UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

UNITED STATES OF AMERICA	)	
	)	
vs.	)	CR No.: 17-09JJM
	)	
JERROLD ROSENBERG	)	

DEFENDANT JERROLD ROSENBERG'S SENTENCING MEMORANDUM

The Defendant, JERROLD ROSENBERG, hereby submits the instant Sentencing Memorandum to aid the Court in imposing a sentence in this case.

I. BACKGROUND

On February 1, 2017, a Federal Grand Jury for the District of Rhode Island returned a 19 count Indictment that charged the Defendant, Jerrold Rosenberg with 13 counts of health care fraud, in violation of 18 U.S.C. § 1347, one count of conspiracy to pay and receive kickbacks, in violation of 18 U.S.C. § 371, and five counts of receiving a kickback, in violation of 42 U.S.C. § 1320(a)-7b(b). On February 2, 2017, Dr. Rosenberg was arrested by federal law enforcement agents. He was subsequently arraigned that same day before U.S. Magistrate Judge Lincoln D. Almond and released on an unsecured bond. On October 25, 2017, pursuant to a written plea agreement, Dr. Rosenberg entered a plea of guilty to Counts 1 and 14 of the Indictment. As part of the plea agreement, the Government agreed to dismiss the remaining counts in the Indictment.

The United States Probation Office has prepared a Presentence Investigation Report ("PSR") which has been made available to Dr. Rosenberg and his counsel. The PSR indicates that Dr. Rosenberg has zero (0) criminal history points, with a corresponding Criminal History Category ("CHC") of I. Dr. Rosenberg's Total Offense Level is computed in the PSR to be 27. Based

upon a CHC of I and a Total Offense Level of 27, the PSR computes the applicable guidelines sentencing range ("GSR") to be 70 to 87 months of imprisonment. Dr. Rosenberg has asserted multiple objections to various components of the guidelines computation contained in the PSR. If all of his objections are sustained by the Court, Dr. Rosenberg's CHC would remain I, his Total Offense Level would be 20, and his GSR would be 33 to 41 months. Dr. Rosenberg is scheduled to be sentenced on March 9, 2018.

II. POST *BOOKER* SENTENCING

Sentencing proceedings should begin with a calculation of the applicable sentencing guidelines range. Gall v. United States, 552 U.S. 38, 49 (2007), citing Rita v. United States, 551 U.S. 338, 347-348 (2007). The sentencing guidelines function as a starting point and initial benchmark for the Court, however they are not the only consideration. Id. After both parties are afforded an opportunity to argue for whatever sentence they deem appropriate, the Court should then consider all of the § 3553(a) factors to determine whether they support the sentence requested by a party. Id. The Court may not presume that the guidelines range is reasonable, but must make an individualized assessment based on the facts presented. Gall v. United States, 552 U.S. at 50. The sentence imposed by the district court is subject to review under an abuse of discretion standard, including the substantive reasonableness of the sentence. Gall v. United States, 552 U.S. at 51. As stated by the First Circuit Court of Appeals, the sentence imposed by the court is subject only to the ultimate requirement of "reasonableness." United States v. Jiminez-Beltre, 440 F.3d 514, 517 (1st Cir. 2006)(en banc). The Court must use its independent judgment, guided by section 3553(a)'s instruction to "construct a sentence that is minimally sufficient to achieve the broad goals of sentencing." United States v. Rodriguez, 527 F.3d 221, 228 (1st Cir. 2008). As set forth below, when the foregoing analytical framework is applied to

the unique facts of this case, a sentence that does not include a period of incarceration is appropriate.

III. STATUTORY SENTENCING FACTORS

A. The History and Characteristics of the Defendant, 18 U.S.C. § 3553(a)(1)

Information concerning Dr. Rosenberg's personal and family characteristics is set forth in detail in Part C of the PSR. Dr. Rosenberg is 63 years old. In 2009 he married his wife, Lori Martino. Dr. Rosenberg and Ms. Martino share a loving and supportive relationship. Dr. Rosenberg has two adult sons, from a prior marriage. He has one sibling, a younger sister who resides in Pennsylvania, with whom he shares a close and supportive relationship. Dr. Rosenberg's father, who is 80 years old, resides in New York City. He is supportive of his son. A sentence that includes a period of incarceration would have a deleterious effect on Dr. Rosenberg's family. Further, given Dr. Rosenberg's father's age, the collateral effect of an incarcerative sentence would be exacerbated. All of Dr. Rosenberg's family is supportive of him and seeks the Court's leniency at sentencing.

Dr. Rosenberg was born in Toms River, New Jersey. He lived in New Jersey until he was approximately nine years old, when his family relocated to New York. Dr. Rosenberg and his family lived in New York for approximately two years. When he was approximately 11 years old his family moved to Brookline, Massachusetts. Dr. Rosenberg lived in Massachusetts until he moved to Washington, D.C., where he attended medical school. Subsequently, he resided in Bronx, New York while he completed his residency. Dr. Rosenberg then started his first employment position as a physician in New Haven, Connecticut. In 1987, Dr. Rosenberg moved to Rhode Island, where he has continuously resided to the present.

As set forth in paragraph nos. 65 and 66 of the PSR, Dr. Rosenberg suffers from multiple chronic medical conditions. Notably, he suffered a serious spinal injury in 2009 that required the surgical implantation of metal rods and a metal plate in his back. Post-surgery, Dr. Rosenberg's physical activities are limited due to the injury. He also continues to experience mild quadraparesis from the injury. Additionally, Dr. Rosenberg suffers from, and is receiving treatment for, multiple conditions including high blood pressure, high cholesterol and arthritis. He has also had laparoscopic surgery on both of his knees. A third procedure is anticipated in the near future. As indicated in paragraph no. 68, Dr. Rosenberg has a history of mental health counseling and has been prescribed an anti-depressant. He does not have a history of substance abuse for illegal drugs. Dr. Rosenberg does not have a criminal history. As expressed in several of the character letters submitted to the Court in support of Dr. Rosenberg, he is a caring person and talented physician. The foregoing personal history and characteristics support the exercise of leniency by the Court in sentencing Dr. Rosenberg.

A. The Nature and Circumstances of the Offense, 18 U.S.C. § 3553(a)(1)

The offenses that Dr. Rosenberg pleaded guilty to are serious offenses, which he acknowledges and accepts responsibility for his actions. Nevertheless, the charges he stands convicted of are not crimes of violence or narcotics offenses, but rather are economic offenses. Dr. Rosenberg's offense conduct should not be viewed in a vacuum. Instead, his conduct should be examined in the context of the surrounding circumstances. Attached hereto as Exhibit 1 is a copy of a letter from Dr. Rosenberg to the Court for its consideration at sentencing. Included in the letter are statistics regarding the Doctor's practice during the relevant time period. Significantly, Doctor Rosenberg saw approximately 1,600 patients during the time period set forth in the Indictment. However, he only prescribed Subsys to a total of 56 patients, i.e., less

than 4% of the patient population. Of those 56 patients, only 13 are the subject of the charges in the Indictment. Additionally, not every patient with a history that included a cancer diagnosis was prescribed subsys by the Doctor. The foregoing statistics are inconsistent with any argument that Dr. Rosenberg was operating a "pill mill". Further, those statistics do not support the argument that Dr. Rosenberg was blinded by greed in his prescribing practice.

As set forth in his letter, Dr. Rosenberg never issued a prescription for subsys that exceeded a dose of 800 mcg. Indeed, only 34 of the 462 subsys prescriptions that he wrote were for 800 mcg. The remainder of the subsys prescriptions were for lesser dosages. Dr. Rosenberg's average prescription dose for subsys was less than 400 mcg, well below the manufacturer's preferred dosage. The foregoing is contrary to Insys's efforts to encourage physicians to write subsys prescriptions for greater amounts. Dr. Rosenberg does not seek to excuse his conduct, but asks that it be considered in context and that his sentence be correspondingly proportional. Utilization of such an analysis warrants a nonincarcerative sentence.

B. The Need for the Sentence Imposed, 18 U.S.C. § 3553(a)(2)

A necessary factor to be considered by the Court in sentencing Dr. Rosenberg is punishment. He has accepted responsibility for his conduct and acknowledges the seriousness of what he did. By choosing to plead guilty, Dr. Rosenberg spared the Government the expense and resources associated with a trial.

As a result of this prosecution, Dr. Rosenberg has suffered significant punishment already. In his attached letter to the Court, Dr. Rosenberg sets forth several of the consequences he has endured. He has lost his medical license in Rhode Island and New York. His practice is closed, he lost all his hospital privileges, and he was fired from a part-time position he had. He has also lost his teaching appointment at Brown University. Dr. Rosenberg has been dismissed

from professional organizations and removed as an eligible provider from every health insurance network in which he was associated. In short, his professional career is over. Not only has Dr. Rosenberg been punished in a professional and financial sense, he has also endured the pain and humiliation associated with his conviction in this case. Further, he suffers for the embarrassment that he has caused his family. For the remainder of his life, Dr. Rosenberg will carry the burden of being a convicted felon and disgraced doctor. Finding employment as a convicted felon at Dr. Rosenberg's age is a daunting task, made all the more difficult because he cannot practice his profession. Suffice to say he has already suffered significantly and will likely continue to endure hardships for the long term. In light of the foregoing, a term of incarceration would be greater than necessary to comply with the statutory factor of punishment.

Another factor in the sentencing equation is deterrence. Dr. Rosenberg appreciates the seriousness of his situation and realizes the harm caused by his conduct. He recognizes that he cannot engage in this type of conduct ever again. Individual deterrence of Dr. Rosenberg has been accomplished. Given the professional and financial consequences Dr. Rosenberg has suffered due to this case, the loss of his career, the emotional toll it has taken on him, the public humiliation he has endured and will continue to endure, and the burdens of being a convicted felon, the deterrence of others will also be achieved without the necessity of an incarcerative sentence. A period of probation that includes restrictive conditions, including a term of home confinement, is significant punishment to Dr. Rosenberg and provides more than adequate protection to the public. Such a sentence would be sufficient but not greater than necessary to comply with the statutorily mandated purposes of sentencing as set forth in 18 U.S.C. § 3553. To sentence Dr. Rosenberg to a period of incarceration would result in an overly severe and disproportionate sentence given the specific circumstances of this case. Further, restrictions

imposed on Dr. Rosenberg as special conditions of probation, will act as a deterrent to others as well. A sentence of imprisonment is not required, nor is it the only means of achieving deterrence of others under the unique circumstances of this case.

IV. CONCLUSION

In consideration of the foregoing, the Defendant, JERROLD ROSENBERG, M.D., respectfully requests that the Court impose a sentence of a term of probation, including a period of home confinement, with such additional conditions as it deems appropriate.

Respectfully submitted this 6th day of March, 2018.

JERROLD ROSENBERG, Defendant
By his Attorneys,

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CERTIFICATION

I hereby certify that this document, filed through the ECF system, will be sent electronically to the registered Participants as identified on the Notice of Electronic Filing (NEF) and paper copies will be sent to those indicated as nonregistered Participants on March 6, 2018.

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EXHIBIT 1

Jerrold Rosenberg, MD

March 5, 2018

Before sentencing me, I would like the opportunity to explain how I arrived at this point.

I started as an orderly at Beth Israel Hospital in Boston when I was 16 years old. I completed college, medical school, residency and became board certified in a newer medical specialty called Physiatry or Physical Medicine and Rehabilitation. This is the only medical specialty dedicated to helping people who have survived illness and injury.

The goal is to improve a patients functional level and quality of life despite their diagnosis or disability. I can not help that your leg was amputated but I can design a prosthetic leg and teach you to walk again. You might be paralyzed on one side but I can design braces to support you and strengthen your unaffected side to compensate for your weak extremities. The specialty runs the gamut from infants with birth defects to elderly with arthritis.

Physiatry utilizes a multi-disciplined team approach utilizing professionals from different specialties including physical therapy, occupational therapy, speech therapy, personal training, art therapy, music therapy, chiropractic therapy, etc. The Physiatrist is the captain of the ship developing treatment plans. Part of that responsibility includes pain management as referenced in The Journal of Physical Medicine and Rehabilitation 2015.

During my training in the 1970's and early 1980's, doctors were taught that pain was under treated and an important part of the patients management.

I came to RI in 1987 after four years at St. Raphael's Hospital and Yale University and have practiced medicine here since, treating thousand of patients. The first half of my career was primarily in academics with numerous research activities, publications, and academic presentations. Since coming to Rhode Island, I have always maintained my academic appointment at Brown and taught medical students winning two awards for excellence in teaching. I consider myself an educator. It is why I enjoy preparing and presenting educational Grand rounds at Hospitals.

In the mid 1990s, I left my hospital based practice and went into solo private practice. I developed a Physiatric approach to pain management using a poly-pharmacy model. This involved using small doses of multiple medications that attack pain at various points in the pain pathway.

I am a specialist. If a patient has a simple problem treated routinely with good effect, they are not referred to me. My referrals are patients who have failed management elsewhere. Typically, their pain issues are multi-focal and complex. Frequently, they arrived on large ineffective doses of pain medications.

Often the problem was their physician was only treating one aspect of their pain etiology. An orthopedist, for example, was only treating the orthopedic component to their pain and failing to resolve their overall pain issues.

Typically, I would include an anti-inflammatory (NSAID) to treat the arthritic component of a patients pain. Then, if indicated, a Norepinephrine uptake inhibitor (like Gabapentin) to treat the nerve pain or neuralgic component of a patients pain. Or a muscle relaxant (like baclofen) to treat the muscle pain component of a patients overall pain pattern.

Finally, I might incorporate a narcotic pain medication using immediate release and timed released analgesic medication in combination. The timed released would reduce the overall constant pain level while the immediate released would be available as needed for episodic breakthrough pain episodes most often associated with activity. When combined with a Physical Medicine exercises and therapy programs the patients functional level improves. All patients were seen monthly to review their condition, response to treatment and need for continued therapy as per the CDC Guidelines for prescribing opioids.

Utilizing five medications synergistically allowed me to reduce the overall dose of any one medication thereby reducing side effects, tolerance and dependency. This also follows the recommendation of the CDC, to use the lowest dose of any medication to achieve therapeutic effect. If a patient developed tolerance, rather than increasing the opiod dose I simply switched to another chemical base. In other words, if the patient felt they needed more percocet (oxycodone) I would rotate to vicodin (hydrocodone) and visa versa.

For example, a patient might be referred to me on large doses of pain medication like 10-12 percocet a day. That told me the percocet was ineffective and they were having pain all day long which is why they needed 10-12 short acting percocet a day. It also increased the possibility of addiction since the patient was always waiting for their next dose.

In this case, I would add a timed released narcotic to help throughout the day and prescribe only 1-2 vicodin for the patients' episode pain during the day. The patients' overall narcotic load and dangers of large doses would be reduced. The end result was smaller doses, fewer pills better effect and less risk of addiction.

I took the responsibility of prescribing opioids seriously. I read extensively and attended numerous courses on safe prescribing. My standard practice included all the recommendations of the CDC, RI Dept. of Health, AMA and FDA including pain scales to confirm the patient was indeed in pain, an opioid risk assessment to determine if this patient was at risk for addiction, a pain agreement detailing the patients and doctors responsibilities, review of the PMP data to determine if the patient was treating elsewhere, and random urine toxicology testing to confirm compliance as per the CDC Guidelines for prescribing opioids and the RI Department of Health Rules and Regulations for Pain Management.

Patients in my practice underwent these protocols. Additionally, I participated in the Risk Evaluation and Mitigation Strategies, REMS, program that requires the doctor, the

patient and the pharmacist to all confirm they understood the reason for treatment and risks involved as referenced in the FDA Elements of the REMS.

Over the two and one half years in question, I discharge 207 patients for failed urine testing. Failed urine testing could occur in various ways. If there was no evidence of the prescribed medication in their urine then they were not taking it as prescribed, did not need it or were diverting it. If there were other narcotics in their system not prescribed by me then they were abusing and at risk of overdosing. My Physicians Assistant identified an additional 92 patients whom I also discharged.

These patients were not abandoned but referred to appropriate counseling and addiction treatment. When they had difficulty finding a treatment facility, I became certified and began a Suboxone program to help them with their addiction. This program was entitled the RI Addiction & Recovery Ctr.

Please understand that the use of narcotic medication was always an adjunct to my Physiatry practice. It was used in combination with therapy, exercise, diet, non-narcotic medication etc. This was not a pill mill. I integrated non-opiod treatments with opioids when appropriate as recommended in the CDC Guidelines for prescribing opioids.

My programs and policies were effective. Over thirty years, thousand of patients under my care improved. Several patients have been with me for decades. I am proud to say that in over thirty years of practice, I have never had a malpractice judgement or opioid overdose death related to my care.

When the opioid crisis hit RI the pendulum had completely swung around from the 1970's. Doctors were not under treating pain, they were over treating it. Patients were on gigantic opioid doses and being prescribed hundred of pills a month. Suddenly, doctors recognized these mistakes and simply stopped prescribing opioids for any reason to anyone. Thousands of appropriate patients with legitimate objective pain problems whom had never abused or diverted their medication were suddenly unable to obtain their medications.

Patients flooded into my office. Rather than avoid this difficult population of patients, I chose instead to attempt to help them. I identified the legitimate patients and helped them reduce their narcotic load safely. I incorporated Physical Medicine and Rehabilitation principles into their care.

Emerged in this flood of patients were cancer pain patients. The more I learned about cancer pain, the more interested I became in treating cancer patients. I discovered that dozens of pier reviewed medical journals all identified cancer pain as a real problem. It was under treated and patients functional levels were compromised.

With the improvements in the treatment of various cancers, patients are living longer with their disease with a reduced quality of life. The National Comprehensive Cancer Network, NCCA, is the gold standard for cancer care. These guidelines report that 30%

of all cancer patients have pain throughout the course of their disease and remaining life. This pain reduces function as referenced in numerous peer reviewed cancer journals.

Another remarkable finding was that cancer patients with adequate pain management lived longer. Survival improved with pain management most likely secondary to improved nutrition with reduced pain as reported in the NCCN Guidelines.

I discovered that Oncologists do not treat pain. They are not trained to do so. They are more focused on the control of the disease rather than control of pain as reported in Journal of Clinical Oncology 2011 and the Annals of Oncology 2009. Furthermore, their office procedures provide for office visits once or twice a year and is not conducive to prescribing pain medications that require monthly visits Traditionally, the oncologists left the pain management to the family doctors, internists and primary care physicians who were now no longer prescribing opioids.

These cancer patients fit the Physiatry/Physical Medicine model perfectly. Here was a legitimate group of patients who were being under treated as identified in the Journal of Clinical Oncology 2013,. I provided therapy, medication and injections to help them improve their functional level. I started the Cancer Pain Management Ctr. of RI and shifted my practice to better serve this patient population. I felt as though I had found a problem in the medical system that I was uniquely trained to manage.

Cancer pain has unique characteristics. There is both chronic pain and breakthrough pain secondary to activity. Chronic pain is associated with the cancer and the procedures to treat the cancer including surgery, radiation and chemotherapy as reported in the Cleveland Clinics. This pain can be exacerbated by physical activity and result in cancer patients with breakthrough pain. Cancer breakthrough pain has a rapid onset and modest length. This resulted in the invention of a rapid onset, short duration medication specifically for cancer patients with breakthrough pain. This medication was sub-bucal fentinyl as reported in the Journal of Opioid Management.

The first medication in this class was Actiq with a 20-25 minute onset. I incorporated this medication into my treatment programs. Then came an improvement, Fentora with a 10-15 minute onset. And finally, a sub-lingual medication, Subsys, with a 5-10 minute onset. I continued to upgrade to the best available medication for my patients.

Fentinyl is a very powerful medication. That is why it is prescribed in micrograms, not milligrams. That is 1/1000 of a milligram. It is also a legitimate regulated pharmaceutical product. It is also why I prescribed the lowest effective dose well below the company's recommendations.

I treated a variety of patients including those with throat and esophageal cancer whom could not swallow pills, patients with colon cancers and no gastrointestinal tract who could not absorb pills, patients with vaginal and uterine cancers with painful adhesions, bone cancers, leukemias and lymphomas, lung cancers with chest wall and breathing

pain, liver and kidney cancers with painful adhesions, bladder and prostate cancers with painful voiding, anal cancers with painful defecation, and breast cancer following mastectomies.

The advantages of this medication is that the patient is pain free for a set period of time, usually 2-4 hours. Patients began describing to me wonderful success with this medication. Patients relayed stories about how they were now able to drive to mall and have 2 hours to enjoy shopping, or go to a movie, or dinner etc.

I developed an academic Grand Rounds lecture about cancer pain and treatment that I presented at numerous hospitals and pain centers including Memorial Hospital April 1, 2013, Hospice of RI April 25, 2013, Fatima Hospital November 20, 2013, Hospice of RI February 28, 2013, Woman's and Infants Hospital March 21, 2014, and the AAPM&R annual meeting October 3, 2015. This was an academic lecture purely for the education of my hospital based colleagues. I was not reimbursed for my time. Meals were provided by the hospital. This was an opportunity for me to educate my hospital based colleagues about the problem and proper treatment of cancer pain.

During the time of the indictment, I saw approximately 1,600 individual patients. I prescribed Subsys to 56 patients whom I believed appropriate. Of those, only 13 are the subject of the charges in the indictment against me. Thirteen out of 1,600 potential users is less than 1% of my patient population.

Of those 56 patients, two have died from their cancers, 12 were discontinued for side effects and 28 for failed urine testing. Of those 13 patients identified in the indictment, 9 were discharged for failed urine testing. One patient was discontinued for of side effects to Subsys. I tried to be as diligent possible to make sure my patients were using this medication correctly and safely. I never put the pharmaceutical company or myself before the safety of my patients.

Off label prescribing by physicians is a common legitimate practice sanctioned by the FDA and AMA as noted in The Archives of Internal Medicine 2006. One patient in particular, DN, had no GI tract and could only absorb medication sublingually. After discontinuation of her sub-lingual Subsys medication she was given pills that obstructed her stoma and she almost died. Another patient, TB, had severe burns. The very first use of Actiq was in fact for children with burns. That is why it was in lollypop form. I have asked both patients as well as others to write letters of support for you to review.

The company literature recommends the best dose of the medication is 800-1200mcg with a maximum of 1600mcg. The profit margin to the company is greatest at the higher doses. The sales representatives told me I was under dosing and not obtaining the maximum benefit from the medication. I, nevertheless, continued my standard practice of prescribing conservatively and I never exceeded the 800mcg dose. Of the 462 prescriptions for Subsys that I wrote, only 34 out of the 462 were for 800mcg (7%) involving a grand total of five individual patients. My average dose across all patients on Subsys was less than 400mcg, 1/3 to 1/4 of the companies recommended dosing.

To obtain a brand named medication insurance companies require a prior approval form be filled out explaining why this more expensive medication is necessary. I have to fill out these forms routinely for virtually every brand name medication I prescribe.

The office procedure was for my staff to fill out the forms and I would then sign them. My office manager at the time apparently scanned the prior approval form into the computer as a time saving convenience and on occasion, filled it out above my signature.

The Insys sale representatives offered to fill out these forms to reduce the burden on my staff. Since I had a small practice, I accepted this help. My staff provided the data and the Insys representative filled out the form while literally sitting in my office. The prior approval forms were then forwarded directly to the Insys Reimbursement Center in Arizona whom may or may not have modified these forms above my signature and submitted them directly to the insurance carrier. Despite repeatedly asking for a final copy for our patients chart we rarely, if ever, received a copy of the finalized Prior Approval form.

In addition, depending upon the insurance company, I would be asked to provide a letter of medical necessity. This was a pre-populated letter that I would print and sign myself. Depending upon the insurance carrier it was either sent directly to the carrier or was sent to the Insys Reimbursement Center. Once again, it may or may not have been modified. I am unaware of receiving a final copy back from the Insys.

When a patient presented with pain and loss of function, I would perform an overall evaluation, identify the cause or causes of their pain and prescribe appropriately. I would determine if there was a low back pain component, an arthritic component and/or a cancer pain component. If I believed it was indicated I would prescribe low doses of a back pain medication, an arthritic pain medication and a cancer pain medication.

You should also appreciate that not every patient with a history of a cancer diagnosis was prescribed Subsys. I only prescribed Subsys to those patients whom I believed had a cancer pain component to their current overall pain pattern and loss of function.

Unfortunately, there were inaccuracies in some of these forms submitted to the insurance carriers. I misstated patients diagnosis. I am culpable for these errors.

At the present time, I have lost my medical license in NY and RI, had to close my practice, have lost my privileges from Lifespan including Rhode Island Hospital, Miriam Hospital and Newport Hospital, been fired from my part time in-patient rehabilitation employment at Fatima Hospital, been dismissed from every insurance company network, been kicked out of the American Academy of Physical Medicine and Rehabilitation and lost my teaching appointment at Brown University. I have had to sell my family home in Jamestown. I have been publicly humiliated and suffered significant financial consequences.

Moving forward, I am virtually unemployable in health care. Even if I somehow was able to have my medical license reinstated, because I have a felony conviction the Department of Health & Human Services, HHS, would prevent me from working for any organization that accepts medicare and medicaid.

Finally, in determining my sentencing, I would ask for you to also consider my age and current health. I am 63 years old and treated for high blood pressure, hyperlipidemia, depression, sleep apnea, and urine retention. I have a history of an arthritic toe that limits my ambulation and bilateral knee arthritis that has resulted in bilateral arthroscopic procedures. A third procedure is anticipated in the near future. I have asked Dr. Michael Mariorenzi whom I have known for decades and operated on my knee to write a letter for you to review.

Most significant of all is that in April of 2009 I sustained a C6 spinal cord injury. I underwent a C6 corpectomy with placement of a titanium rod and titanium plate as well as a bone fusion. This left me with quadraparesis or weakness in all four extremities left worse than right. It is the reason that I have only been working part time since 2009. I have also asked Dr. Phillip Lucas whom I have also known for decades and operated on my spine to write a letter for you to review.

I take full responsibility for my conduct. I was aware that the talks were considered a financial inducement to prescribe this medication and I knew that some forms were filled out incorrectly.

I have spent my entire life and professional career helping to take care of patients with illness, injury, handicaps, disabilities and pain. Everything I did, was motivated by my training to provide the best and safest care I could for my patients.

I would like to apologize to you, the court, my family, my patients, my friends, my colleagues and my students. I have let a lot of people down including myself. I committed errors in judgement and allowed my integrity to be compromised.

I believe I still have a lot to offer and would like an opportunity to utilize my talents, knowledge and experience to help my patients and the Rhode Island community. I would humbly ask for whatever leniency you determine appropriate and I am ready to accept your judgement.

Thank you for your time and consideration.

Jerrold Rosenberg, MD