NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

BRUCE N. SILVERSTEIN, M.D.

CONSENT
ORDER

BPMC No. 09-130

Upon the application of (Respondent) BRUCE N. SILVERSTEIN, M.D. in the attached Consent Agreement and Order, which is made a part of this Consent Order, it is

ORDERED, that the Consent Agreement, and its terms, are adopted and it is further

ORDERED, that this Consent Order shall be effective upon issuance by the Board, either

- by mailing of a copy of this Consent Order, either by first class mail to Respondent at the address in the attached Consent Agreement or by certified mail to Respondent's attorney, OR
- upon facsimile transmission to Respondent or Respondent's attorney, whichever is first.

SO ORDERED.

Redacted Signature

DATE: 7-10-2009

KENDRICK A. SEARS, M.D.
Chair
State Board for Professional Medical Conduct

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

BRUCE N. SILVERSTEIN, M.D.

CONSENT AGREEMENT AND ORDER

BRUCE N. SILVERSTEIN, M.D., represents that all of the following statements are true:

That on or about June 17, 1991, I was licensed to practice as a physician in the State of New York, and issued License No. 185639 by the New York State Education Department.

My current address is Redacted Address

, and I will advise the Director of the Office of Professional Medical Conduct of any change of address.

I understand that the New York State Board for Professional Medical Conduct (Board) has charged me with Thirteen specifications of professional misconduct.

A copy of the Statement of Charges, marked as Exhibit "A", is attached to and part of this Consent Agreement.

I do not contest the Eleventh Specification [negligence on more than one occasion], in full satisfaction of the charges against me, and agree to the following penalty:

> That I shall receive a censure and reprimand, and that I shall comply with the three year Order of Conditions, including monitoring, attached hereto as Exhibit "B". I also agree that my medical license in New York State shall be restricted so that I do not treat patients for the management of chronic pain, unless and until I demonstrate my competence to treat such

patients by the successful completion of an intensive course in pain management, to be proposed by me and agreed to by the Director of OPMC. If I do not complete such course to the satisfaction fo the Director of OPMC within the first year after the effective date of the Order herein, the said restriction on my license shall be permanent.

I also agree that I shall pay a fine of $25,000, in accord with the Order of Conditions. The fine is payable in full within 30 days of the effective date of this Order. Payments must be submitted to:

Bureau of Accounts Management
New York State Department of Health
Empire State Plaza
Corning Tower, Room 1717
Albany, New York 12237

I further agree that the Consent Order shall impose the following conditions:

That Respondent shall remain in continuous compliance with all requirements of N.Y. Educ Law § 6502 including but not limited to the requirements that a licensee shall register and continue to be registered with the New York State Education Department (except during periods of actual suspension) and that a licensee shall pay all registration fees. Respondent shall not exercise the option provided in N.Y. Educ. Law § 6502(4) to avoid registration and payment of fees. This condition shall take effect 120 days after the Consent Order's effective date and will continue so long as Respondent

remains a licensee in New York State; and

That Respondent shall cooperate fully with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Consent Order and in its investigations of matters concerning Respondent. Respondent shall respond in a timely manner to all OPMC requests for written periodic verification of Respondent's compliance with this Consent Order. Respondent shall meet with a person designated by the Director of OPMC, as directed. Respondent shall respond promptly and provide all documents and information within Respondent's control, as directed. This condition shall take effect upon the Board's issuance of the Consent Order and will continue so long as Respondent remains licensed in New York State.

I stipulate that my failure to comply with any conditions of this Consent Order shall constitute misconduct as defined by N.Y. Educ. Law § 6530(29).

I agree that, if I am charged with professional misconduct in future, this Consent Agreement and Order **shall** be admitted into evidence in that proceeding.

I ask the Board to adopt this Consent Agreement.

I understand that if the Board does not adopt this Consent Agreement, none of its terms shall bind me or constitute an admission of any of the acts of alleged misconduct; this Consent Agreement shall not be used against me in any way and shall be kept in strict confidence; and the Board's denial shall be without prejudice to the pending disciplinary proceeding and the Board's final determination pursuant to N.Y. Pub. Health Law.

I agree that, if the Board adopts this Consent Agreement, the Chair of the Board shall issue a Consent Order in accordance with its terms. I agree that this Consent Order shall take effect upon its issuance by the Board, either by mailing of a copy of the Consent Order by first class mail to me at the address in this Consent Agreement, or to my attorney by certified mail, OR upon facsimile transmission to me or my attorney, whichever is first. The Consent Order, this agreement, and all attached Exhibits shall be public documents, with only patient identities, if any, redacted. As public documents, they may be posted on the Department's website.

I stipulate that the proposed sanction and Consent Order are authorized by N.Y. Pub. Health Law §§ 230 and 230-a, and that the Board and OPMC have the requisite powers to carry out all included terms. I ask the Board to adopt this Consent Agreement of my own free will and not under duress, compulsion or restraint. In consideration of the value to me of the Board's adoption of this Consent Agreement, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive my right to contest the Consent Order for which I apply, whether administratively or judicially, I agree to be bound by the Consent Order, and I ask that the Board adopt this Consent Agreement.

I understand and agree that the attorney for the Department, the Director of OPMC and the Chair of the Board each retain complete discretion either to enter into the proposed agreement and Consent Order, based upon my application, or to decline to do so. I further understand and agree that no prior or separate written or oral communication can limit that discretion.

Redacted Signature

DATE 07-02-09

BRUCE N. SILVERSTEIN, M.D.
RESPONDENT

The undersigned agree to Respondent's attached Consent Agreement and to its proposed penalty, terms and conditions.

DATE: 7/1/09

Redacted Signature

WILFRED T. FRIEDMAN, ESQ.
Attorney for Respondent

DATE: 7/6/09

Redacted Signature

MICHAEL A. HISER, ESQ.
Associate Counsel
Bureau of Professional Medical Conduct

DATE: 7/10/09

Redacted Signature

KEITH W. SERVIS
Director
Office of Professional Medical Conduct

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

EXHIBIT A

IN THE MATTER

OF

BRUCE N. SILVERSTEIN, M.D.

STATEMENT

OF

CHARGES

BRUCE N. SILVERSTEIN, M.D., the Respondent, was authorized to practice medicine in New York State on or about June 17, 1991, by the issuance of license number 185639 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A, a male 44 years old when treatment began, at various time between 2004 and 2007 at Respondent's office at Redacted Address ["Respondent's office"]. Respondent provided general medical care for Patient A, as well as more directed care for Patient A's workman's compensation related complaints of mid-low back pain, among others. Respondent's care of Patient A failed to meet minimum standards of care, in that:

1. Respondent, on repeated occasions between approximately January 2005, and August 2007, failed to obtain an adequate medical history of the patient, with attention to the patient's symptoms and conditions, and/or failed to document that he had obtained an adequate medical history of the patient's symptoms and conditions.

2. Respondent, on repeated occasions between approximately January 2005, and August 2007, failed to perform an adequate physical examination of the patient, in light of his presenting history, and/or failed to document that he had performed such an adequate physical examination of the patient.

3. Respondent, beginning in January 2005, failed to adequately evaluate or otherwise address whether Patient A was dependent on narcotics or benzodiazepines or should pursue alternative therapies to such medications, and/or failed to document that he had adequately evaluated or otherwise addressed whether Patient A was dependent on narcotics or benzodiazepines, or should pursue alternative therapies to such medications.

4. Respondent, beginning in January 2005, prescribed high doses of narcotics and/or benzodiazepines to Patient A, including Percocet, Xanax, Norco, Oxycontin, and/or Hydrocodone, that were without adequate medical indication, and/or without documenting such adequate medical indication.

B. Respondent provided medical care to Patient B, a male 25 years old when treatment began, at various time between 2005 and 2007, at Respondent's office. Respondent provided both general medical care for Patient B, as well as directed care for Patient B's worker's compensation related complaints of neck, upper back, and left arm and shoulder pain. Respondent's care of Patient B failed to meet minimum standards of care, in that:

1. Respondent, on repeated occasions between approximately September 2005, and December 2007, failed to obtain an adequate medical history of the patient, with attention to the patient's symptoms and conditions, and/or failed to document that he had obtained an adequate medical history of the patient's symptoms and conditions.

2. Respondent, on repeated occasions between approximately September 2005, and December 2007, failed to perform an adequate physical examination of the patient, in light of his presenting history, and/or failed to document that he had performed such an adequate physical examination of the patient.

3. Respondent, beginning in September 2005, failed to adequately evaluate or otherwise address whether Patient B was dependent on narcotics or benzodiazepines or should pursue alternative therapies to such medications, and/or failed to document that he had adequately evaluated or otherwise addressed whether Patient B was dependent on narcotics or benzodiazepines, or should pursue alternative therapies to such medications.

4. Respondent, despite ordering an MRI that was performed on or about October 18, 2005, which results showed, among others, disk herniation in the cervical spine area, failed to evaluate and/or review such MRI findings, and/or document that he had evaluated or reviewed such findings, and/or acted upon the abnormalities identified.

C. Respondent provided medical care to Patient C, a female 26 years old when treatment began, at various time between approximately July 2004 and November 2007, at Respondent's office. Respondent provided both general medical care for Patient C, as well as directed care for Patient C's worker's compensation related complaints of back pain, right leg tingling, and loss of bladder control. Respondent's care of Patient C failed to meet minimum standards of care, in that:

1. Respondent, on repeated occasions between approximately July 2004 and November 2007, failed to obtain an adequate medical history of the patient, with attention to the patient's symptoms and conditions, and/or failed to document that he had obtained an adequate medical history of the patient's symptoms and conditions.

2. Respondent, on repeated occasions between approximately September 2005, and November 2007, failed to perform an adequate physical examination of the patient, in light of the patient's presenting history, and/or failed to document that he had performed such an adequate physical examination of the patient.

3. Respondent, beginning in 2004, failed to adequately evaluate or otherwise address whether Patient C was dependent on narcotics or benzodiazepines or should pursue alternative therapies to such medications, and/or failed to document that he had adequately evaluated or otherwise addressed whether Patient C was dependent on narcotics or benzodiazepines, or should pursue alternative therapies to such medications.

D. Respondent provided medical care to Patient D, a female 50 years old when treatment began, at various time between September 2003 and September 2007, at Respondent's office. Respondent provided medical care for Patient D's worker's compensation related complaints of neck and shoulder pain. Respondent's care of Patient D failed to meet minimum standards of care, in that:

1. Respondent, on repeated occasions between approximately September 2003, and September 2007, failed to obtain an adequate medical history of the patient, with attention to the patient's symptoms and conditions, and/or failed to document that he had obtained an adequate medical history of the patient's symptoms and conditions.

2. Respondent, on repeated occasions between approximately September 2003, and September 2007, failed to perform an adequate physical examination of the patient, in light of her presenting history, and/or failed to document that he had performed such an adequate physical examination of the patient.

3. Respondent, during the time he was prescribing narcotics or benzodiazepines to Patient D, failed to adequately evaluate or otherwise address whether Patient D was dependent on narcotics or benzodiazepines or should pursue alternative therapies to such medications, and/or failed to document that he had adequately evaluated or otherwise addressed whether Patient D was dependent on narcotics or benzodiazepines, or should pursue alternative therapies to such medications.

E. Respondent provided medical care to Patient E, a female 28 years old when treatment began, at various time between May 2005 and September 2007, at Respondent's office. Respondent provided both medical care for Patient E's worker's compensation related complaints of a herniated disk, numbness and tingling in her fingers, and leg weakness. Respondent's care of Patient E failed to meet minimum standards of care, in that:

1. Respondent, on repeated occasions between approximately May 2005 and September 2007, failed to obtain an adequate medical history of the patient, with attention to the patient's symptoms and conditions, and/or failed to document that he had obtained an adequate medical history of the patient's symptoms and conditions.

2. Respondent, on repeated occasions between approximately May 2005 and September 2007, failed to perform an adequate physical examination of the patient, in light of her presenting history, and/or failed to document that he had performed such an adequate physical examination of the patient.

3. Respondent, beginning in May 2005, failed to adequately evaluate or otherwise address whether Patient E was dependent on narcotics or benzodiazepines or should pursue alternative therapies to such medications, and/or failed to document that he had adequately evaluated or otherwise addressed whether Patient E was dependent on narcotics or benzodiazepines, or should pursue alternative therapies to such medications.

SPECIFICATION OF CHARGES

FIRST THROUGH FIFTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

1. The facts in paragraphs A and A.3 and/or A and A.4.
2. The facts in paragraphs B and B.3.
3. The facts in paragraphs C and C.3.
4. The facts in paragraphs D and D.3.
5. The facts in paragraphs E and E.3.

SIXTH THROUGH TENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

6. The facts in paragraphs A and A.3 and/or A and A.4.
7. The facts in paragraphs B and B.3.
8. The facts in paragraphs C and C.3.
9. The facts in paragraphs D and D.3.
10. The facts in paragraphs E and E.3.

ELEVENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

11. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, B and B.1, B and B.2, B and B.3, B and B.4, C and C.1, C and C.2, C and C.3, D and D.1, D and D.2, D and D.3, E and E.1, E and E.2, and/or E and E.3.

TWELFTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of

the following:

12. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, B and B.1, B and B.2, B and B.3, B and B.4, C and C.1, C and C.2, C and C.3, D and D.1, D and D.2, D and D.3, E and E.1, E and E.2, and/or E and E.3.

THIRTEENTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

13. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, B and B.1, B and B.2, B and B.3, B and B.4, C and C.1, C and C.2, C and C.3, D and D.1, D and D.2, D and D.3, E and E.1, E and E.2, and/or E and E.3.

DATE: April 21, 2009
Albany, New York

Redacted Signature

Peter D. Van Buren
Deputy Counsel
Bureau of Professional Medical Conduct

EXHIBIT "B"

ORDER OF CONDITIONS

1. Respondent's conduct shall conform to moral and professional standards of conduct and governing law. Any act of professional misconduct by Respondent as defined by N.Y. Educ. Law §§ 6530 or 6531 shall constitute a violation of probation and may subject Respondent to an action pursuant to N.Y. Pub. Health Law § 230(19).

2. Respondent shall maintain active registration of Respondent's license (except during periods of actual suspension) with the New York State Education Department Division of Professional Licensing Services, and shall pay all registration fees.

3. Respondent shall provide the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299 with the following information, in writing, and ensure that this information is kept current: a full description of Respondent's employment and practice; all professional and residential addresses and telephone numbers within and outside New York State; and all investigations, arrests, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility. Respondent shall notify OPMC, in writing, within 30 days of any additions to or changes in the required information.

4. Respondent shall cooperate fully with, and respond in a timely manner to, OPMC requests to provide written periodic verification of Respondent's compliance with the terms of this Consent Order. Upon the Director of OPMC's request, Respondent shall meet in person with the Director's designee.

5. Respondent's failure to pay any monetary penalty by the prescribed date shall subject Respondent to all provisions of law relating to debt collection by New York State, including but not limited to: the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law § 171(27); State Finance Law § 18; CPLR § 5001; Executive Law § 32].

6. The conditions period shall toll when Respondent is not engaged in active medical practice in New York State for a period of 30 consecutive days or more. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in, or intends to leave, active medical practice in New York State for a consecutive 30 day period. Respondent shall then notify the Director again at least 14 days before returning to active practice. Upon Respondent's return to active practice in New York State, the conditions period shall resume and Respondent shall fulfill any unfulfilled conditions terms and such additional requirements as the Director may impose as reasonably relate to the matters set forth in Exhibit "A" or as are necessary to protect the public health.

7. The Director of OPMC may review Respondent's professional performance. This review may include but shall not be limited to: a review of office records, patient records, hospital charts, and/or electronic records; and interviews with or periodic visits with Respondent and staff at practice locations or OPMC offices.

8. Respondent shall adhere to federal and state guidelines and professional standards of care with respect to infection control practices. Respondent shall ensure education, training and oversight of all office personnel involved in medical care, with respect to these practices.

9. Respondent shall maintain complete and legible medical records that accurately reflect the evaluation and treatment of patients and contain all information required by State rules and regulations concerning controlled substances.

PRACTICE MONITOR

10. Within thirty days of the effective date of the order, Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC.

    a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection (no fewer than 20) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care, and whether Respondent has sought to provide management of chronic pain. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

    b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

    c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

    d. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

11. Respondent shall comply with this Consent Order and all its terms, and shall bear all associated compliance costs. Upon receiving evidence of noncompliance with, or a violation of, these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding, and/or any other such proceeding authorized by law, against Respondent.