# On The Prosecution of Pain-Treating Physicians

## The author was fully exonerated six years after being charged with murder and Medi-Cal fraud

**By Frank Fisher, M.D.**

Most citizens assume that physicians regulate the practice of medicine, but state medical boards are composed primarily of law enforcement personnel. When the state Medical Board receives a complaint concerning a physician's conduct, a police officer equipped with a badge, a gun, and a degree in criminology is assigned to investigate. Worse yet, the decision about whether or not to take action on any given complaint, falls entirely to law enforcement.

After evidence is gathered, the case is referred to a deputy attorney general for prosecution. This publicly employed lawyer works for the Attorney General, otherwise known as the state's "top cop." The fact that the Attorney General's name appears at the bottom of the ensuing accusation should remove any doubts about the law-enforcement nature of a Medical Board action against a physician.

The ensuing prosecution takes place not before a medically sophisticated jury of the physician's peers, but before an administrative law judge. Many ALJs have been previously employed as deputy AGs, and maintain their offices within the Attorney General's quarters. During an administrative hearing, the ALJ functions as both judge and jury. These facts raise concerns around the issues of due process, and law-enforcement bias.

Not surprisingly, the outcomes of these Medical Board proceedings, where controlled substances issues are at stake, have little to do with the Board's stated mission to protect the public. In fact, the nature of these proceedings raise concerns about who will protect the people of California from the Medical Board?

An examination of the Board's quarterly *Action Report,* which lists disciplinary measures taken against California physicians, suggests that as many as 50% originate from complaints about the prescription of opioid analgesics. The exact percentage remains to be quantified, as many actions when they are finally reported describe alleged transgressions in record keeping, or fraud. The origin of a disciplinary action in a complaint concerning the prescription of opioid analgesics may, in this manner, be concealed.

*The Medical Board may spend half its budget pursuing pain-treating physicians.*

*Action Report* data suggest that the Medical Board of California may be expending as much as $20 million of its $38 million per year budget on investigating and prosecuting pain-treating physicians.

A sane regulatory system would expend these financial resources on identifying dangerous physicians who might actually pose a threat to the public.

This improvident allocation of MBC resources results in the under-treatment of chronic pain by intimidated doctors. It also leads to the escalation of malpractice premiums as doctors who cause harm avoid scrutiny.

**Implications for Standards**

The involvement of law enforcement in the regulation of medical practice is basically inimical to the availability of good medical care.

Under ideal circumstances, medical standards arise from a combination of 1) scientific research, and 2) a mindset geared towards serving the best interests of the patient. When law enforcement regulates the practice of medicine, neither occurs. Scientific research is replaced by a social agenda, driven by drug war ideology. Under these circumstances, law enforcement sets the standards for medical practice.

*The medical profession is coerced into imposing a system of drug control upon pain victims, rather than providing them with pain control.*

As an unintended consequence of the war on drugs, physicians are required, in order to keep their licenses, to assume a quasi law enforcement role in society. The medical profession is in this manner coerced into imposing a system of drug control upon pain victims, rather than providing them with pain control.

While prosecutions against both marijuana-recommending and opioid-prescribing physicians are driven by law enforcement agendas, their respective effects on both physicians and patients differ. An examination of the differences reveals useful insights about how the regulatory morass around these medically important substances may eventually be resolved.

Although law enforcement is actively engaged in the persecution of physicians who recommend medical marijuana, and as a result, the majority of California physicians are too intimidated to provide this service to their patients, most patients who need a marijuana recommendation are able to obtain one. These patients are also usually able to obtain their medication.

Patients who need opiates to treat chronic pain, on the other hand, are rarely so lucky. They are often unable to obtain the medication upon which their very survival may depend.

The existence of this paradox is counterintuitive. One would expect that legal substances such as opioid analgesics would be more available to patients than illegal ones such as marijuana. The contrast between the respective availabilities of these medicinal substances illustrates the exquisite vulnerability of the medical profession to the social agendas that are imposed when law enforcement regulates the practice of medicine in accordance with its drug war agenda. There is a lesson that must be learned from this paradox.

**Prohibition Prevents Treatment**

Prohibition inevitably prevents much needed medical treatment. The ensuing regulation of medical practice by law enforcement perverts medical standards, and thus creates an insurmountable bottleneck that prevents needed medications from getting to patients.

The current regulation of marijuana though Proposition 215 to some extent bypasses this bottleneck. While Prop 215 allowed physicians to approve mariuana use, it would be a mistake to make it a prescribable drug. If this approach were to backfire, medical marijuana might end up less available to patients than it is now. It makes sense to remove marijuana entirely from the schedule of controlled substances, not to reschedule it for use as a prescription drug.

The nature of the controlled substances scheduling apparatus itself bears scrutiny. The existence of this system is based on the assumption that society needs the federal government to protect it from supposedly abusable substances. Marijuana and opioid analgesics have been successfully demonized to the point where the general public feels that government intervention is necessary to protect us.

On a scientific basis, the controlled substances schedule is malarkey, as opioids and cannabinoids are unusually safe for medicinal use. Patients rarely, if ever get addicted, and deaths from appropriate medical use range from rare, in the case of opioids, to nonexistent in the case of medical marijuana. Consequently, the schedule is most accurately characterized as a law enforcement drug hysteria index.

**How to Proceed**

What won't resolve the crisis in the treatment of chronic pain is fine-tuning the current system. Attempts to do so over the last 15 years have only made it worse.

The enactment of intractable pain acts and the promulgation of medical board guidelines for the use of controlled substances in the treatment of chronic pain are based on the misguided assumption that some iteration of the regulation of medical practice by law enforcement could possibly succeed in delivering needed care to patients. This assumption reflects a profound misunderstanding of

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**PAIN MAPPING by Albrecht Durer in a small pen-and-watercolor self-portrait c. 1521. The region the artist is pointing to was colored yellow. Durer did the painting to send to an out-of-town doctor, hoping for a diagnosis. Neurologist G.D. Schott described it as a precursor of moden pain mapping in the *British Medical Journal***

## *"Fisher's Ordeal Finally is Over"*

*As reported by Maline Hazle in the* Redding Record Searchlight, *February 2, 2005:*

Six years after state agents raided his medical clinic in Anderson, Dr. Frank Fisher's legal problems appear to have ended with the quiet dismissal of the last of four wrongful death suits against him.

The dismissal papers were filed late Monday in Shasta County Superior Court and delivered to Fisher's attorneys Tuesday —the sixth anniversary of his arrest for multiple murders and massive Medi-Cal fraud.

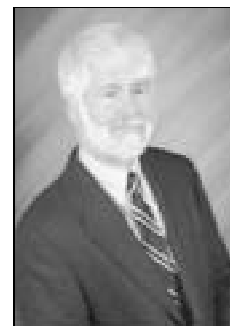
"This tells me that those malpractice lawsuits were frivolous, but I knew that all along," Fisher said Tuesday. "I'm just glad it's over."

The four civil cases were filed by relatives of patients who allegedly died of OxyContin overdoses in some of the same cases that prompted his arrest.

At that time Fisher was roundly criticized by law enforcement and some members of the medical community for prescribing what they said were huge doses of the drug, a sustained-release pain opioid that since has grabbed nationwide headlines and spurred numerous criminal cases against doctors.

Also arrested and named in the wrongful death suits were Redding pharmacist Stephen Miller and his wife, Madeline.

That all the cases were dismissed in Fisher's favor is a testament to the doctor's insistence on "standing on principle ... sometimes to his own detriment because it took so long to have an ending he can live with," said attorney James Goodman of San Francisco, who helped defend Fisher in the civil cases.



**Frank Fisher, MD**

"I feel sorry for the people who sued me. I believe that they were misled by the (state) agents," Fisher said.

Fisher said he also believes he has remedied a long-running state Medical Board investigation that once threatened his license to practice medicine.

He said he has signed an agreement with the state that he will pass a refresher course in general medicine, will keep a list of any controlled substances he prescribes and will allow his cases to be monitored for a while.

Although Shasta County Superior Court Judge William Gallagher forbade Fisher to practice medicine while he was out on bail on the criminal charges, the state never yanked his license. But Fisher was in jail for five months before his $15 million bail was finally reduced and spent the next five years fighting his legal battles, so he hasn't practiced.

Fisher said he hopes to open a clinic somewhere in rural Northen California, possibly even in Shasta County.

"I don't have anything against Anderson or Shasta County," he said, characterizing his arrest as "part of a nationwide witch hunt."

# Medical Board Watch

## Mystery at the Fall Meeting

## MBC drops prescription-drug analogy, CMA signs on to cannabis guidelines

**By Frank Lucido, MD**

I almost didn't go to the Nov. 5 Medical Board of California (MBC) meeting, despite my unofficial motto: "I will follow them around like they're the Grateful Dead." It was in San Diego, medical cannabis wasn't on the agenda (so I thought), and no one else I knew was going.

On arrival, I got an agenda and various other handouts, and lo and behold, on the agenda: "Item 4. Proposed Revision to May 7, 2004 Statement to California Physicians on Medical Marijuana (Wender/Thornton)."

The proposed change was to remove the words "or prescription drug treatment" in two places from the guidelines originally approved by the Board in May 2004 (without approval from the California Medical Association).

"These accepted standards are the same as any reasonable and prudent physician would follow when recommending or approving any other medication, or prescription drug treatment and include the following:

1. History and good faith examination of the patient.
2. Development of a treatment plan with objectives.
3. Provision of informed consent including discussion of side effects.
4. Periodic review of the treatment's efficacy.
5. Consultation, as necessary.
6. Proper record keeping that supports the decision to recommend the use of medical marijuana.

In other words, if physicians use the same care in recommending medical marijuana to patients as they would recommending or approving any other medication, or prescription drug treatment, they have nothing to fear from the Medical Board."

When the proposed revision came up for discussion, Dr. Wender described having met with Vasconcellos to discuss removing the references to prescription drugs, which the CMA found objectionable. Wender had anticipated a very contentious meeting but it actually took about 10 minutes, he said. The CMA's only objection seemed to be the terminology. "When I said to the Senator, 'It doesn't mean anything, we'll take it out,' the meeting ended," Wender told his DMQ colleagues. "So I bring it to you for approval."

David Thornton (the Medical Board's executive director, having retired with a full pension as chief of the Enforcement Division) said: "I just wanted to add the representatives from the Attorney General's office also were at this meeting. They said this would not change anything significantly."

Sandra Bressler from CMA: "We were happy to have the change. It was one we had suggested from the beginning, and we're fully in support of the statement at his point."

**The CMA Position**

CMA does not believe that marijuana is like a prescription drug. For example, there are no standards for dosage and there are no standards for composition of active ingredients or even complete knowledge about what are active ingredients. Furthermore, some prescription drugs should be monitored very closely while others do not require such close monitoring. There were no distinctions made on any of those issues in the original MBC statement, so we did not like a blanket assertion that physicians needed to treat marijuana like a prescription medication. In addition, a physician is making a recommendation that the patient might benefit from medical marijuana not giving a prescription. Thus the patient is responsible for what and how much they take and how they get it, not the physician.

Those objections are obviated by the amended statement.

**—Sandra Bressler, VP, CMA Center for Medical and Regulatory Policy**

**LINDA LUCKS IS OUT, MITCH KARLAN IN AS PRESIDENT of the Medical Board thanks to Gov. Arnold Schwarzenegger. Lucks, the Board member most supportive of pro-cannabis doctors, was not reappointed. Karlan and VP Ron Wender, MD, frequently recuse themselves from Board votes because they sit on insurance company boards.**

**A Minor Mystery**

Something mysterious seems to have taken place. Why, if the prescription drug analogy was a dealbreaker in the first quarter of 2004 when Wender and Enforcement Chief Joan Jerzak were negotiating with Bressler and Alice Mead of CMA, had it become insignificant by the time Wender met with Vasconcellos? It doesn't make sense to the CMA representatives or to Linda Lucks, a Board member who helped draft the guidelines.

To date, Wender and Jerzak have not responded to inquiries from *O'Shaughnessy's*. Fred Gardner suspects the prescription-drug analogy was retained in early 2004 at the direction of the Attorney General's office. "Tod needed to conduct a good-faith physical exam because of the prescription drug analogy. Their whole authority for prosecuting him stemmed from their treating marijuana like a prescription drug."

**My Public Comment/Summary**

MedicalBoardWatch.com, I announced, is now up and running. My intention is to help physicians safely and appropriately recommend medical cannabis. I post important information on medical cannabis and physician investigations, as well as all my testimony to the MBC, and all medical and legal documentation I have given the Medical Board.

I reminded the Board about inappropriate investigations of physicians for having recommended cannabis and law enforcement's institutional bias against cannabis. I pointed out that Board investigators and undercover police posing as legitimate patients contribute to rising medical costs and undermine the trusted doctor-patient relationship, and reiterated my call for an independent audit of the Medical Board.

**MBC Legal Staff Still Ignores *Bearman v. Joseph.***

David Bearman, MD, was vindicated in Superior Court after resisting turning over records of a patient who did not want his personal health information disclosed. I read comments from Dr. Bearman's attorney, Seymour Weisberg:

"Medical Board subpoenas should be resisted (unless the patient has waived privacy)... In short, a physician should not turn over an objecting patient's records without, at least, an order from a Superior Court judge...

"Dr. Bearman's case should also be cited to resist subpoenas for medical records issued by the prosecution in criminal cases against a patient unless the patient consents to the disclosure."

*Full text at: http://www.medboardwatch.com/Bearman-v-Joseph.htm*

## On Prosecution *from page 3*

the actual consequences for medical standards associated with requiring law enforcement to regulate medical practice.

The only certain way to restrict law enforcement's grasp on this aspect of medical practice is to remove opioid analgesics from the schedule of controlled sbustances. This action would signify the end of opioid prohibition as we know it. Not until the under-treatment of chronic pain becomes a national scandal will there be a movement to end opioid prohibition.

Most assume that when the time comes, their pain will be treated. They are sadly mistaken. In place of available pain treatment, there exists a widespread myth of available treatment.

An incremental step towards solving the pain crisis would eliminate physicians as the bottleneck, by decriminalizing the possession of opioids for medical use. This would resemble the current approach to the regulation of medical marijuana.

Such a strategy would be based on the understanding that many pain sufferers might have better luck procuring opioid analgesics through the black market than they currently have obtaining them from their own physicians. Many pain sufferers are forced into the black market already. Society probably isn't ready for this solution either, as the realization is only just dawning that the undertreatment of chronic pain is a major public health problem.

When the realization sinks in that the regulation of medical practice by law enforcement is a far greater menace than the illicit substances themselves, and people realize that the desecration of the physician-patient relationship is too high a price to pay for these illusory protections, social policy regulating medicinal substances will change.

The eventual solution may resemble the time-honored and relatively sane regulation of alcohol and tobacco. The less law enforcement is involved in the regulation of medicinal substances and hence medical practice, the better off we all will be.

## Special Session in Burbank

## Enforcement Monitor's Report —"In house," not Independent

The Medical Board held a special session in Burbank Jan. 21 to discuss the preliminary report of the "Enforcement Monitor" (EM). This report had been requested two years ago by Senator Liz Figueroa (D-Hayward), chair of the State Senate's Boards, Commissions and Consumer Protection Committee.

Julianne D'Angelo Fellmeth of UC San Diego's Public Law Center wrote the report with cooperation from the Board's staff. Although the media described Fellmeth's report as critical, the reforms she proposes are ones that the Board's legal staff wants to make.

*The report calls for "Vertical Prosecution" (having the AG's office direct the MBC investigators) and increasing the budget and staff.*

A key problem identified by Fellmeth was the length of time it takes investigators to pursue complaints. She attributed this to an inefficient relationship between the investigators and the Attorney General's office, and to understaffing (a result of underfunding). Her solution: "vertical prosecution" (having the AG's office direct the MBC investigators), and increasing the budget and staff.

The "vertical prosecution" Fellmeth proposes would give the lawyers control over which complaints get pursued and, supposedly, would eliminate the forwarding of inappropriate cases by investigators.

Fellmeth's report was "embraced" by David Thornton, a 30-year veteran of the Enforcement Division who retired in 2004 and has returned as executive director. Enforcement Chief Joan Jerzak also endorsed the report. MBC president Mitch Karlan MD seemed quick to declare a "unanimity of opinion." Karlan even interrupted new board member Cesar Aristequieta MD, who insisted on finishing a question about whether the restructuring was financially feasible. Karlan said, "We just want to get this moving so we have consensus for Tuesday" when Figueroa's committee would meet in Sacramento.

Sandra Bressler testified that the CMA opposed vertical prosecution because "the consequences are unknown, the details are unknown."

She and others with misgivings were advised by Dr. Wender to focus on "the concept, not the details."