz’s defense, for if a fact-finder is not permitted to consider whether Hurwitz’s prescribing practices fall within an objective good faith standard, it seems almost impossible to construct an argument that he was operating a legitimate medical practice.

The core of the government’s case is simple: Hurwitz repeatedly prescribed high doses of opioid analgesics “to patients who turned out to be drug dealers and addicts.” Accordingly, the government claims, he acted outside the grounds of legitimate medical practice and is therefore guilty of narcotics conspiracy and trafficking under the federal Controlled Substances Act. In the first trial, prosecutors “portrayed Hurwitz as a common drug dealer whose waiting room was filled with sleeping and incoherent patients with track marks on their arms.”

The defense counters that Hurwitz was something of a last resort for chronic pain patients. To assess this narrative properly requires at least some understanding of the widespread undertreatment of pain in the U.S. (and in much of the industrialized world). There is an overwhelming body of evidence supporting the proposition that pain, and in particular chronic pain, are consistently undertreated such that the majority of patients suffering pain

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2 See United States v. Hurwitz, 459 F.3d 363, 480 (4th Cir. 2006).
3 Id. at 480-81. There is also an interesting federalism issue in this case, relating to the tension between the state’s prerogative in defining the contours of “legitimate medical practice” and the federal government’s regulation of narcotics. This tension was directly at issue in Gonzales v. Oregon, the case arising out of then Attorney General John Ashcroft’s Executive Order essentially invalidating the Oregon Death with Dignity Act. 546 U.S. 243 (2006).
5 Id; see also 21 U.S.C. § 841 et seq. (West Supp. 2007).
6 Jerry Markon, Conviction of McLean Pain Doctor Overturned, WASH. POST, Aug. 23, 2006, at B01.
persist in experiencing such pain even while receiving medical treatment. These problems are particularly pronounced among chronic pain patients; as Jean Jackson observes, it is no accident that relations between chronic pain patients and their physicians are among the worst observed.

The reasons for this hostility are intricate, and go well beyond the simple fact that many chronic pain patients do not receive adequate treatment for their pain. By this I mean that the reasons why chronic pain patients frequently do not receive adequate treatment are integral in explaining both the nature of the problem itself and the nature of the hostility.

Indeed, one of the expert witnesses for the defense, Dr. James Campbell, testified that the “‘problem patients’ consumed so much time and energy that most doctors refused to treat them ‘regardless of what the consequences would be for the patient’ . . . .” The labeling of chronic pain patients as “problem patients” evinces one of the reasons Jackson identifies for our current difficulties in caring for chronic pain patients: the assessment of culpability for pain. Drew Leder rightly points out that the Latin root of pain is *poine*, which means punishment. The connection between sin and suffering has old roots in Western culture, and Jackson explains how chronic pain patients are widely perceived as the least worthy pain patients, primarily because their pain cannot be traced to any kind of organic insult.

The latest New York Times article records a particularly revealing cross-examination of Dr. Robin Hamill-Ruth, a pain management specialist who was testifying as an expert witness for the prosecution. Hamill-Ruth, who upon direct had pronounced Hurwitz’s behavior “illegal and immoral,” was shown the medical records of a patient named Kathleen Lohrey, who had switched physicians from Hamill-Ruth to Hurwitz. Lohrey complained of migraines so severe that she was frequently unable to leave her bed, and was once committed to a mental health facility in handcuffs due to suicidal ideation. Lohrey apparently sought relief at Hamill-Ruth’s pain clinic, but was dismayed to find that the “clinic’s philosophy ‘includes avoidance of all opioids in chronic headache management,’” especially because the only

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7 See, e.g., Barry R. Furrow, *Pain Management and Provider Liability: No More Excuses*, 29(1) J. L. MED. & ETHICS 28, 28, 36 (2001). The issue Furrow’s article appears in is a symposium on problems and policies relating to pain management, and is a particularly good source, especially for those unfamiliar with the issues.


9 Tierney, *supra* note 3, at F1. The reasons why chronic pain patients are deemed “problem patients” are various and complicated. Aside from the assignment of personal responsibility for such pain, chronic pain patients are notoriously difficult to treat, they often experience poor relations with their physicians, which results in frequent movement among providers, and providers’ fears of facilitating addiction and drug-seeking behavior in such patients also contributes to the phenomenon. All of these reasons are examined in Jackson’s article. See Jackson, *supra* note 8. Though time and space do not permit full exposition of this topic here, examining why exactly such patients are so “problematic” is part of my original research project. See note 23 *supra*.


12 Jackson, *supra* note 7, at 339-41.


14 Id.

15 Id.
relief Lohrey had ever felt from her pain was due to several common opioid analgesics (Percocet and Vicodin).\textsuperscript{16}

After declining a nerve block in her forehead (which would require a painful injection), Lohrey was referred to a psychologist, given a prescription for an anxiety drug named BuSpar, and told to come back in two-and-a-half months.\textsuperscript{17} Hamill-Ruth admitted under cross-examination that she was unaware that headaches are a side effect of BuSpar.\textsuperscript{18}

Lohrey, who has already testified as a defense witness in the retrial, wrote to Hurwitz seeking help, explaining that “I currently have a physician who has said that I am psychologically manufacturing my headaches, and that I am addicted to narcotic pain relief. This of course is not the first time I have been treated as a ‘nut’ or a junkie.”\textsuperscript{19} As Jackson documents, such experiences are the rule rather than the exception for chronic pain patients.\textsuperscript{20}

Many commentators concerned with the effect of drug policy on pain management have endorsed the principle of balance as a guiding light in such policy assessments.\textsuperscript{21} Under this approach, the ultimate policy goal is to balance the state’s interest in preventing diversion of opioids from legitimate medical use against the provider and patient’s needs in obtaining needed medications for pain. Such a view is to be commended; it seems difficult to imagine who would oppose the perspective that pain and drug policy should reflect a proper balance between legitimate competing interests.

However, aside from the epistemic problem – ascertaining what set of policies reflects the best balance – there is a deeper problem with pursuing balance as a self-sufficient policy goal.\textsuperscript{22} The problem is that nothing about the goal of balance explains why pain remains so undertreated. One might respond that the problem is exactly a lack of balance, but this is blatantly circular, and still does nothing to explain precisely why such balance has proven so elusive. The key, then, is to trace the reasons why pain remains so undertreated both in the U.S. and in most of the “allopathized” world. Doing so may engender policy solutions that may then be specifically tailored to address the causes for the problem itself. This is not to eschew the principle of balance in pain policy, but rather to provide additional guidance in crafting sensible policy towards pain management and the use of opioids.\textsuperscript{23}

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\textsuperscript{16} Id.
\textsuperscript{17} Id.
\textsuperscript{18} Id.
\textsuperscript{19} Id.
\textsuperscript{20} See Jackson, supra note 7, at 339-42.
\textsuperscript{22} To be fair, few of the commentators in favor of balance claim that it alone is sufficient to guide policy and practice as to pain management. But there is a notable paucity of supplemental policy perspectives, which is problematic if indeed the principle of balance is by itself insufficient.
\textsuperscript{23} This analysis is the subject of my dissertation, which I hope to complete in the 2007-08 academic year.