Convicted for Treating Pain: Lessons to Be Learned

Samuel Nigro, M.D.

On June 26, 2013, the *Cleveland Plain Dealer* carried a story headlined "Cleveland Heights Doctor Sentenced to Prison for Selling Painkillers." It tells how I was sentenced to 9 months in prison, at age 76, for illegally prescribing painkillers and receiving cash in return. It stated: "He prescribed large doses of painkillers at patients' requests without performing medical treatment or testing. In exchange, he would receive $100-$200 in cash per visit from these patients."

The article states that detectives with the Cleveland police department and Ohio pharmacy board agents began receiving tips concerning my prescribing from several pharmacists and former patients.

The article notes that I pleaded guilty to one count of attempted engaging in a pattern of corrupt activity, one count of tampering with drugs, two counts of attempted drug trafficking, and four counts of trafficking. Besides the jail term, it said I must also pay a $250,000 fine.

Sequence of Events and My Guilty Plea

Beginning about 2004, I began to complain to the Ohio State Board of Pharmacy about pharmacists mistreating my patients by making crude, non-therapeutic remarks; asking inappropriate questions; assuming an arrogant and capricious level of responsibility; and at times refusing to fill my prescriptions. If I were willfully doing anything criminal, I certainly would not have repeatedly complained to the pharmacy board for more than 10 years.

I noticed some improvement in the treatment of pharmacy customers, but inappropriate events still occurred. I was informed that Ohio law gave pharmacists (most with only a high school diploma before their pharmacy school) a level of responsibility equal to that of physicians with respect to prescription drugs—without any documentation of training in patient evaluation and decision making. Pharmacists were found to rely on the *Physician's Desk Reference*, a book usually containing only the original studies that qualified a medicine to be listed in the *PDR*, with little to no information about subsequent findings for use of the medicine. Thus, I did not think pharmacists were qualified to be making treatment decisions about the use of medications. Instead, I thought they needed directions on how to handle concerns about filling prescriptions without mistreating patients or slandering prescribers.

I presented my comments, findings, and a proposed "Pharmacy Customer Rights" law to replace Ohio Administrative Code 4749-5 to the Ohio General Assembly, medical groups, and others. About 3 months after that, my home and both of my offices were suddenly the object of search warrants by the pharmacy board and prosecutor's office, falsely accusing me of running "pill mills" and having $40,000 in cash, among other trumped-up exaggerations. I called my attorney, who advised me to say little or nothing because all would likely be used against me. Fifty counts from nine patients were used, and of the nine, seven had been terminated by me for misuse of medications. Then, again without intervention-like efforts to explore and correct fairly, the state medical board asked for records also, confirming Machiavelli's assertion that power corrupts and metastasizes in government to destroy those who criticize.

Without offering any explanations, clarification opportunities, or fact-finding due process, the State Medical Board of Ohio was apparently co-opted by the pharmacy board into compounding the accusations.

My attorneys, shocked at the application of an obscure law (Ohio Revised Code 4731-21-02, see below) to the extraordinary volume of complaints, told me to retire and surrender my license, which, with a plea bargain, would likely result in a minimal sentence for a 76-year-old man, first offender, with no charges of violence. They said, "You will not have any money left after fighting all this maliciousness. Cut your losses!" My attorneys told me that the police state has arrived and fighting the government is a bad way to end my career, especially since I had been considering retirement for the past 5 years anyway. Several emphasized that I already was flooded with accusations and would face an extremely costly fight, and extreme punishment if I lost.

After being told that government workers including judges are very sensitive, and generally tend to retaliate for public explanations and complaints, I withdrew a comprehensive explanation to the Ohio inspector general that requested an investigation of the Ohio pharmacy board for "false accusations, malicious prosecution, prevarications, ignoring exculpatory evidence, witness coaching, false evidence creation and retaliation." Self-censorship seems to be required. I felt that the reporters asking for responses were hostile and had already assumed that I was guilty. The fact that prosecutors make false statements to the press and defendants cannot present facts without adverse consequences is a sign of tyranny.

The aggressive prosecution ignored the mitigating finding that I never earned a criminal dime and that all cash had been recorded and deposited into my corporate bank account. Also given no mitigating influence was the fact that I had terminated all three of the patients used for the initial plea-bargained prosecution, one each in 2008, 2009, and 2010. Hoping to give notice to other physicians, I, ignorant of doing anything criminal, reported the facts of each termination to the pharmacy board and medical board. Yet these were the three cases used to overcriminalize me at sentencing.

Truth and justice are seemingly irrelevant; judges, prosecutors, and investigators take no oath to tell the truth when presenting evidence or communicating with the judge. As David Brock explained, "The Supreme Court has ruled that

unsworn statements made to a Court or Congress are not covered by criminal statutes prohibiting false statements."[1]

I found that my attorney's "cut your losses" advice seems to be the current meaning of equality before the law. Believing an attorney's advice should be followed, and being ready to retire, I did retire and then completed the license surrender form to the medical board. There was a plea bargain between my attorneys and the prosecutor, which reduces the work of the prosecutor as the right to expensive jury process is bargained away to reduce the number of counts. As part of the plea bargain, the defendant's speaking out to explain his position likely violates the agreement—but the prosecutors can continue to provide defamatory and inflammatory information as they did in my case, even though they had agreed not to do so.

I was told that judges resent being challenged in their planned prejudgements as orchestrated by the prosecution. I am certain the pharmacy board investigator maliciously provided "evidence" to the judge, never presented to me or my attorney but mentioned at sentencing by the judge! I concluded that "plea perjury" is a more accurate description of the proceedings.

Plea bargains generate quick fees and enhance the conviction rate by flooding the court with counts rapidly created to pressure defendants' acquiescence, and then discarded. I understand that 90 percent of convictions are based on plea bargains now.

In my opinion, plea bargaining should be prohibited as a legal miscarriage or abortion because it excludes the jury and makes a travesty of the concept of being held innocent until proven guilty. Multiplying counts that cannot be proven increases the perception that the accused must be guilty, and serves to coerce him to forgo his right to a jury trial.

At my sentencing, the young new judge, personally touched by the government's continuing reaction against practices previously encouraged (see below), and influenced by the retaliatory magnifications of the pharmacy board investigator, admitted to using me as "an example" beyond objective judicial prosecutorial plea-bargain routines. I felt that the judge was being manipulated into non-judicial emotionality by prosecutorial propaganda.

My Medical Practice

I had been in practice since 1961 and full-time psychiatry practice since 1969. Around 2005, after bilateral knee replacements and a terrifying laryngospasm problem, I began to consider retiring, and I cut back somewhat on my practice. I did not accept new patients except for select referrals. However, about that time, a government-supported "Help Pain Medication Patients" initiative occurred. Originating from the White House and Congress, it was named "The Pain Decade 2000-2010" and promoted, among other things, the use of old and new pain medications; added "pain scales" to routine "vital signs"; and required pain assessment in each hospital shift's notes. Also, methadone was released for general use. Naïvely, I felt I should help out—but only with my known patients.

Consistent with unforeseen consequences of laws, by 2008 an opiate epidemic reportedly began, doctors were being falsely accused of misprescribing, and the reaction to the Pain Decade promotions was launched.

Among my 400 chronic poly-syndromic atypical medication-dependent patients (not an unusual accumulation over 40 years of practice), there were about 100 who had gone to pain centers for years. About half of them had complained to me that pain centers had become injection sites, getting much more in fees for giving injections than from cheaply prescribing pain medications that worked as well or better. Because this was nationwide, pain patients and their families had organized and implemented the Pain Decade programs. Hearing this from my patients and nurses, I decided to stay in practice without new patients, in order to help my chronic longstanding psychiatric patients remain well, but also to assist those with chronic pain who had repeatedly spoken of their dissatisfaction with their treatment by pain specialists. I did not take any new pure pain patients—only my old patients already on several psychiatric medications. Reasonable successes occurred with a few high-dose patients, who were grateful to be at maximum benefit most of the time by visits to me for all care rather than an expensive, ineffective, or unwanted pain visit elsewhere.

All my 50 pain-also patients (the other 50 remained with their pain specialists because they were content with them) continued on treatment of their chronic atypical anxiety, depression, attention deficit, bipolar disorder, psychotic condition, developmental disorder, and so forth, all reasonably stable on an atypical mixture of medications that were well-tolerated and closely monitored. All I did was add a pain medication effort to what I had been doing for a long time. There was no fee increase or change in frequency of office visits, and I continued to charge $50 to $150 a visit, as I had for years. I did not start a "pain clinic." I just added pain treatment to my evaluation-and-management sessions. Some higher dosing occurred, consistent with patient need and variability. These patients had all failed routine dosing and care for years from pain specialists.

Naturally, a few drug abusers/drug seekers were identified and terminated as patients. I was surprised and grieved by the need to terminate about 15 of these longstanding patients, nine of whom were used by the pharmacy board to attack me. I am certain that at least one, caught selling, turned against me to mitigate any charges against himself, for he had made veiled threats against me when I discharged him.

Unfortunately, having prescribed only propoxphene (Darvon) for pain for 40 years, I overlooked Ohio Revised Code 4731-21-02 on utilizing stronger drugs for treatment of intractable pain. The law was effective in 2008, after a prior more limited promulgation in 1998, before the pain injection procedures took over. This old, largely ignored law required acute physical examination reports and a pain specialist confirmation of pain medication dosing *every three months*. Prescribing without these was "misprescribing" by law, and applicable to most of my chronic atypical patients. Like almost all laws regulating medical care, it was well intended, but quickly became unreasonable because medicine is not an exact science. Giving pain specialists such a semi-monopoly on routine pain medications was unique. The procedures and monitoring used by specialists are not imposed on all physicians in any other area of medicine (not in cardiology, psychiatry, infectious disease, etc.). Routine medications have always been available to all physicians competent to use them. When pain specialists moved to injections, many patients had difficulty getting prescriptions for pain medications, leading

to the Pain Decade 2000-2010, which resulted in opiate and drug misuse, which was followed by over-reaction and attack on physicians recruited, as I was, into the original Pain Decade campaign against the inadequate treatment of chronic pain. Nevertheless, I discovered that I had broken the law requiring concurrence with pain specialists' procedures—a law that no one seemed to know about until it was used against me. It was not mentioned in the "Pain Decade" advertising.

No acute physical examination was ever needed for my patients, whose surgery was decades healed. I would never have started pain medications had I known that a pain specialist consultation was required, especially when pain specialists had already failed these patients.

My treatment agreement, signed by all patients, had a "self-termination" section, which states that the patient has terminated me as his doctor if he misuses pain medications. Thus, if any of these patients did misuse my medications for non-medical purposes, they were technically, according to this agreement, not my patients any longer. My attorneys said my contract did not matter.

I have always provided evaluation-and-management services, of which, as I discovered from original code books, time is the least important component. With that discovery, I developed templates from Medicare guidelines for evaluation-and-management (E&M) codes so that I could comply with the intensity requirements in short periods of time. Time was not a factor for these codes unless formal counseling was involved, and it was not. I was able to see a high volume of patients for psychopharmacologic care. Patients were seen to their satisfaction in an effective, brisk manner appropriate to a physician who knew them well for several years at least, almost all starting before 2008. And no reviewer from Medicare, Medicaid, Workers Compensation, or others ever faulted the absence of law-required pain specialist review in my records.

Apparently, however, the law requires pain-center doctors to judge all others. Also, contrary to common sense, it applies retroactively, requiring evaluations of hundreds of old patients who had been stable on medications for years.

The Oath of Hippocrates

At this time, the Oath is no longer taught and is as dead as the traditional collegiality of the medical profession itself.

The "family" of physicians no longer exists, as many self-righteous mercenary physicians eagerly provide paid testimony against those who were once their "brothers." The concept of looking to other physicians for help and offering help to other physicians when requested is deformed by payment and program factors, which often result in abandonment of patients, especially those who are stigmatized as drug abusers. This is worse than the rejection of AIDs patients 30 years ago. No doubt, drug dealing should be criminalized, but patients do need care that is now being denied. The lack of an intervention process to help rather than destroy allegedly wayward physicians is an outrage symptomatic of a punitive, power-corrupted society, estranged from real treatment, mercy, and forgiveness.

Refusing to divulge information that should remain private, as required by the Oath, is now an anachronism. The 5-year-old movement to electronic records means that documentation as treatment is replacing the Oath's priority of patient as the main object of medical care. Global misappropriation of medical records has created a medical bureaucracy of third-party payers, costing more than $800 billion annually. For the ruling bureaucracy, records now primarily exist to deny payment, control physicians, prevent long-term care—and "document" activity that can later be considered criminal. This inflates cost, violates ethical standards, affects access, is often unreasonable for improperly stereotyped patients, scapegoats medical professionals, is burdensome to say the least, and has made paperwork more important than the patient. The doctor no longer has patients, just medical records—which had better be legally exact. Unlike bureaucratic rules, which may change at a glacial pace, major changes occur every 5 years in scientific concepts, every 3 years in medical procedures, and as often as every few days in patients. The law might, just as appropriately, try to regulate the weather.

The massive, corrupt medical-records industry imposes pseudo-medical supervision, including that by medical boards, which no longer primarily protect physicians or patients. Doctors have become mostly indentured servants of the state, which displays spurious, grandiose idealism, almost always counterproductive in the long run. Medical boards and pharmacy boards need ethics and professionalism to help correct wayward physicians and patients, rather than the exercise of punitive power reminiscent of Communist China's treatment of dissidents.

Freedom and Independence

If freedom means anything, it means free speech. If independence means anything, it means individuals taking free steps as "a minority of one," as defined by Stanley Milgram[2] in his study on how ordinary citizens could be co-opted by evil by the Nazis and how a minority of one could at times prevent this.

My first dissent, on the first nuclear missile submarine, resulted in the prohibition of all evaporating solvents on submarines, no doubt preventing many illnesses. Over the years, many were unhappy with my frequent dissents, but generally all were accepted as the give-and-take of free-spirited citizens living their independence. There was no open personal retaliation until I dissented about the Ohio State Board of Pharmacy.

I have concluded that the only real medical professionals left are independent practitioners belonging to the Association of American Physicians and Surgeons or possibly the Catholic Medical Association. To allow politicians, law enforcement agencies, third-party bureaucracies, and pharmacists to run medicine is to have the ticket agents and baggage handlers fly the plane in which technology is always changing.

One part of the Oath of Hippocrates still applies: the Curse. "If I keep this Oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot."

Having abjured the Oath, medicine has become a cursed bureaucracy that poorly serves physicians, patients, and society.

Samuel Nigro, M.D., is a psychiatrist residing in Cleveland Heights, Ohio. Contact sam@docnigro.com.

REFERENCES

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