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Remarks
by
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Thank you for your kind invitation to appear on this panel. In listening today, I have above all been struck by the common concerns we share – you, as leaders in treating addiction, and I as a prosecutor – as we address the problem of prescription drug misuse.

My office was established by the Legislature in 1972 to address a narcotics epidemic – which back then, meant heroin abuse and overdose. Since then, the challenges we have faced have changed, and changed again. During the 1980s, my Office saw a flood of crack cocaine abuse that was unprecedented, both in its addictive potential, as well as in the social pathology and violent crime it generated.

And then, a couple of years ago, we saw a surge in heroin production. At the time, the cause of the sudden spike was a mystery. Now we believe that the heroin surge may have been just the side effect of our current public health crisis – opioid prescription drug abuse. Opiate pill addicts were turning to heroin when the prescription drugs became too expensive.

Trends in drugs of choice wax and wane, but we have never quite seen anything like the current epidemic of prescription opioid drug abuse.

Just last year, my office investigated a major prescription diversion ring in Staten Island that pumped nearly 43,000 pills worth $1 million onto the black market in New York City the course of one year. The manager of a Manhattan orthopedist's office stole prescription pads, sold them to a former patient, and those stolen pads provided the basis for the operation. Dozens of friends, relatives and former high school football team mates were recruited to present forged prescriptions for oxycodone at pharmacies. Many were already addicted to oxy, and the former patient knew it. For the service they provided, getting the prescription filled with their personal identification information, they were paid in pills. One woman, who was originally paid in cash, began taking her payment in pills and soon became an addict. The drugs were then sold retail out of a Lickety Split ice cream truck in Staten Island. Our investigation culminated in the indictment of 31 members of the extensive drug trafficking ring.

There could be no more vivid illustration of the magnitude of the problem facing us than that case. My investigators would come back from conducting surveillance in strip malls in Staten Island, and report scenes of countless young people nodding out just a few yards from the pharmacies where they had gotten their pills. Some of our investigators patrolled the streets during the heroin epidemic of the 1970s – and say what they have seen in Staten Island matches the horror they recall four decades ago.

To gauge the larger problem, we looked at the data collected in the Prescription Monitoring Program (PMP) by the Bureau of Narcotics Enforcement and learned that in 2010 there were over a million prescriptions for oxycodone filled in New York City (1,059,799). This is double the number of prescriptions filled for that drug just three years earlier in 2007. If you add hydrocodone prescriptions into the mix (787,724) the total for New York City in 2010 grows to a stunning 1,847,523. That's the equivalent of a prescription for 22 out of every 100 people in New York City.

On Staten Island, the statistics are even more alarming. There were 136,808 prescriptions filled for oxycodone alone – the equivalent of a prescription for 28 out of 100 people. But if you add in hydrocodone (87,829), the total is 224,637. That is enough for 45 out of 100 people on Staten Island.

This is a public health crisis that has had few equals in our history. It is now a law enforcement crisis, one for which we have had to develop new tools and techniques. In the Staten Island case, we saw the damage that could be caused by one rogue employee stealing prescription pads. But since then, we have seen how a very tiny percentage of rogue doctors – those very few doctors who are not treating illness, but simply selling prescriptions – can imperil the health of thousands of patients. Their reckless prescribing practices have contributed to the deaths of hundreds.

Make no mistake – these doctors are not practicing medicine as you understand it. They operate clinics where patients line up on the street without appointments, and see the doctor to collect a prewritten prescription. There are no physical examinations, no x-rays, no urinalysis, no MRI reports. At the end of every visit, there is a prescription for a controlled substance, and usually more than one. And usually, payment in cash. A first-time patient complaining of back pain may leave with a prescription for fentanyl patches. Drugs are prescribed in combinations, and in dosages, that defy logic. The doctor may charge a higher fee for prescribing a higher dosage of opioid.

In one case we saw, a patient ended up in the emergency room, unresponsive, overdosing not just on opioids prescribed to him, but on the Tylenol contained in the Vicodin tablets he'd taken. The emergency room staff of course informed the prescribing doctor. On the next visit to the prescribing doctor, there was no decrease in dosage, no substitution of Suboxone, no discussion about gradually reducing opiate levels. That patient is now dead, having overdosed after chewing on fentanyl patches.

This kind of pill mill doctor may see a hundred or more patients in a single day. Even aside from the terrible addiction problems that end up in your examining rooms, there are all the tragedies that follow any time powerful drugs are abused. One doctor we indicted treated at least 11 patients who died from overdose within a two year period. You are no doubt familiar with the terrible

tragedy in the pharmacy in Medford, Long Island on Father's Day last year, when a man with a history of doctor shopping and his pill-addicted wife robbed a drug store, and killed four people in cold blood. Another Long Island pharmacy robbery turned deadly on New Year's Eve, when a veteran ATF agent who was picking up cancer medication for his father tried to stop the robber and was killed by friendly fire. Those of you who live on Long Island may have seen the hand-made signs hanging on some drugstore doors: No Oxy. Make no mistake – those addicted to prescription opioid drugs are no less desperate and dangerous than those addicted to illegal drugs like crack and heroin.

Together, members the medical community, officials with the state and city health departments and other government entities are working with my office to put an end to these tragedies. My first mission is to decrease the amount of opioid drugs being prescribed – because so much ends up out on the street. Unlike the other drugs in the other epidemics that we have faced, heroin in the 70s and crack cocaine in the 80s, prescription drugs come from a legal source – they are manufactured by pharmaceutical companies and are prescribed by doctors. Overprescribing is the root cause of this problem.

As Dr. Thomas Frieden, the Director of the Centers for Disease Control said last fall: "This stems from a few irresponsible doctors. The problem is more from them than from drug pushers on street corners."

The medical community must take a lead role in ending this medically induced epidemic.

As you know, New York has an established Prescription Monitoring Program, or PMP, which collects information from pharmacists after a prescription is filled. That is a step in the right direction. But doctors have complained to us that their access to the database is limited, and the current system is too inconvenient to use regularly in a busy practice. As a result, a patient may be doctor-shopping, but the prescribing physician may not get that information until it is too late.

And even I, as a prosecutor, armed with a court order, am sometimes frustrated in trying to get on a timely basis data my office needs for our investigations.

Clearly, the Prescription Monitoring Program in New York has to be improved to fulfill the goals for which it was established. Attorney General Schneiderman has proposed an expansive revision of the program, which would accomplish many important goals. Whether the PMP is improved through the passage of that legislation or some other proposal, there are short term fixes that must be implemented immediately. Senior members of my office, in consultation with medical doctors and other experts, are now drafting a proposal that will, even without comprehensive new legislation:

- streamline access for treating physicians
- allow appropriate and timely access for law enforcement
- Respect the confidentiality of the doctor-patient relationship.

We are also working to consistently track information on fatal overdoses, so that we may quickly see if a pattern of overprescribing by a single physician is tied to multiple overdose deaths. We are also advocating that treating physicians have access to information about prior overdose hospitalizations. My office is supporting information programs directed toward high school students to try to prevent addiction. Finally, my office has been privileged to be a part of the OASAS Task Force and the Mayor's Task Force devising best practices for use and control of these powerful drugs. Both of these groups have been truly collegial, and the work productive and rewarding.

I urge this organization to reach out to you colleagues in other specialties – to the orthopedists, the surgeons, and the internists – to share with them what you have learned about these powerful drugs. Urge them to adopt Dr. Frieden's recommendations:

- Standard painkiller prescriptions should be for three days
- Narcotics should be the last resort for pain control.

As always, whenever we work alongside the public health community, we feel a strong sense of commonality -- for you, like us, have committed your professional life to serving the public. And that is why I am especially honored to be part of your program today.