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COVER STORY

When Is a Pain Doctor a Drug Pusher?

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Corrections Appended

Ronald McIver is a prisoner in a medium-security federal compound in Butner, N.C. He is 63 years old, of medium height and overweight, with a white Santa Claus beard, white hair and a calm, direct and intelligent manner. He is serving 30 years for drug trafficking, and so will likely live there the rest of his life. McIver (pronounced mi-KEE-ver) has not been convicted of drug trafficking in the classic sense. He is a doctor who for years treated patients suffering from chronic pain. At the Pain Therapy Center, his small storefront office not far from Main Street in Greenwood, S.C., he cracked backs, gave trigger-point injections and put patients through physical therapy. He administered ultrasound and gravity-inversion therapy and devised exercise regimens. And he wrote prescriptions for high doses of opioid drugs like OxyContin.

McIver was a particularly aggressive pain doctor. Pain can be measured only by how patients say they feel: on a scale from 0 to 10, a report of 0 signifies the absence of pain; 10 is unbearable pain. Many pain doctors will try to reduce a patient's pain to the level of 5. McIver tried for a 2. He prescribed more, and sooner, than most doctors.

Some of his patients sold their pills. Some abused them. One man, Larry Shealy, died with high doses of opioids that McIver had prescribed him in his bloodstream. In April 2005, McIver was convicted in federal court of one count of conspiracy to distribute controlled substances and eight counts of distribution. (He was also acquitted of six counts of distribution.) The jury also found that Shealy was killed by the drugs McIver prescribed. McIver is serving concurrent sentences of 20 years for distribution and 30 years for dispensing drugs that resulted in Shealy's death. His appeals to the U.S. Court of Appeals for the Fourth Circuit and the Supreme Court were rejected.

McIver's case is not simply the story of a narcotics conviction. It has enormous relevance to the lives of the one in five adult Americans who, according to a 2005 survey by Stanford University Medical Center, ABC News and USA Today, reported they suffered from chronic pain — pain lasting for several months or longer. According to a 2003 study in The Journal of the American Medical Association, pain costs American workers more than $61 billion a year in lost productive time — and that doesn't include medical bills.

Contrary to the old saw, pain kills. A body in pain produces high levels of hormones that cause stress to the heart and lungs. Pain can cause blood pressure to spike, leading to heart attacks and strokes. Pain can also consume so much of the body's energy that the immune system degrades. Severe chronic pain sometimes leads to suicide. There are, of course, many ways to treat pain: some pain sufferers respond well to surgery, physical therapy, ultrasound, acupuncture, trigger-point injections, meditation or over-the-counter painkillers like Advil (ibuprofen) or Tylenol (acetaminophen). But for many people in severe chronic pain,

an opioid (an opiumlike compound) like OxyContin, Dilaudid, Vicodin, Percocet, oxycodone, methadone or morphine is the only thing that allows them to get out of bed. Yet most doctors prescribe opioids conservatively, and many patients and their families are just as cautious as their doctors. Men, especially, will simply tough it out, reasoning that pain is better than addiction.

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It's a false choice. Virtually everyone who takes opioids will become physically dependent on them, which means that withdrawal symptoms like nausea and sweats can occur if usage ends abruptly. But tapering off gradually allows most people to avoid those symptoms, and physical dependence is not the same thing as addiction. Addiction — which is defined by cravings, loss of control and a psychological compulsion to take a drug even when it is harmful — occurs in patients with a predisposition (biological or otherwise) to become addicted. At the very least, these include just below 10 percent of Americans, the number estimated by the United States Department of Health and Human Services to have active substance-abuse problems. Even a predisposition to addiction, however, doesn't mean a patient will become addicted to opioids. Vast numbers do not. Pain patients without prior abuse problems most likely run little risk. "Someone who has never abused alcohol or other drugs would be extremely unlikely to become addicted to opioid pain medicines, particularly if he or she is older," says Russell K. Portenoy, chairman of pain medicine and palliative care at Beth Israel Medical Center in New York and a leading authority on the treatment of pain.

The other popular misconception is that a high dose of opioids is always a dangerous dose. Even many doctors assume it; but they are nonetheless incorrect. It is true that high doses can cause respiratory failure in people who are not already taking the drugs. But that same high dose will not cause respiratory failure in someone whose drug levels have been increased gradually over time, a process called titration. For individuals who are properly titrated and monitored, there is no ceiling on opioid dosage. In this sense, high-dose prescription opioids can be safer than taking high doses of aspirin, Tylenol or Advil, which cause organ damage in high doses, regardless of how those doses are administered. (Every year, an estimated 5,000 to 6,000 Americans die from gastrointestinal bleeding associated with drugs like ibuprofen or aspirin,

according to a paper published in The American Journal of Gastroenterology.)

Still, doctors who put patients on long-term high-dose opioids must be very careful. They must monitor the patients often to ensure that the drugs are being used correctly and that side effects like constipation and mental cloudiness are not too severe. Doctors should also not automatically assume that if small doses aren't working, that high doses will — opioids don't help everyone. And research indicates that in some cases, high doses of opioids can lose their effectiveness and that some patients are better off if they take drug "holidays" or alternate between different medicines. Pain doctors also concede that more studies are needed to determine the safety of long-term opioid use.

But with careful treatment, many patients whose opioid levels are increased gradually can function well on high doses for years. "Dose alone says nothing about proper medical practice," Portenoy says. "Very few patients require doses that exceed even 200 milligrams of OxyContin on a daily basis. Having said this, pain specialists are very familiar with a subpopulation of patients who require higher doses to gain effect. I myself have several patients who take more than 1,000 milligrams of OxyContin or its equivalent every day. One is a high-functioning executive who is pain-free most of the time, and the others have a level of pain control that allows a reasonable quality of life."

All modern pain-management textbooks advocate "titration to effect" — in other words, in cases where opioids are helping, gradually increasing the dosage until either the pain is acceptably controlled or the side effects begin to outweigh the pain-relief benefits. But the vast majority of doctors don't practice what the textbooks counsel. In part, this is because of the stigma associated with high-dose opioids, the fear that patients will become addicted and the fact that careful monitoring is very time-consuming. And most doctors have received virtually no training in medical school about managing pain: many hold the same misconceptions about addiction and dosage as the general public.

And even pain specialists can be conservative. Sean E. Greenwood died in August at age 50 of a cerebral hemorrhage that his wife, Siobhan Reynolds, attributes to untreated pain. Greenwood was seeing various pain specialists. What makes his undertreatment especially remarkable is that he and his wife founded the Pain Relief Network, an advocacy group that has been the most vocal opponent of prosecutions of doctors and financed part of the legal defense of many pain doctors. "Here I am — I know everyone, and even I couldn't get him care that didn't first regard him as a potential criminal," Reynolds said.

According to the pharmaceutical research company IMS Health, prescriptions for opioids have risen over the past few years. They are used now more than ever before. Yet study after study has concluded that pain is still radically undertreated. The Stanford University Medical Center survey found that only 50 percent of chronic-pain sufferers who had spoken to a doctor about their pain got sufficient relief. According to the American Pain Society, an advocacy group, fewer than half of cancer patients in pain get adequate pain relief.

Several states are now preparing new opioid-dosing guidelines that may inadvertently worsen undertreatment. This year, the state of Washington advised nonspecialist doctors that daily opioid doses should not exceed the equivalent of 120 milligrams of oral morphine daily — for oxycodone or OxyContin, that's just 80 milligrams per day — without the patient's also consulting a pain specialist. Along with the guidelines, officials published a statewide directory of such specialists. It contains 12 names. "There are just

not enough pain specialists," says Scott M. Fishman, chief of pain medicine at the University of California at Davis and a past president of the American Academy of Pain Medicine. And the guidelines may keep nonspecialists from prescribing higher doses. "Many doctors will assume that if the state of Washington suggests this level of care, then it is unacceptable to proceed otherwise," Fishman says.

In addition to medical considerations real or imagined, there is another deterrent to opioid use: fear. According to the D.E.A., 71 doctors were arrested last year for crimes related to "diversion" — the leakage of prescription medicine into illegal drug markets. The D.E.A. also opened 735 investigations of doctors, and an investigation alone can be enough to put a doctor out of business, as doctors can lose their licenses and practices and have their homes, offices and cars seized even if no federal criminal charges are ever filed. Both figures — arrests and investigations — have risen steadily over the last few years.

Opioid drugs have been used to treat pain for decades, mostly for acute postsurgical pain or the pain of cancer patients. But in January 1996, Purdue Pharma helped increase the use of these drugs by introducing OxyContin — oxycodone with a time-release mechanism. Oncologists and pain doctors were the principal prescribers of opioids. But Purdue introduced the drug with an aggressive marketing campaign promoting OxyContin to general practitioners and the idea of opioid pain relief to doctors and consumers. The product's time-release mechanism, Purdue claimed, allowed steadier pain relief and deterred abuse.

Many pain sufferers found that OxyContin gave them better relief than they ever had before. But Purdue misrepresented the drug's potential for abuse. Last month, the company and three of its executives pleaded guilty to federal charges that they misled doctors and patients. The company agreed to pay $600 million in fines; and the executives, a total of $34.5 million. The pill's time-release mechanism turned out to be easily circumvented by crushing the pill and snorting or injecting the resulting powder. By the late 1990s, OxyContin abuse was devastating small towns throughout Appalachia and rural New England. Pharmaceuticals, mainly opioids, are still widely abused — now more so than any illegal drug except marijuana. In 2005, according to the government's National Survey on Drug Use and Health, 6.4 million Americans, many of them teenagers, had abused pharmaceuticals recently. Most got the drug from friends or family — often, in the case of teenagers, from their parents' medicine cabinets.

At the time the OxyContin epidemic emerged, the D.E.A. had far more experience seizing illegal drugs like cocaine and heroin. According to Mark Caverly, the head of the liaison and policy section for the D.E.A.'s Office of Diversion Control, the OxyContin epidemic, however, required the agency to step up its antidiversion efforts. In 2001 the D.E.A. established the OxyContin Action Plan. The D.E.A. dispatched investigators to the most troubled states and trained local law-enforcement officials.

The basis of the physician-patient relationship is trust. Trust is especially valued by pain patients, who often have long experience of being treated like criminals or hysterics. But when prescribing opioids, a physician's trust is easily abused. Pain doctors dispense drugs with a high street value that are attractive to addicts. All pain doctors encounter scammers; some doctors estimate that as many as 20 percent of their patients are selling their medicine or are addicted to opioids or other drugs. Experts are virtually unanimous in agreeing that even addicts who are suffering pain can be successfully treated with opioids. Indeed, opioids can be lifesaving for addicts — witness the methadone maintenance therapy given to heroin addicts. But treating addicts requires extra care.

Identifying the scammers is especially tricky because there is no objective test for pain — it doesn't show up on an X-ray. In one British study, half the respondents who complained of lower-back pain had normal M.R.I.'s. Conversely, a third of those with no pain showed disk degeneration on their M.R.I.'s. The study suggested there could be a profound disconnection between what an M.R.I. sees and what a patient feels.

There are red flags that indicate possible abuse or diversion: patients who drive long distances to see the doctor, or ask for specific drugs by name, or claim to need more and more of them. But people with real pain also occasionally do these things. The doctor's dilemma is how to stop the diverters without condemning other patients to suffer unnecessarily, since a drug diverter and a legitimate patient can look very much alike. The dishonest prescriber and the honest one can also look alike. Society has a parallel dilemma: how to stop drug-dealing doctors without discouraging real ones and worsening America's undertreatment of pain.

In July 2002, an insurance agent was sifting through records in Columbia, S.C., and paused at the file of one Larry Shealy. Shealy was getting OxyContin from a doctor named Ronald McIver — a lot of it. "The amounts were incredible; it jumped out in my face," the agent, who spoke on condition of anonymity, told me. "He was either selling them or taking so much he couldn't live." The agent did two things. He recommended to Shealy's employers that they exclude OxyContin coverage from their health insurance plan — which they did. And he called the D.E.A. Two days later, a D.E.A. agent showed up in the insurance agent's office with an administrative subpoena to collect Shealy's file.

McIver wanted to be a doctor all his life, two of his daughters told me. But he taught and traveled for years before he finally enrolled at Michigan State University to become a D.O., or doctor of osteopathy, a more holistic alternative to a traditional medical education. (Osteopaths can do everything that traditional M.D.'s can do, including prescribe opioids.) He began practicing pain medicine in the late 1980s. He had a practice in Florence, S.C., which ended when he declared bankruptcy in 2000. He moved to Greenwood to start over, establishing his new office in a storefront next to a chiropractor.

McIver was, by the account of his patients, an unusual doctor in the age of the 10-minute managed-care visit. He usually saw about 6 to 12 patients each day. One patient I spoke with — who never got high-dose opioids — said that his first visit with McIver lasted four hours, and in subsequent visits he spent an hour or more doing various therapies. Many patients said their visits lasted an hour. Patients taking opioids had to sign a pain contract and bring their pills in at each visit to be counted.

Many doctors take little interest in the administrative side of their practices, but McIver's neglect was epic. To save money, he employed mostly family. His wife, Carolyn, whose only medical training was from her husband, served as his assistant, giving shots and administering therapies. "His doctor's office did not resemble my family's doctor's office," said Sgt. Bobby Grogan, who was the investigator on the case for the Greenwood County Sheriff. While McIver's treatment rooms were normal, his and his wife's offices — off limits to patients — were a mess, according to pictures presented at McIver's trial by Adam Roberson, the D.E.A.'s principal investigator. Used syringes, for example, overflowed their storage box. "His patient records were manila envelopes stuffed with receipts," Grogan told me.

When I interviewed him in prison recently, McIver told me that his records were complete but scattered. He said that he and his wife, distracted by a series of family tragedies, had employed a series of temporary

receptionists who had botched the filing. He and his wife were trying to piece them together. “The records were probably half in the office and half at home for me to work on at night,” he said. “I kept a box in the back of the car I worked on while Carolyn drove.”

Leslie Smith first came to see McIver in the fall of 2001. Smith was in his mid-40s and lived in Chapin, a small town near Columbia, a 60-mile drive from Greenwood. He filled out a medical-history form and told McIver that his wrists hurt so badly that he was getting only three or four hours’ sleep a night. He also said that a previous doctor helped him by prescribing OxyContin, and he mentioned the name of a doctor he said referred him. McIver examined Smith’s wrists. Smith walked out with an opioid prescription and an appointment to come back the next week.

Smith’s wrists did not hurt him, as he testified at McIver’s trial. He was addicted to OxyContin and Dilaudid, which he injected. He complained of wrist pain because it was plausible: he had injured one wrist previously, requiring an operation that left scars, and he had arthritis in the other. Until June 2002, Smith kept getting prescriptions.

Smith saw McIver every few weeks. He testified that he had track marks on his arm at the time but always wore long sleeves to cover them. He said McIver never saw them. McIver put him on an electric nerve stimulator every visit for 15 or 30 minutes on each hand and did osteopathic manipulations. He prescribed exercises. Smith bought a nerve-stimulator machine to use at home and told McIver it was helping. At McIver’s request he filled out a pain chart and reported that his pain rated a 5 or 6 upon awakening, reached 7 during the day and occasionally hit 9. “I answered all the questions exactly like I thought he’d want to hear them answered,” Smith testified. At one point McIver found a syringe in Smith’s pocket. Smith told McIver that he was going fishing later that day and that he used the syringe as part of his fishing equipment. That apparently satisfied McIver, who testified that his grandfather kept syringes in his tackle box to pump air into his bait.

Smith filled some of his prescriptions at the Hawthorne Pharmacy in West Columbia. There, Addison Livingston, the pharmacist, got suspicious. He noticed that Smith sometimes came in with other patients of McIver’s, despite the fact that McIver worked nearly two hours’ drive away. The patients obviously knew each other and would pick up large opioid prescriptions, paying cash and asking for brand-name drugs. Livingston called McIver, who confirmed he had written the prescriptions. At one point, McIver told Livingston that he, too, was suspicious, and that he had sent a letter about Smith to the state’s Bureau of Drug Control.

In February 2002, McIver wrote to Larry McElrath, a B.D.C. inspector, who read the letter at the trial. “Dear Larry,” it read, “There are several people out of the Columbia/Chapin area who have aroused my curiosity about their use and possible misuse of medications. Some are referred by [another doctor] and seem legitimate. . . . They all pay cash despite some of them having insurance with prescription cards. . . . When they are in the office, they sometimes make a show of not knowing each other. . . . The situation is made complicated by the fact that each has some real pathology with objective findings that would justify the use of opiates if their pains are as bad as they say. I have given them the benefit of the doubt, but I’m becoming less inclined to do so. I would appreciate it if you could make some discrete inquiries and let me know whether my concerns are justified. . . . I certainly don’t want to refuse help to someone who needs it. On the other hand, I want even less to be implicated in diversion or other improprieties.” He listed their names and

Social Security numbers.

McElrath did nothing with the letter. “It’s incumbent upon the physician to have a trust with his patients,” McElrath testified at the trial. “Here there was nothing that I could assume or conclude that any crimes had been committed.”

Smith was the most damning of the several patients who testified against McIver. (Smith and the other patients mentioned here did not agree to be interviewed for this article, as they are suing McIver for alleged overprescription of addictive drugs. Such suits often prosper after successful criminal convictions, as civil suits are easier to win.) Smith had a confederate in Seth Boyer, who lived in Chapin and followed a similar pattern in his dealings with McIver: he exaggerated pains in his foot, never provided records from a previous doctor and had needle tracks that he later testified McIver never saw. At one point, Boyer told McIver that he had spilled a bottle of liquid OxyFast, another opioid. (In reality, Boyer had injected it.) McIver wrote him a prescription for a replacement — apparently a violation of his standard pain-medication contract, which had a “no early refills” stipulation.

But McIver ended up discharging Boyer in June 2002, when Boyer altered a prescription so he could fill it three days early. He wrote McIver three pleading letters of protest, to no avail. “I was looking for an excuse to discharge them, and with Seth I found it,” McIver told me. “I needed more than suspicion. With Les, he never actually did anything that allowed me to say, ‘O.K., here’s that concrete piece of evidence.’ ”

McIver may have felt he needed more proof, but medically he probably had enough. Pain specialists told me that doctors can stop prescribing a drug whenever the risks outweigh the benefits, which includes the risk of abuse.

Another drug-dealing patient of McIver’s was Kyle Barnes. She testified that she suffered from fibromyalgia, a chronic-pain syndrome, but exaggerated her pain to get higher levels of OxyContin and Roxicodone. She was addicted to those drugs before she began seeing McIver in July 2001. She also brought no medical records and drove three hours to each appointment. She got prescriptions on her second visit, during which McIver also did osteopathic manipulations and massage.

Barnes was in real pain. McIver did several different therapies at each visit. He set up an appointment for her at a sleep clinic, sent her for X-rays and put a cast on her wrist. He knew she had trouble paying for her medicines, and he contacted Purdue Pharma to see if she qualified for reduced-price drugs. She kept claiming the drugs were not helping enough and was soon taking 16 times the dose of OxyContin she took when she first saw him. One tip-off in her case should have been that she paid thousands of dollars a month in cash for her prescriptions, even though she was on Medicaid. She told McIver that her father and boyfriend were helping her buy them, which she later testified was partly true. But most of her income came from selling some of the drugs he prescribed, she testified. In December 2003, McIver told her that he would stop treating her unless she took a drug screen. She did nothing. Three weeks later he told her again. She never returned.

Another patient whose story was particularly troubling was Barbee Brown. Brown was not a drug seeker but a genuine pain patient seeking relief from Reflex Sympathetic Dystrophy. McIver gave her very high doses of OxyContin right away, before she produced any records from other doctors. This was especially disturbing,

because she had been addicted to crack cocaine for three months in the year before she came to him.

Brown saw McIver at least twice a week for six weeks. He did a thorough physical exam and took a complete history. He used many different kinds of therapies. But he also started her — someone who had never taken opioids — on 40-milligram pills of OxyContin and allowed her to control her own dosing schedule. “As long as you are not having side effects, do not be afraid to take the doses you need to get out of pain,” he wrote to her. It was the same advice he gave many patients. “The number of milligrams does not matter. What matters is the number on the 0-to-10 scale.”

The medicine helped. Brown testified that she ranked her pain at 9 or 10 when she first got to McIver. After seeing him, it dropped to a 4. Her pain diary, which appears to be sincere, had various passages giving thanks that she met McIver. Brown did not become addicted. But allowing an opioid-naïve recovering crack addict to start on high-dose pills and control her own dosage, and telling her that her dosage didn’t matter, seems reckless.

McIver’s 30-year sentence was the result of the death of Larry Shealy, a 56-year-old man who suffered intense back and knee pain, in addition to many other health problems. He first came to see McIver in February 2002, with full referrals and records. He was on OxyContin before seeing McIver but complained that his pain was still terrible, so McIver doubled his dose. This allowed Shealy to go back to work in an auto body shop.

Shealy was not a careful patient. A month after he started with McIver, he took 15 OxyContin tablets in one day instead of the 6 he was prescribed. He was not harmed, but McIver testified that he asked Shealy to bring his family in so he could explain the dosing to them. At one point, McIver tried to taper down the OxyContin and replace it with methadone, but Shealy complained that the methadone made him drowsy. Shealy’s son, David, an auto mechanic, testified that the OxyContin pain relief also came at a price. He said he felt his father was overmedicated — often sleepy. Once, his father backed his truck into a tree.

Shealy died in his sleep early on the morning of May 29, 2003. He had OxyContin pills in his stomach, and his bloodstream contained alprazolam — Xanax — as well. The pathologist at McIver’s trial testified that the levels of drugs were consistent with the prescriptions McIver had been writing — the high levels that so alarmed the insurance agent. Shealy was taking five 80-milligram tablets of OxyContin every 12 hours, plus up to six 30-milligram tablets of Roxicodone every 4 hours for breakthrough pain, plus as much as 2 milligrams of alprazolam every 8 hours. The prosecution’s toxicologist, Demi Garvin, concluded that the OxyContin and Roxicodone caused Shealy’s death by respiratory depression. The pathologist testified that she looked up this dosage and found it to be a fatal level.

But there is reason for doubt. According to Shealy’s prescriptions, he had been taking the same dosage for at least two months, and possibly much longer. Pain specialists say that respiratory depression is extremely unlikely when dosage is consistent. In her testimony, Garvin agreed that what would be a toxic level in an opioid-naïve patient would be safe for someone titrated up properly. But she said she could not conclude he had been properly titrated, in part because she had not seen his medical records. Garvin declined to talk about the Shealy case with me because she is a witness for the Shealy family in their planned civil suit against McIver. But in a deposition for that lawsuit, she appeared to back away from blaming the OxyContin. She described her view as: “Hey, there’s a red flag here. This can certainly be your cause of death, but you

need to go further in exploring whether or not it is."

There was something else that might have caused Shealy's death: he suffered from advanced congestive heart failure. The pathologist testified that he had 90 percent blockage in one coronary artery and 50 percent in another, and a greatly enlarged heart and other organs. He had a scar on the back wall of his heart that indicated he at one time suffered a heart attack. Opioids do not worsen heart disease and would likely have helped, because pain causes stress to the heart.

The testimonies of the patients Smith, Boyer and Barnes were the parts of the trial that most directly addressed the question of whether McIver intentionally wrote prescriptions for a nonmedical purpose. This is the relevant legal test for the statute under which he was prosecuted. Several Supreme Court and district court cases have made it clear that under the Controlled Substances Act, a doctor is guilty of a crime if he intentionally acts as a drug pusher.

The judge in the McIver case, Henry F. Floyd, told the jurors that bad prescribing is the standard for malpractice, a civil matter. "That is not what we are talking about," he said. "We're not talking about this physician acting better or worse than other physicians." If McIver was a bad doctor — but still a doctor, with intent to treat patients — he was innocent. "If you find that a defendant acted in good faith in dispensing the drugs charged in this indictment, then you must find that defendant not guilty," Floyd said. But Floyd also told the jury to take bad doctoring into account in deciding McIver's intent.

This instruction — that bad doctoring does not prove intent but could be considered when weighing his intent — is subtle and potentially extremely confusing. It apparently confused the jurors. I spoke to two jurors, who told me their own views and characterized the jury discussion. The overwhelming factor, they said, was that McIver prescribed too much — the very red flag that alerted the insurance agent and set the case in motion.

The jurors I spoke with said that by far the most important testimony came from Steven Storick, a pain-management doctor in Columbia and the government's expert witness. Reviewing the records of patient after patient, Storick consistently testified that there were too many drugs. "This amount of medication is just extremely high in a situation like this," he said of one patient. This is "excessive," he said of another. "That's just an extremely high dose of drug," he said of a third. Storick, who declined to be interviewed for this article, testified that if he had a patient who exhibited no objective evidence of pain, he would not prescribe opioids. He would not have titrated patients as rapidly as McIver did or given them discretion. He disagreed with McIver's position that a doctor should try to bring a patient's chronic pain down to a level of 2. He would stop titrating when a patient reached 5 out of 10.

The jurors took Storick's caution to heart, in part, they told me, because it resonated with their own experience with opioids and fears of addiction. I asked Jo Handy, a tall, elegant woman who is now 39 and a real estate agent outside Greenville, why McIver was convicted. "It was the excessive prescriptions," she said in an interview in her office. "Excessive, and the number of them. I've been on some pain medication. But along with some other jurors we were, like, 'No — it's too much.' "

Handy said she knew McIver's treatment was excessive because Storick said so, and because of her own experience. "Thirty counts is normal," she said. "He was giving 60 or 90. A few of us had been on prescribed

medicine. I had female issues. You as a person know not to take so much of that medication. If you were, you had a motive. Me, I still have a whole bottle left."

Christopher Poore, another juror, agreed that what swayed the jury was the volume of drugs prescribed. "The jury kept going back to the expert testimony of the prosecution's expert," he told me when I met him in Anderson, a town 40 minutes from Greenwood. "It was beyond. It was too much." What should McIver have done, I asked, if he wanted to avoid jail? "He should have followed the convention more of what people are doing with pain medicine — not giving so much," Poore said.

Poore, who is 40 and runs his family's heating and cooling business, described himself as the juror most skeptical of the prosecution's case. "There was another guy on the jury who said his sister-in-law had been taking pain pills and she had gotten addicted," Poore said. "He said I was taking up for McIver. I said, No, I'm taking up for you and me and anyone else who's on trial. I wanted to see rules, that this guy broke the rule. I never saw a rule he broke."

In the end Poore voted to convict. As is always the case, the jurors were dismissed before McIver was sentenced. Poore told me he supposed McIver was in prison. When I said McIver was serving 30 years, he looked shocked.

Interviews with jurors and the judge's sentencing decision indicated that photos of the messy conditions in McIver's and Carolyn's private offices also contributed to the impression that he was not a real doctor. Surprisingly, McIver's contacts with law enforcement — the letter about Smith and the others was one of several — helped the prosecution's case. "He called an officer about a patient," John P. Flannery II, McIver's appellate lawyer, explained to me. "There is no response. He gets zero. He took their silence as a sign everything was O.K. They take that as knowledge of drug dealing." It mattered: the Fourth Circuit's opinion rejecting McIver's appeal said, "That Appellant knew or suspected his patients of drug abuse is reflected by the fact that he wrote to state authorities to express concern that his patients might be selling their medication."

I asked Grogan, the local diversion investigator on the case, why he didn't follow up on McIver's suspicions. "I'm a cop, not a doctor," Grogan said. "I can't say to prescribe medication or not. How do I know he's not trying to fish me for information?"

"He doesn't have to call us to cut someone off," Mike Frederick, the chief deputy at the sheriff's office, told me. "This is no different than when regular illegal drug dealers will very often call us about other drug dealers. He did it most likely because he thought that person was a risk."

I had assumed that McIver's use of many different types of therapies would help his case, by showing he was not running a classic pill mill. But it may have hurt. During the appeal, the prosecutor William Lucius argued that the other treatments represented the profits of drug diversion. He addicted patients with high doses of opioids, Lucius contended, "so they would continue to come back to him" and "he could charge them for the treatments he gave."

How typical is McIver's case? On the D.E.A.'s Web site the agency lists some of the doctors who have been prosecuted, and their crimes. There are some strikingly obvious and egregious cases of shady dealings: a doctor who wrote prescriptions in a gas station for a person who wasn't present; one who sold blank

prescription forms; one who dispensed drugs to people who then shared them with him.

But not every doctor's intent to deal drugs is as clear. McIver was a crusader for high-dose opioids, credulous with patients and sloppy with documentation — a combination unwise in the extreme. But some of his patients said he was the only doctor who ever brought them relief. Prosecutors never brought any evidence that he intended to write prescriptions to be abused or sold. They never accused him of profiting from his patients' diversion except in collecting office fees. His patients who diverted or abused their opioids all testified they got their prescriptions by consistently lying to him. Nor is it convincing that his prescriptions killed Larry Shealy.

No one has analyzed the various prosecutions of pain doctors, so it is hard to determine how many of them look like McIver's. The D.E.A.'s list is incomplete. There have been many cases like McIver's, and most of these cases are not listed on the D.E.A.'s Web site. (One possible reason for this omission is that some of these cases are still being appealed.) And many cases that do appear on the list detail only vague crimes: convictions for prescribing "beyond the bounds of acceptable medical practice" or "dispensing controlled substances . . . with no legitimate medical purpose" — which is how the agency will most likely describe the McIver case if it ever includes the case on the list.

The D.E.A. claims that it is not criminalizing bad medical decisions. For a prosecutable case, Caverly, the D.E.A. officer, told me: "I need there to be no connection of the drug with a legitimate medical condition. I need the doctor to have prescribed the drug in exchange for an illegal drug, or sex, or just sold the prescription or wrote prescriptions for patients they have never seen, or made up a name."

I read this statement to Jennifer Bolen, a former federal prosecutor in drug-diversion cases who trained other prosecutors and now advises doctors on the law. "That's a good goal," she said. "I don't think they have yet reached that goal." McIver's case had no such broken connection, and in many cases the government has not produced testimony of intent to push drugs, providing evidence only of negligence or recklessness. In 2002, Bolen was one of the authors of a Justice Department document intended as part of a basic guide to prosecuting drug-diversion cases. The document, in the form of a reference card, dispenses with any need for a broken connection. It suggests that prosecutors need not prove a doctor had bad motives, that to be within the law a doctor had to prescribe "in strict compliance with generally accepted medical guidelines" and that doing an abbreviated medical history or physical examination is "probative" of lack of a legitimate medical purpose. The reference card was on the Justice Department's Web site but was pulled, according to the Pain Relief Network, which provided the card to me. Bolen told me: "I have no problem saying that if the card was all there was, it was not acceptable. But it isn't all there was." She described the card as one piece of a more thorough training, but added that many prosecutors followed its theories.

Prosecutors are in essence pressing jurors to decide whether an extra 40 milligrams every four hours or a failure to X-ray is enough to send a doctor to prison for the rest of his life. One doctor, Frank Fisher, was arrested on charges that included the death of a patient taking opioids — who died as a passenger in a car accident. A Florida doctor, James Graves, is serving 63 years for charges including manslaughter after four patients overdosed on OxyContin he prescribed — all either crushed and injected their OxyContin or mixed it with alcohol or other drugs. "A lot of doctors are looking for safe harbor," Caverly said. "They want to know as long as they do A, B, C, D or E, they're O.K."

The D.E.A. once thought that this was not an unreasonable desire. A few years ago, it worked with pain doctors to develop a set of frequently asked questions that set out what doctors needed to do to stay within the law. The FAQ recommended, for example, that doctors should do urine tests and discuss a patient's treatment with family and friends. In October 2004, the FAQ were erased from the agency's Web site. One reason was that one of their authors, who is a doctor, was about to use the list to testify on behalf of William Hurwitz, a pain doctor in McLean, Va. (Hurwitz was convicted on 50 counts of drug trafficking in 2004. His conviction was overturned, and he was recently retried and convicted on 16 lesser counts. He is awaiting sentencing.)

Caverly acknowledged the Hurwitz trial was one reason the FAQ were pulled, but said there were other reasons. He said such a checkoff list could tie the D.E.A.'s hands. "Some doctor's going to pull that list of dos or don'ts out and say: 'See, I'm O.K. I did these 10.' But there's a new wrinkle there — an 11th one the doctor didn't do," he said. Most important, he went on to say, the FAQ had stepped over the line to insert the D.E.A. into issues of medical practice. "We have to stay in our lane," he said. "Those definitions are the professional community's — not the D.E.A.'s."

In a perfect world, such reasoning would make sense. But the agency is defining issues of medical practice in dramatic fashion — by jailing doctors who step over the line. It would not seem to be bothering, however, to draw the line first.

The dilemma of preventing diversion without discouraging pain care is part of a larger problem: pain is discussed amid a swirl of ignorance and myth. Howard Heit, a pain and addiction specialist in Fairfax, Va., told me: "If we take the fact that 10 percent of the population has the disease of addiction, and if we say that pain is the most common presentation to a doctor's office, please tell me why the interface of pain and addiction is not part of the core curriculum of health care training in the United States?" Will Rowe, the executive director of the American Pain Foundation, notes that "pain education is still barely on the radar in most medical schools."

The public also needs education. Misconception reigns: that addiction is inevitable, that pain is harmless, that suffering has redemptive power, that pain medicine is for sissies, that sufferers are just faking. Many law-enforcement officers are as in the dark as the general public. Very few cities and only one state police force have officers who specialize in prescription-drug cases. Charles Cichon, executive director of the National Association of Drug Diversion Investigators (Naddi), says that Naddi offers just about the only training on prescription drugs and reaches only a small percentage of those who end up investigating diversion. I asked if, absent Naddi training, officers would understand such basics as the whether there is a ceiling dose for opioids. "Probably not," he said.

There is another factor that might encourage overzealous prosecution: Local police can use these cases to finance further investigations. A doctor's possessions can be seized as drug profits, and as much as 80 percent can go back to the local police.

There are ways to prevent diversion without imprisoning doctors who have shown no illegal intent. They are increasingly used — but state authorities and doctors need to push even harder. The majority of states, South Carolina among them, do not yet have prescription monitoring — a central registry of prescriptions, which could help catch people getting opioids from several different doctors and pharmacies. Doctors should

use more urine and blood tests, including screens that can tell quantities of drug present.

Last year, state medical boards took 473 actions against doctors for misdeeds involving prescribing controlled substances. In many cases, their licenses were pulled. Physicians can also lose their D.E.A. registration, and with it the right to prescribe controlled substances. A few dozen do every year, although there is considerable overlap with medical-board actions. Washington is the first state to recommend that only pain specialists handle high-dose opioids; other states are likely to follow.

But such guidelines are futile while there is one pain specialist for, at the very least, every several thousand chronic-pain sufferers nationwide. And even though pain is an exciting new specialty, doctors are not flocking to it. The Federation of State Medical Boards calls "fear among physicians that they will be investigated, or even arrested, for prescribing controlled substances for pain" one of the two most important barriers to pain treatment, alongside lack of understanding. Various surveys of physicians have shown that this fear is widespread. "The bottom line is, doctors say they don't need this," said Heit. "They're in a health care system that wants them to see a patient every 10 to 15 minutes. They don't have time to take a complete history about whether the patient has been addicted. The fear is very real and palpable that if they prescribe Schedule II opioids they will come under the scrutiny of the D.E.A., and they don't need this aggravation."

Proper pain management will always take time, but the D.E.A. can at least ensure that honest doctors need not fear prison. It should use the standard it claims to follow: for a criminal prosecution to occur, a doctor must have broken the link between the opioid and the medical condition. If the evidence is of recklessness alone, then it should be a case for a state medical board, the D.E.A.'s registration examiners or a civil malpractice jury.

Undoubtedly, such a limit will allow a small group of pill-mill doctors to escape prison. But America lives with freeing suspects whose possible crimes are discovered through warrantless searches or torture — and unlike other suspects, doctors who lose their licenses are as incapacitated as those behind bars. For cases without the broken connection, prosecution is too blunt an instrument. It runs too high a risk of condemning innocent physicians to prison and discourages the practice of a medical specialty desperately needed by millions of Americans.

Pain patients are the collateral victims here. It is worth remembering that the vast majority of McIver's patients were not people who abused or sold their medicines. One of those who didn't was a man named Ben, a tall, heavy man in his 50s who lives about 45 minutes from Greenwood. (He asked that his last name not be used because of the stigma still attached to taking opioid drugs.) Ben was once a mail carrier and a farmer and cattle rancher. But years of pushing 800-pound bales of hay wore out his back. In 2001 he had an operation to fuse the bottom three vertebrae. The few Vicodin his neurosurgeon prescribed did not control his pain. "I never had enough to get me through the night," he said. "He wasn't going to go any further than Vicodin — and he was doing me a favor by doing that, because his other partners wouldn't have done as much as he did." His neurosurgeon recommended he find a pain doctor. He started seeing McIver. The first examination, Ben said over coffee in a local Waffle House, was "extremely thorough — he had me crying. I hardly ever got out of there in less than two hours — he would be on top of me popping my back."

And he got opioids. With his typical imprudence, McIver told Ben: "You don't worry about it, take whatever you need to be pain-free, if it takes 2 pills or 10 pills. If you're taking too much and slurring your words, you

know to back off. Use some common sense." At McIver's request, Ben kept a diary of what he took and how much. He reached a top dosage of five 80-milligram pills of OxyContin four times a day — more opioids than Shealy was taking at the time of his death. "I never felt high," he said. "They helped my pain. I could get out and work, use the bulldozer. I was working a 250-head cattle herd. I was doing everything relatively pain-free because of the drugs. They gave me my life back."

When McIver was closed down, Ben was lucky enough to have a family physician he knew well who took over his case. But the new doctor took a very different approach. Ben now gets three 80-milligram pills of OxyContin a day, plus some breakthrough Roxicodone and 800 milligrams of Advil every four to six hours. "That's it and I'm very, very lucky to have it," he said. "My doctor is afraid they will say it's over the limit. I now get about three hours' sleep a night. I can stand for 30 minutes, maybe." He can no longer handle ranching and has sold his cattle. He considers himself retired.

With Ben's permission I talked to his current doctor, who said Ben was a good patient but had been taking way too much. "I thought Ben made an error," he said. "He had been taking five or six times the recommended dosage. There are well-recognized levels, and you don't step across the line. You may have to live with some pain."

Opioids have immense power — both to harm and to heal. They can be life-destroying, but high doses allowed Ben to work, to be with his family, to be who he is. In its prosecutions of pain doctors, the government fails to recognize the duality of these drugs. Ben's wife told me: "When Ben first went to Dr. McIver and filled out the form on what he used to be able to do and what he could do now, he cried. McIver said to him, 'I'm going to get you back to doing what you used to do.' And he did."

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Correction: June 17, 2007

An article on Page 48 of The Times Magazine today, about Dr. Ronald McIver, who is imprisoned for drug trafficking, gives an erroneous account of the trial testimony of one of his patients, Leslie Smith. Mr. Smith testified that he injected drugs that Dr. McIver prescribed; he did not testify that Dr. McIver sold the drugs.

Correction: June 19, 2007

An article in The Magazine on Sunday about Dr. Ronald McIver, who is imprisoned for drug trafficking, gave an erroneous account of the trial testimony of one of his patients, Leslie Smith. And a correction in this space on Sunday again referred incorrectly to that testimony. The only point Mr. Smith made in his testimony was that he acknowledged injecting drugs prescribed by Dr. McIver. Mr. Smith never raised the issue of whether he himself sold any drugs that were left over to buy other drugs. And he never referred to Dr. McIver in the context of the leftover drugs — either that Dr. McIver sold them or did not sell them.