Details of the Accusation

Table of contents

Why is this Happening?

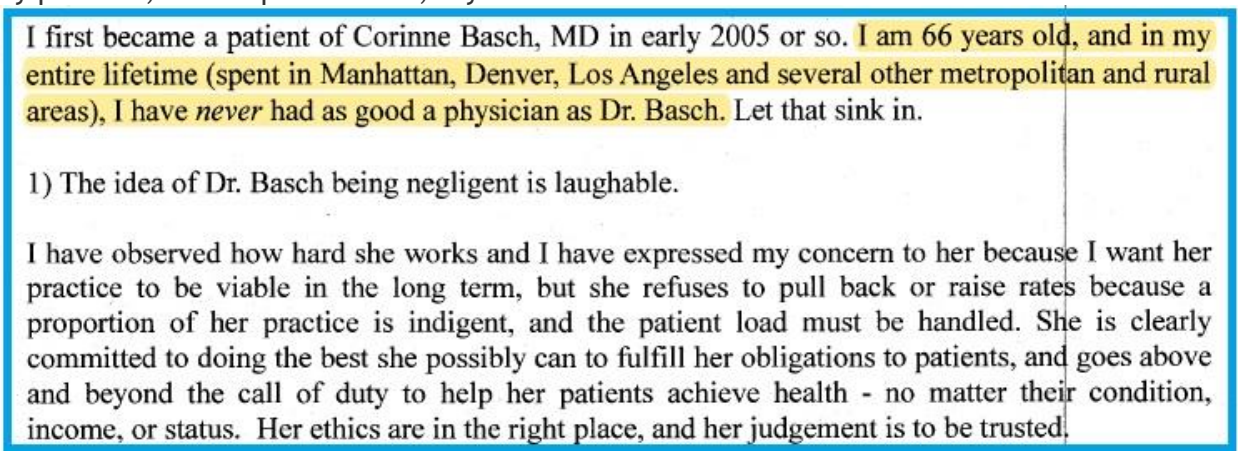
The investigation was purportedly started because of an anonymous allegation that I was overprescribing to someone who I knew was selling their pills. I would never do that, the investigation found no evidence of that, and that suspicion is actually a reason that patients have been discharged from my practice in the past. (Another doc who has communicated with me was investigated because of a patient who died of a stroke, but there had been a question about whether it may have been an overdose death.) Once the investigation starts, however, the original complaint is no longer relevant.

The investigation was not based on a random sampling of patients or any queries to local providers or other effort to get a balanced view of my prescribing or the practice. Had they done that they might have discovered:

- I have been helping people get off opioids since 2005. There are a great number of patients here and now elsewhere who have stopped opioids, gotten off disability, gone back to school and so on as a result of my care.
- Most of my patients are somewhere in a taper process, but I actually monitor that process, rather than announcing it and proceeding regardless of response.

Who am I as a Physician?

Anyone's impression from reading the Accusation would be that I am a sloppy doctor, with poor record-keeping and dangerous prescribing practices, but the reality is that in fact I am a driven, dedicated physician who goes to great lengths to provide Service to vulnerable patients. See Letters of Support for the words of my patients regarding that, and I'll let one of my patients, a local professional, say it for me here:



I first became a patient of Corinne Basch, MD in early 2005 or so. I am 66 years old, and in my entire lifetime (spent in Manhattan, Denver, Los Angeles and several other metropolitan and rural areas), I have *never* had as good a physician as Dr. Basch. Let that sink in.

1) The idea of Dr. Basch being negligent is laughable.

I have observed how hard she works and I have expressed my concern to her because I want her practice to be viable in the long term, but she refuses to pull back or raise rates because a proportion of her practice is indigent, and the patient load must be handled. She is clearly committed to doing the best she possibly can to fulfill her obligations to patients, and goes above and beyond the call of duty to help her patients achieve health - no matter their condition, income, or status. Her ethics are in the right place, and her judgement is to be trusted.

My focus on documentation is that patients have a clear understanding of sometimes complex treatment plans, and the bulk of my time and energy goes into my interactions and counseling with patients, not to the work on my charting. **What would you prefer YOUR doctor to focus on?**

I hope that you will therefore keep an open mind that perhaps my stance on this issue of pain management in legacy pain patients is also based on an attempt to protect my patients, even at the expense of my personal interests.

The Accusation Against Me

Regarding Negligence:

If the Medical Board is trying to shame me publicly, there are a number of *true* and unkind things they could say about me:

- I am obese
- I am a workaholic
- I am late - I almost never run on schedule in the office
- I am hypocritical- I counsel people about exercise and yet spend 16+ hours per day sitting at a computer
- I am naïve – I thought they were going to praise my pain program when they found out what I have been able to accomplish on a shoestring in this remote part of the state, and how dedicated I am in continuing to work with such difficult patients.
- I may be codependent, in that I try to help people who have messed up, including my diabetics who eat donuts, my chronic lung disease patients who continue to smoke, and my patients wth chronic pain who have, in desperation, continued their previous doses of pain medication rather than sticking to the taper I asked them to try.

The label that I feel does NOT fit, however, is negligent. I have taken the “Do No Harm” oath very seriously. I do not drink, use drugs, cross sexual boundaries with patients, or profiteer with my license (in fact, I continue to see people with any insurance, including Partnership, at tremendous personal financial sacrifice.) I have never exchanged a prescription for cash, sex, or any other inducement. Since the two other physicians who were in my call group moved out of the area, I take call 24/7 for my practice, with coverage from a nurse practitioner only when I leave town to go to medical conferences. I make home visits on the sick and elderly who cannot come into the office. As my patients know, I respond to messages at night, in the wee hours of the morning, on weekends and on holidays. I do extra research to be sure I am as up to date as possible for the treatment of patients with complex or unusual problems. Prior to this, I do not think “negligent” was the term that would come to most people’s lips if they were asked to describe my practice of medicine. I earned a 4.0 GPA at Hopkins (one of 4 people in a century to do so) and continue to work as hard as I humanly can to provide the best care I can.

As an idealist, who has worked diligently to do the right thing for patients, I am aware that I fall short of the ideal at all times, but the label “negligent” is still particularly rankling. Again, for the 5 patients mentioned in the complaint, I did not escalate pain medication use for any of these patients to the dosage levels on which they arrived at my practice, but I have worked with them where they are. At times doses went up when they had surgery or new injuries, then coming down over time. All are currently at lower doses of medication than when they established care with me.

Overprescribing

See The Truth about Overprescribing and the Opioid Epidemic for my take on how we got where we are. Overprescribing of opioids has indeed resulted in addiction of patients and in deaths. Avoiding starting people down that road is an important thing. The complex and thorny issue, however, is what to do for the folks who are already hooked, and whose nervous systems have been changed by long exposure to high doses of these medications. It is a little late for "just say no" for those individuals.

Privacy issues

I am disturbed by the way this is playing out in the public eye, that the accusation is made in detail on the web and that I am constrained by my own regard for my patients’ privacy to respond to it in detail. I am particularly dismayed to see the histories of patients P1-P5 posted in often inaccurate and intentionally unflattering detail on a local website – these are human beings, and our neighbors, and I believe the details may be sufficient for their stories to be recognized by their neighbors or family members. I made the error once before of sharing “Anonymous” details of a patient’s history of infections which I thought might be related to a controversial food choice in a public way in this small town; it is one of the great regrets of my career that that individual felt exposed and publicly shamed as a result, since she believed others may have recognized the story as being hers.

For that reason, I will not address the details of the complaint against me in a public forum except with explicit consent of the people involved.

PLEASE do not read the Accusation in its full detail unless you are in some way involved in the case. Please respect the privacy of the individuals involved. For my part, you can just know that I am accused of sloppy charting, careless prescribing and general lousy doctoring. 'Nuff said.

Underlying issues:

PAIN AND ADDICTION

If you are interested in the guiding principles behind my choices with patients in chronic pain, see My Philosophy in Pain Management I believe all human beings deserve compassionate care, regardless of age, social status, financial resources, political convictions, or medical conditions. I do not think any of us are beyond redemption, and that meeting people where they are is the way to establish trust and move them forward. Please also see Diseases of Despair below.

MEDICAL RECORDS

I was an early adopter of Electronic Health Records in 2001, because they facilitate communication with patients, which is still my focus. I am careful about communication with consultants as well, to be sure my patients get the best possible care from the full team involved in their care. I have not practiced or documented with regulators in mind, however. If you are interested in an explanation for the medical records issues cited in the Accusation, see Issues with records reviewed by the state

PATIENT-CENTERED CARE

Finally, my plans for patients change in response to my assessment of how my they are doing, as well as their feedback and preferences. I was surprised to read that as a *criticism* in the complaint (that my treatment plans "on a number of occasions were altered in deference to P-5's assessments and preferences.") I was taught and have taught that patient-centered care means negotiating an agreed treatment plan taking into account the patient's values and preferences. That is why some of my patients with high cholesterol are following an Ornish or Esselstyn diet, some take red yeast rice extract and some take a statin. I inform them of the options and the costs, risks and benefits, and we make choices together about what is right for them, of course then monitoring the results of that treatment and making adjustments if it is not working. There is no one-size-fits-all in medicine as I practice it. I actually consider that a feature, not a bug.
See Trust No One for an explanation of why I might not follow a pain specialist's advice.

What can we do?

END THE FAILED WAR ON DRUGS

For those interested in understanding the history of the War on Drugs and alternative approaches to addressing the problem that have proven more successful internationally, I

highly recommend Chasing the Scream by Johann Hari. Switzerland, Portugal and other places have more successful approaches.
There is also a nice summary on the misidentification of culprits for the current crisis, and the actual culprit being the failed War on Drugs itself here: True Offender

BE COMPASSIONATE TO PEOPLE LIVING WITH CHRONIC PAIN

For those interested in speaking up for some of the most vulnerable among us, those living with chronic pain who are being cut off from compassionate care providers, check out https://dontpunishpainrally.com/

ASK THE MEDICAL BOARD TO TAKE A SECOND LOOK

And for those who are concerned about the 1600 patients I care for (1400 of them active patients) and who risk being added to the number of patients in our area without primary care providers, ask your representatives to look at the Medical Board's history and strategy for protecting people here in our community. They would not have had to ask too many people in town to find out if I run a "pill mill" or attempt to provide conscientious care. Perhaps it will be possible to persuade them to take another look at me and my practice, at the feedback of my patients and those who know them, without forcing me to go through a costly formal hearing that I am afraid I may not be able to manage.

The Cost of Defense

I was informed by my attorney that the legal costs for protecting my license and my practice with a hearing is likely to cost more than 3 times my total income last year. I am 55 years old and still at risk for cancer recurrence myself, and have a child who is college age who depends on me. Borrowing for this purpose seems unwise. Asking our strapped community to raise money for this purpose also is unfair. see The Impact of the Investigation, and Finances. If I were an alcoholic, I could make a settlement with the state, go on probation, and continue to practice. Ditto if I were accused of sexual offenses and managed to have the charges changed to assault. See the Medical Board of California Manual of Model Disciplinary Orders.

For those of us who are conscientious objectors to the current trend in abandonment of pain patients, however, no such settlement options are possible. Any probation would involve closure of my solo practice (Unfortunately, I do not believe I have what it takes to provide safe care in local clinics or under the current medical model of 10 – 15 minute visits. That was why I resigned my clinic job in the past.) Probation would likely also involve an agreement to rapidly taper or abruptly discontinue medications in these patients, which I believe would cause them harm (and I took that pesky oath to "DO NO HARM.")

So whether the accusation is true or not, I may still be forced to leave the practice of medicine in California, simply because I cannot afford the legal fees to prevent that outcome. I would not be the first caring and well-reputed local doc to leave medicine here for this reason, but I feel it is a tragic waste of my education. I also think it is tragic that I am faced with that choice, that they are forcing me to choose between my patients and my son's

future and economic security. He will be better off if I leave medicine and get a job doing something else, or even if I were to drive Uber, than if I fight to protect my license.

Learning More

There are a number of excellent recent articles written about the current issues in abandonment of pain patients, for those who would like more information. A sampling of them are linked here:

For Physicians:

International Stakeholder Community of Pain Experts and Leaders Call for an Urgent Action on Forced Opioid Tapering

CDC Advises Against Misapplication of the Guideline for Prescribing Opioids for Chronic Pain

Opioid moderatism and the imperative of rapprochement in pain medicine

A Piece of My Mind: Hailey – a heartfelt editorial by William Weeks, MD, PhD, Associate Professor of Psychiatry and of Community and Family Medicine at Dartmouth Medical School, describing the death of his sister

For Laypeople:

The Pain Refugees

Some People Still Need Opioids

Pain patients left in anguish

Stop persecuting doctors for legitimately prescribing opioids for chronic pain

A series from Fox News:

As doctors taper or end opioid prescriptions, many patients driven to despair, suicide

Doctors caught between struggling opioid patients and crackdown on prescriptions

The CDC is correcting, but is the Medical Board listening?

And for Feedback from the patients themselves:

Survey: CDC Guideline Having 'Horrendous' Impact on Pain Patients

The Unseen Victims of the Opioid Crisis are Starting to Rebel

Finally, a story of a conscientious physician who was driven out of his practice by a similar complaint:

Mark Ibsen, MD

Diseases of Despair

I believe it is time we stopped scapegoating this vulnerable group of patients with chronic pain for the malaise, hopelessness, and lack of opportunity that has driven the increase in deaths from substance abuse, alcohol, and suicide around the country.

Imagine farmers were upset about wolves eating their sheep, so they came into town and shot your dog and your neighbor's dog. . . These patients did not cause this problem, and making them suffer will not fix it.

The Commonwealth Fund report defines deaths from alcohol, drug abuse and suicide as

“Deaths of Despair.” In Humboldt County, our suicide rate is 2.5 times that of the rest of the state. Drug-induced deaths are three times those of the rest of California, but of the 50 deaths in 2017, only 7(14%) were from prescription opioids alone. Over the last 15 years, in my practice 4 of my patients who have lived with chronic pain have taken their own lives. In that same time period, none of my chronic pain patients have died of accidental overdose on their pain medications, though one patient in my practice died of a complex overdose with methamphetamines. And in the tapering process, even with the much slower tapers that I supervise, I know of at least two and suspect one other in my practice who have turned to street drugs to supplement their pain management. This does not make anyone safer.