STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Karen Schimke
Executive Deputy Commissioner

November 14, 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Kevin C. Roe, Esq.
NYS Dept. of Health
Corning Tower-Room 2438
Empire State Plaza
Albany, New York 12237

Leonard W. Krouner, Esq.
Two Greyledge Drive
Albany, NY 12211-2054

E. Stewart Jones, Esq.
28 Second Street
Troy, NY 12181

RE: In the Matter of Bernard Barry Greenhouse, M.D.

Dear Mr. Roe, Mr. Krouner and Mr. Jones:

Enclosed please find the Determination and Order (No. 95-278) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by **certified mail**, upon the Administrative Review Board **and** the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:rlw
Enclosure

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

IN THE MATTER

OF

BERNARD BARRY GREENHOUSE, M.D.

DETERMINATION

AND

ORDER

BPMC-95- 278

The undersigned Hearing Committee consisting of **THERESE G. LYNCH, M.D., Chairperson, ROBERT A. MENOTTI, M.D.** and **TRENA DE FRANCO** was duly designated and appointed by the State Board for Professional Medical Conduct. **DAVID A. SOLOMON, ESQ.,** Administrative Law Judge, served as Administrative Officer.

The Hearing was conducted pursuant to the provisions of Section 230(10) of the New York Public Health Law and Sections 301-307 of the New York State Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Section 6430 of the New York Education Law by **BERNARD BARRY GREENHOUSE, M.D.** (hereinafter referred to as "Respondent"). Witnesses were sworn or affirmed and examined. A stenographic record of the Hearing was made. Exhibits were received in evidence and made a part of the record.

The Hearing Committee has considered the entire record in the above captioned matter and hereby renders its' decision with regard to the charges of medical misconduct.

RECORD OF PROCEEDINGS

Notice of Hearing and Statement of Charges:	March 14, 1995
Affidavit of Service of Notice and Charges:	March 17, 1995
Amended Statement of Charges:	May 22, 1995

Date and location of Pre-hearing Conference:		May 23, 1995 Cultural Education Center Conference Room E Empire State Plaza Albany, New York
State Board of Professional Medical Conduct appeared by:		Jerry Jasinski, Esq. Acting General Counsel NYS Department of Health
	BY:	Kevin C. Roe, Esq. Associate Counsel NYS Department of Health Division of Legal Affairs Empire State Plaza Corning Tower-Room 2438 Albany, New York 12237
Respondent appeared in person represented by:		E. Stewart Jones, Esq. 28 Second Street Troy, New York 12181; and Leonard W. Krouner, Esq. Two Greyledge Drive Albany, NY 12211-2054
Dates and Location of Hearing:		June 8, 1995 June 21, 1995 August 2, 1995 August 9, 1995 Justice Building Court of Claims #1 Empire State Plaza Albany, New York 12237
Conferences Held:		June 8, 1995 September 9, 1995 September 20, 1995
Closing Briefs received:		September 16, 1995

SUMMARY OF PROCEEDINGS

The Amended Statement of Charges alleges that the Respondent practiced medicine with gross negligence, gross incompetence, negligence on more than one (1) occasion, incompetence on more than one (1) occasion, and in the fraudulent practice of medicine. The allegations stem from the treatment of five (5) patients between January, 1991 and August, 1992 (Patient A); May, 1985 and November, 1993 (Patient B); March, 1989 and October, 1993 (Patient C); May, 1988 and October, 1993 (Patient D); and April, 1991 and October, 1993. Thereafter, the Attorney for the Board of Professional Medical Conduct withdrew the charges and related specifications set forth in Factual Allegations A.1., C.1., D.4. , E.1., E.2. and E.3. (T. 93-95.)[1]; See Attachment I for the Charges, as amended.

The Respondent denied each of the charges. (T. 8)

The State called the following witnesses:

Richard P. Patt, M.D.	June 8, 1995 Expert Witness
Subhash Jain, M.D.	June 21, 1995 Expert Witness

The Respondent testified on his own behalf.

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[1]NOTE: Herein, numbers following the letter "T." refer to page numbers of the Hearing Transcript.

The Respondent submitted affidavits from the following witnesses in lieu of testimony:

B.1. Richard T. MacDowell, M.D.
B.2. Howard Smith, M.D.
B.3. Paul E. Spurgas, M.D.
B.4. Richard T. Beebe, M.D.
B.5. Reynaldo P. Lazaro, M.D.
B.6. Marc D. Fuchs, M.D.
B.7. Richard L. Uhl, M.D.
B.8. Farhan Sheikh, M.D.
B.9. Donald P. Swartz, M.D.
B.10. Richard L. Jacobs, M.D.

See Attachment II

The Hearing Committee took official notice of four (4) pages and a publisher's source note from the 1995 27th Edition of "The Official ABMS Director of Board Certified Medical Specialists", Volume 1, re: Anesthesiology and Pain Management.

See Attachment III

SIGNIFICANT LEGAL RULINGS

The definitions of medical conduct as alleged under the Education Law were available to and consulted by the Hearing Committee.[2] The Administrative Officer confirmed that negligence is the failure to exercise the care and diligence that would be exercised by a reasonably prudent physician under the circumstances, a deviation from acceptable medical standards of treatment of a patient. Negligence has been proved if it is established that there was a deviation from acceptable standards of care; there is no requirement that there be established that injury actually resulted from deviating from such standard.

[2]See T. 2-3, Comments by Respondent to be submitted prior to the last hearing day, herein August 9, 1995.

Gross negligence is a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct. Egregious means conspicuously bad, a severe deviation from standards.

A licensee who does not possess the requisite skill or knowledge to practice medicine is said to be incompetent. The incompetent physician lacks the ability to discharge the physician's required duty to his patients because of a want of skill or knowledge. Incompetence, or unskillfulness, means a lack of the learning or skill necessary to perform the characteristic tasks of a given calling in at least a reasonably effective way. Gross incompetence is a complete lack of ability necessary to perform an act in connection with the practice of the profession. Such involves a total and flagrant lack of necessary knowledge or ability to practice.

The intentional misrepresentation or concealment of a known fact, made in some connection with the practice of medicine, constitutes the fraudulent practice of medicine. To sustain the charge, the Hearing Committee must find a false representation by the licensee when he knew such was false and it was intended to mislead. Knowledge and intent may be inferred from facts, but the Committee must state the inferences it is drawing regarding the knowledge and the intent.

FINDINGS OF FACT

All findings and conclusions herein were unanimous unless noted otherwise. The findings and conclusions of the Petitioner and the Respondent submitted herein were each considered and rejected by the Hearing Committee unless specifically set forth herein as findings and/or conclusions of the Committee.

The following findings of fact were made after review of the entire record. Numbers following a finding refer to page numbers of the transcript "(T.___)". Numbers and/or letters following a findings preceded by a reference to exhibits refer to exhibits in evidence "(Ex.___)". The citations represent evidence the Committee found persuasive in arriving at a particular finding.

All findings of fact were established by at least a preponderance of the evidence. Evidence which conflicted with any finding of the Hearing Committee was considered and rejected. The extent that one expert or witness's opinion was given more weight than another's is demonstrated by the Committee's reference to one person's testimony rather than another's.

1. The Respondent, BERNARD BARRY GREENHOUSE, M.D., was authorized to practice medicine in New York State by the License Number 089671. During the period 1985 through 1993, the Respondent was the Director of the Acute and Chronic Pain Management Center at Albany Medical Center College Hospital, Albany, New York. (Resp. Ex. A)

PATIENT A

2. On or about August 18, 1987, Patient A sustained a crush injury of his left hand which was caught between two (2) 250 pound barrels. In retrospect, he may also have received a traction injury to the brachial plexus when he pulled his hand out from between the barrels. (Dept. Ex. 2, p. 12)

3. From September 11, 1987 to December 7, 1989, Patient A was treated by Bruce Abrams, M.D. in Salisbury, Massachusetts. Dr. Adams' treatment included stellate ganglion blocks on September 25, 1987; October 1, 1987 and October 19, 1987. These were of no value in decreasing the patient's pain. (Dept. Ex. 2, pp. 10-13)

4. In December 1987, Patient A returned to Dr. Abrams who prescribed Percocet in conservative doses. (Dept. Ex. 2, p. 14)

5. Prior thereto, on or about November 2, 1987, Dr. Abrams referred Patient A to the Pain Management Center at Beth Israel Hospital, Boston, Massachusetts for a consultation with Ann Marie E. Nehme, M.D. Her impression was findings consistent with a diagnosis of reflex sympathetic dystrophy (RSD), left hand in the medium nerve distribution. Five (5) or six (6) guanethedine Bier blocks and two (2) axillary blocks were performed at Beth Israel Hospital without improvement. (Dept. Ex. 2, pp. 21-22)

6. On September 28, 1988, Patient A was seen by Bruce R. Cook, M.D. of New England Neurological Associates. Patient A told Dr. Cook that Percocet was the only medication that provided any relief. (Dept. Ex. 2, pp. 19-20, 23-24)

7. From December 15, 1988 to December, 1989, Patient A was under the care of Dr. Abrams. Patient A was treated with Percocet (10 to 20 per month) and referred for physical therapy and psychiatric evaluation for depression. By September 19, 1989, Patient A was reporting that he only took an occasional pain pill (Percocet) when symptoms recurred. (Dept. Ex. 2, pp. 27-32)

8. On or about December 28, 1989, Patient A moved to Gloversville, New York and to the care of E. J. Ballantine, M.D. Dr. Ballantine changed Patient A's prescription from Percocet to Lortab, 7.5 mg., one (1) every four (4) hours. In January, 1991, Dr. Ballantine reduced the prescription of Lortab to 5 mg. and referred Patient A to Respondent. (Dept. Ex. 2, pp. 5-9)

9. Respondent treated Patient A from on or about January 28, 1991 to on or about August 10, 1992, at the Albany Medical College Pain Management Center. (Dept. Ex. 2)

10. At the initial office visit on January 28, 1991, Patient A reported that previous stellate blocks, numerous Bier blocks and axillary blocks provided limited pain relief. He further reported that Percocet did provide some pain relief and diminished his pain. Respondent scheduled Patient A for a continuous axillary block and issued a prescription for Percocet, twice a day. (Dept. Ex. 2, pp. 2, 132)

11. On February 4, 1991, Patient A was admitted to the Albany Medical Center Hospital where a continuous axillary block was performed without significant relief. Patient A was discharged on February 8, 1991 with a prescription for Percocet,two (2) tablets every four (4) hours as needed, with a maximum of 12 tablets per day. (Dept. Ex. 2, pp. 92-99; T. 115-116, 162)

12. Patient A was seen for an office visit on February 14, 1991. On February 25, 1991, Patient A was seen for a second office visit by the Respondent. He reported that the pain had returned to its' previous level prior to the continuous axillary block. Respondent prescribed Methadone, five (5) mg., one (1) every four (4) hours and scheduled Patient A for a phenol cervical epidural on March 19, 1991. (Dept. Ex. 2, pp. 170, 52)

13. Patient A discontinued Methadone on March 8, 1991 because it made him drowsy; he returned to Percocet. (Dept. Ex. 2, p. 171)

14. On March 19, 1991, Patient A was admitted to the Albany Medical Center Hospital for cervical epidural phenol injection (neurolysis) via an indwelling catheter. On

March 20, 1991, phenol six percent (6%) was administered. On March 21, 1991, the catheter site was noted to be infected, the catheter was removed, and further procedures cancelled. While hospitalized, Patient A received intravenous (IV) Buprenex. He was discharged on March 23, 1991, on Roxicodone Tablets, #160, two (2) tablets every three (3) hours. Respondent's plan at discharge was to start Patient A on continuous IV Buprenex. (Dept. Ex. 2, pp. 87-91)

15. On March 25, 1991, Patient A reported, during a telephone follow-up, that he had received no pain relief from the phenol neurolysis. (Dept. Ex. 2, p 169)

16. On March 27, 1991, Respondent ordered administration of IV Buprenex through a peripheral line. (Dept. Ex. 2, pp. 115-117)

17. On April 23, 1991, Respondent saw Patient A for an office visit. Respondent scheduled Patient A for another cervical phenol epidural in June and referred Patient A to a surgeon for placement of a Hickman Catheter. (Dept. Ex. 2, p. 51)

18. On May 6, 1991, Donna Pietracola, M.D. inserted a Hickman catheter. Initially, the patient noticed increased pain and edema of the left hand which apparently resolved two (2) weeks later. (Dept. Ex. 2, pp. 33-34)

19. On June 4, 1991, Patient A was admitted to the Albany Medical Center Hospital for cervical phenol neurolysis. Phenol was administered on June 5, and June 6, 1991. During the June 6, 1991 procedure, it was noted that the patient developed sympathectomy on the right instead of the left side. The procedure was discontinued and the patient discharged on IV Buprenex. (Dept. Exs. 2, pp. 82-86, and 6)

20. On June 7 and 14, 1991, Patient A reported no pain relief from the cervical phenol neurolysis. (Dept. Ex. 2, p. 167)

21. Three (3) months later, on September 3, 1991, Patient A was seen by Respondent at an office visit. Respondent noted that the patient had developed sympathectomy on the right side instead of the left as a result of the June, 1991 phenol neurolysis, and noted the onset of numbness and parathesia in the fingers of the right hand. A third cervical phenol neurolysis was scheduled for October 21, 1991. IV Buprenex was changed from intermittent injections/bolus to continuous infusion. (Dept. Ex. 2, p. 50)

22. On September 24, 1991, IV Buprenex was increased to 1.1 cc. per hour and IV morphine sulfate, four (4) mg., every six (6) hours was added. There was no office visit on September 24, 1991. (Dept. Ex. 2, pp. 56-78, 108)

23. On October 14, 1991, Patient A was admitted to the Albany Medical Center Hospital for a cervical phenol neurolysis. On October 15, 1991, five (5) cc. of eight percent (8%) phenol was injected between C6-6 and T2. Anesthesia was obtained for approximately 45 minutes. On October 15, 1991, Patient A was brought to the operating room, but the catheter was plugged and therefore, further injection was not undertaken. On October 17, 1991, Patient A was discharged on IV Buprenex and IV morphine sulphate. (Dept. Exs. 5; and 2, pp. 75-81, 104-105, 108)

24. Prior to discharge from the hospital, Respondent recommended a surgical sympathectomy and referred Patient A to a surgeon. (Dept. Exs. 5, pp. 14, 18, 21; and 3, p. 20)

25. On October 17, 1991, prior to discharge from the hospital, Patient A was seen by a psychiatrist for increasing difficulty in coping with pain and emotional problems. (Dept. Ex. 2, pp. 36-37)

26. On October 18, 1991, Patient A was seen at the emergency department of Albany Medical Center Hospital for repair of the Hickman catheter, which broke apart while the patient was flushing the tubing. (Dept. Ex. 4)

27. On October 21, 1991, Patient A was admitted to the Albany Medical Center Hospital. A left surgical cervical sympathectomy was performed and Patient A was discharged on October 23, 1991. (Dept. Ex. 3)

28. As a result of the surgical sympathectomy, Patient A developed Horner's syndrome including ptosis and myosis of the left eye and left partial paralysis. Patient A's pain was further increased and now included the entire left upper extremity, where it had been isolated to the hand before surgery. (Dept. Ex. 2, pp. 43, 49)

29. On November 13, 1991, Respondent saw Patient A for an office visit. Lack of pain relief, Horner's Syndrome and the left partial paralysis were noted. Respondent's plan was to continue IV Buprenex and have Patient A return in two (2) to three (3) months. (Dept. Ex. 2, p. 49)

30. On December 3, 1991, Patient A complained, in a telephone call to office personnel, of increased pain in his entire upper extremity, which had been isolated to the hand prior to surgery. IV Buprenex was increased. (Dept. Ex. 2, pp. 43, 49)

31. On December 5, 1991, Patient A was seen by Gregory B. Krohel, M.D., a neuro-opthalomogist, who noted left ptosis, blurred vision in the left eye and a visual field defect. (Dept. Ex. 2, p. 38)

32. On December 18, 1991, Patient A was seen by Respondent complaining of severe pain in the left side of the neck shooting down the left arm with no relief with Buprenex. Respondent discontinued IV Buprenex and substituted IV Dilaudid, 1.5 mg. per hour with a .5 mg. bolus every four (4) hours. He planned to have the patient return in three (3) months or as needed. (Dept. Ex. 2, p. 48)

33. On January 23, 1992, Patient A stated in a telephone conversation that he did not like how he felt with the Dilaudid. Respondent discontinued Dilaudid and returned the patient to IV Buprenex. There was no office visit. (Dept. Ex. 2, pp. 55, 60)

34. Patient A was seen for an office visit on May 21, 1992, complaining of intense pain barely controlled with IV Buprenex. Respondent changed the IV Buprenex to continuous infusion then being replaced back to intermittent injections. (Dept. Ex. 2, p. 47)

35. Patient A was seen for an office visit by Respondent on August 10, 1992 to discuss a form of therapy for his planned three (3) month trip to Europe. Respondent discontinued IV Buprenex and prescribed MS Contin, Percocet and Roxicodone to be used sparingly while in Europe. Respondent planned to resume IV Buprenex upon the patient's return from Europe. (Dept. Ex. 2, p. 46)

36. On or about November 9, 1992, Patient A returned from Europe and was restarted on IV Buprenex. The Hickman catheter had been dislodged; on November 19, 1992, a double lumen port-o-cath was inserted. There was no office visit to Respondent. (Dept. Ex. 2, pp. 44, 55)

37. On January 5, 1993, Patient A reported, in a telephone conversation, that he wanted to stop IV Buprenex and begin oral analgesics; he was concerned with the length of time he had been using the medication. The nurse receiving the telephone call consulted with Respondent who extended the frequency of administration from six (6) mg. every four (4) hours to six (6) mg. every four (4) to six (6) hours. (Dept. Ex. 2, pp. 43, 53)

38. On or about February 3, 1993, at 9:20 a.m., Leslie Hyland, R.N., a rehabilitation consultant retained by the insurance carrier to evaluate Patient A, advised Respondent's office personnel that Patient A had weaned himself off Buprenex without the knowledge of, or notification to, Respondent as of February 1, 1993. This was confirmed by the home health care nursing agency and the patient. (Dept. Ex. 2, pp. 146, 41; T. 399)

39. Phenol (carbolic acid) is a neurolytic agent used to destroy nerve fibers. During a cervical epidural phenol block, phenol is injected through a catheter into the cervical ganglion area thought to be responsible for the pain. Both sensory nerve fibers and autonomic nerve fibers are destroyed and the damage is permanent. Risks of the procedure include paralysis, paraplegia, quadriplegia, infection, hematoma, deafferentation pain and creation of unintended sympathectomy to previously unaffected areas. Epidural phenol neurolysis is indicated for the treatment of severe, chronic and/or malignant pain in patients with a short life expectancy in whom all other treatment modalities have been tried and failed. A surgical sympathectomy is a surgical procedure in which the sympathetic chain in the stellate

ganglion area is cut and surgically removed. The procedure is indicated in the treatment of severe, chronic pain when all other treatment modalities have been exhausted and prior sympathetic blocks have been effective. The risks of surgical sympathectomy include bleeding, hematoma, paralysis, paraplegia, pneumothomax, and permanent Horner's syndrome. (T. 117-118, 121, 125-128, 156, 160, 165-166)

40. Patient A was approximately 38 years old with a normal life expectancy. His chronic pain was benign, non-cancerous, and not malignant. Respondent subjected Patient A to phenol neurolysis less than 60 days after the patient came under his care without exhausting all other treatment modalities. Cervical epidural phenol neurolysis was not indicated for Patient A. (T. 119-121, 156, 160, 184)

41. Prior to the surgical sympathectomy, three (3) stellate ganglion blocks, five (5) or six (6) guanethedine bier blocks, at least two (2) axillary blocks and an attempted continuous axillary block had been unsuccessful, providing little, if any, pain relief. Three (3) attempts at phenol neurolysis had been ineffective. Surgical sympathectomy was not indicated. (T. 125-128, 165-166)

42. Buprenex (buprenorphine) is a synthetic narcotic classified as an agonist/antagonist that is associated with a low incidence of physical dependence but is known to have the potential for psychological dependence. Buprenex has a ceiling effect: once a patient receives a certain dose, no further analgesia can be achieved no matter how much more of the drug is given. It is only available in the United States as an intravenous drug. An intravenous drug is NOT a convenient or easy drug to use for chronic pain. (T. 28-30, 129-130, 248-249)

43. The use of Buprenex for chronic pain requires long term intravenous access and the risks and morbidity associated therewith. The intravenous mode of treatment has a significant impact on the patient's independence, mobility and autonomy, and requires them to become significantly more dependent on the medical system with likely psychological harm and interference with possible rehabilitation. The surgical procedure for inserting a line for continuous intravenous infusion is associated with risks. The maintenance of the line carries risks for infection, the device falling out, risks of the patient abusing it and giving other drugs through it. The cost is dramatically, by a number of orders of magnitude, different in that the maintenance of this IV treatment at home requires considerable resources in terms of skilled nursing, home care, frequent visits and the provision of these intravenous drugs which are subject to a high mark-up in the absence of any demonstrated advantages over oral treatment. (T. 34) The intravenous route of administration is not indicated unless all oral opioids have been tried and failed, or oral medications cannot be tolerated by the patient. (T. 33-37, 132-133, 173; T. 46-47, 79-80, 174-175)

44. Prior to coming under the care of Respondent, Patient A was treated from August, 1987 to December, 1989, with Percocet, no more than 20 per month, and Lortab, 7.5 mgs., one (1) every four (4) hours, ten (10) days before Respondent's first office visit. There was neither an adequate trial nor a failure of oral medications, nor was Patient A unable to tolerate oral medications. (T. 129-135, 173-174, 47, 79-80)

PATIENT B

45. Respondent treated Patient B from on or about May, 1985 to on or about November 1, 1993, at the Albany Medical College Pain Management Center and at Respondent's office at 3

Columbia Circle, Albany, New York. (Dept. Exs. 10 and 11)

46. Patient B had a long history of back problems brought about by a series of four (4) separate injuries. The first injury occurred while the patient was in high school, the second (1967) and the third injury (1969) were industrial, and the fourth (1978) an automobile accident. The patient developed severe discogenic disease after injuries three (3) and four (4) and underwent a series of eight (8) back operations for discectomy, laminectomy and fusion, with the last surgery occurring in 1983. There were laminectomies at L3-4 primarily rightsided, L4-5 bilaterally and L5-S1, primarily rightsided. There were also fusions at L3-4 and L4-5. As a result of these surgeries, the patient developed epidural scarring at L3-4, L4-5 and chronic arachnoiditis. The last surgical procedure in April, 1983 was successful, and the patient had no pain whatsoever, received no treatment for his back, and did not see a doctor about his back from April, 1983 until the most recent injury. (Dept. Exs. 11, pp. 14, 17-19 and 23, pp. 3, 45)

47. On March 14, 1985, Patient B was injured when attacked by an irate customer. He was admitted through the emergency room of Albany Memorial Hospital with complaints of severe back and leg pain, greater on the left. He was placed on bed rest, muscle relaxants and physiotherapy. He improved for a couple of days. A lumbar myelogram was performed on April 9, 1985, and did not reveal any clear cut extradural lesions, but demonstrated arachnoiditis. Patient B was discharged on April 12, 1985, to continue bed rest at home with prescriptions for Tylenol #4 and Valium, five (5) mg. for muscle spasms. (Dept. Ex. 23, pp. 43-44, 47)

48. On May 17, 1985, Patient B was admitted to the Albany Medical Center Hospital by Charles H. Kite, M.D., a neurosurgeon, for evaluation and treatment of worsening pain. On May 29, 1985, Respondent evaluated Patient B in consultation. Respondent noted that the patient had

a cold, painful leg with searing and burning pain in the left thigh. He noted that the patient may have a component of reflex sympathetic dystrophy (RSD) and recommended a paravertebral lumbar sympathetic block. (Dept. Ex. 23, pp. 5, 84)

49. On May 30, 1985, Respondent performed a left paravertebral lumbar sympathetic block at L2-3. On June 3, 1985, Respondent performed a second left paravertebral lumbar sympathetic block at L2 and a right paravertebral lumbar sympathetic block at L2-3. Physical therapy was instituted. On June 6, 1985, the patient's burning pain in his lower extremities returned. On June 7, 1985, Respondent administered an epidural infusion of morphine sulfate and depomedrol via an epidural catheter. (Dept. Ex. 23, pp. 3-4, 51, 53, 58)

50. On June 6, 1985, the Respondent, in his consultative capacity to Dr. Kite, reviewed the results of his procedures with Dr. Kite and several options that could be considered including a surgical sympathectomy. The patient with the two (2) surgeons, Drs. Kite and Denton, determined that the surgery should be performed. (Dept. Ex. 23, pp. 56, 59, 105; T. 461, 462-463)

51. Patient B, on June 13, 1985, had a lumbar sympathectomy performed. (Dept. Ex. 23, p. 39; T. 236)

52. On June 24, 1985, Patient B was evaluated by a psychiatrist who noted a strong potential for narcotic addiction and felt that the pain was probably somatic in origin with a psychological component contributing to its continuation. On July 12, 1985, Patient B was discharged from the hospital on Valium, Trilafon, Colace, Tylox and Dalmane. (Dept. Ex. 23, pp. 4, 90-91)

53. Patient B was admitted to the Albany Medical Center Hospital on August 19, 1985, and a permanent thoracic epidural catheter and port-a-cath infusion well was implanted subcutaneously by Respondent on August 23, 1985. At admission, Patient B was taking Tylox, one (1) to two (2) tablets every four (4) hours, Valium, ten (10) mg., every six (6) hours, and Colace, 100 mg., twice a day. His pain had become worse, and was no longer responsive to Tylox. (Dept. Ex. 22, pp. 20, 23-24)

54. The Respondent agreed that the use of the permanent catheter may have been premature, but he had had some success in using the method previously. He would not use the method today. (T. 465, 11. 8-15, T. 521, 11. 12-22)

55. Patient B was discharged from the hospital on August 28, 1985, receiving epidural Duramorph and Colace, 100 mg., by mouth three (3) times a day. (Dept. Ex. 22, p. 4)

56. Patient B had numerous complications relating to the permanent thoracic epidural catheter and port-a-cath infusion well, requiring revision and replacement of the port-a-cath on four (4) occasions and eventual removal of the catheter and infusion pump on May 25, 1986. Percocet and methadone were used when the catheter and/or infusion well were not functioning. (Dept. Ex. 11, pp. 278-279)

57. On May 20, 1986, Patient B was admitted to the Albany Medical Center Hospital for removal of a non-functioning epidural catheter and port-a-cath well. After removal, the Respondent decided to attempt a phenol neurolysis. On May 27, 1986, Respondent

attempted to inject contrast media in the epidural spaces at T12 and L3 and caudally without success. Respondent decided against further blocks because the epidural space did not appear to accommodate any further manipulation and it was believed fruitless to try. (Dept. Ex. 20, pp. 3-4, 23, 30)

58. On May 30, 1986, Respondent prescribed IM Buprenex, 0.3 mg., intramuscularly (IM), every four (4) hours and Robaxisal, 400 mg., by mouth every six (6) hours for Patient B and discharged him from the hospital. On June 20, 1986, Respondent changed the Buprenex prescription from intramuscular to intravenous administration. Patient B received IV Buprenex from June 20 to about October 18, 1986. (Dept. Ex. 11, pp. 81, 285, 297, 346-350)

59. Oral opioids, specifically Percocet and Methadone, had been used to treat Patient B for only short periods of time when the epidural catheter and port-a-cath were not working. Prior to referral to the Respondent, the patient had not been under medical care for two (2) years. There was neither an adequate trial, or a showing that the patient was unable to tolerate oral pain medications. The use of Buprenex for chronic pain requires long term intravenous access with the risks and morbidity associated therewith. There is a significant impact on the patient's independence, mobility and autonomy, requiring the patient to become significantly more dependent on the medical system with likely psychological harm and interference with possible rehabilitation. The IV routes of administration are not indicated unless all oral opioids have been tried and failed, or oral medications cannot be tolerated by the patient. The Respondent did not want to use morphine or "heavy-duty drugs" on Patient B in 1986 and 1987 because it was frowned upon to use these narcotics in the treatment of non-malignant pain. (Dept. Ex. 11, pp. 278-279; T. 33-37, 173, 235-236, 248-249, 480; and see T. 132-133)

60. On July 14, 1986, Respondent admitted Patient B to Albany Medical Center Hospital for caudal epidural phenol neurolysis. Following two (2) injections of six percent (6%) phenol, decreased sensation in the sacral and coccygeal areas was noted and Patient B had difficulty voiding and controlling his bowel movements. The plan to continue further epidural phenol neurolysis was abandoned. (Dept. Ex. 19, p. 3)

61. As a result of the caudal epidural phenol neurolysis in July 1986, Patient B suffered permanent impotence and incontinence of bladder and bowel. (Dept. Ex. 11, pp. 7, 10-12, 15, 18, 36-41, 44; Dept. Ex. 10)

62. Phenol neurolysis for Patient B in July, 1986 was contraindicated. At the time, the patient was 39 years old with a life expectancy of 78 years. Caudal epidural phenol neurolysis carries a high risk of urinary and fecal incontinence and impotence as well as sensory loss, paraplegia and paralysis. Patient B's pain was caused by arachnoiditis, which cannot be treated with neurolysis. Further, as demonstrated by Respondent's previous attempts, Patient B's epidural space was compromised by multiple prior surgeries, including spinal fusions demonstrating that the appropriate nerves could not be neurolyzed via the epidural space. (T. 233-234, 250-251)

63. Patient B's pain did not improve as a result of the caudal epidural phenol neurolysis. (Dept. Exs. 10, 11)

PATIENT C

64. Respondent treated Patient C from on or about March 14, 1989 to on or about October, 1993, at the Albany Medical College Pain Management Center and his office. (Dept. Ex. 24; Dept. Ex. 25)

65. On March 5, 1988, Patient C, a nurse working for the Visiting Nurses' Association, fell leaving a patient's house and sustained an injury to her right wrist. Patient C went to an urgent care center where X-rays were negative. Patient C was referred to Dr. Khanuja, an orthopedic surgeon. A diagnosis of median nerve contusion was made. Conservative treatment was ordered with a cast for three (3) weeks. (Dept. Ex. 25, pp. 6-7, 15)

66. On June 22, 1988, Dr. Khanuja performed carpel tunnel release surgery with no improvement. On August 11, 1988, Dr. Khanuja performed a combined right DeQervains and right trigger thumb release with no improvement. In February, 1989, Dr. Khanuja referred Patient C to Dr. Semenoff, a neurosurgeon. A MRI of the cervical spine was normal and Dr. Semenoff referred Patient C to the Respondent. While under the care of Dr. Khanuja, Patient C was treated with Percocet, one (1) every six (6) hours and Darvocet, one (1) every three (3) hours. (Dept. Ex. 25, pp. 6-7, 15)

67. Patient C was seen for an initial office visit by the Respondent on March 14, 1989. Respondent diagnosed RSD of the right upper extremity, discontinued use of the TENS unit, discontinued Darvocet, and increased Percocet to two (2) tablets every six (6) hours to a maximum of eight (8) per day. (Dept. Ex. 23, p. 25)

68. Respondent was aware of Patient C's history of major depression at the initial visit requiring hospitalization in 1983 and continuing psychiatric treatment to the time of her injury in 1988. (Dept. Ex. 25, p. 9, 15, 17, 61, 199, 311; T. 599-600)

69. On March 15, 1989, Respondent performed a stellate ganglion block which provided four (4) hours of pain relief, after which the hand returned to normal. (Dept. Ex. 25, p 55)

70. On March 20, 1989, Respondent performed a second stellate ganglion block which yielded six (6) to eight (8) hours of hand relief. (Dept. Ex. 25, p. 54)

71. On March 27, 1989, Respondent admitted Patient C to the Albany Medical Center Hospital where a continuous cervical epidural block was attempted. Relief to the affected hand was not achieved. The procedure was abandoned when it was discovered that the catheter was out. A continuous axillary nerve block was performed without significant benefit. Patient C was discharged home on Voltarin. (Dept. Ex. 25, pp. 149-153, 313)

72. On April 13, 1989, Patient C was seen by Respondent for an office visit. Respondent noted that there was not much improvement since the continuous axillary block and the patient was now complaining of neck, shoulder and arm pain. Tegretol and Percocet were continued. (Dept. Ex. 25, p. 53)

73. On May 16, 1989, Patient C was seen for an office visit by an associate of Respondent. It was noted that past management with stellates, cervical epidural and axillary block provided no significant change. Medications were noted to include: Tegretol, Percocet, Amitryptilene, and Voltarin. An IV Lidocaine infusion for two and one-half (2 1/2) hours was performed without effect. (Dept. Ex. 25, pp. 52, 306)

74. On June 29, 1989, Patient C was seen for an office visit by Respondent who noted that the patient still complained of severe pain in the right arm with periods of cold and swelling. The Percocet is barely holding her pain in check. Respondent noted a good range of motion, good color and no neurological deficit. Respondent ordered IV Buprenex, 0.3 mgs., four (4) times a day, which began on June 30, 1989. (Dept. Ex. 25, pp. 51, 188)

75. Patient C was a 35 year old woman suffering from chronic, non-malignant pain. IV Buprenex was not indicated for Patient C. (T. 28-37, 201-202)

76. On July 13, 1989, Respondent referred Patient C to Donna M. Pietrocola, M.D., a surgeon, for placement of a Hickman catheter, which was inserted shortly thereafter at the Albany Medical Center Hospital. (Dept. Ex. 25, p. 269)

77. On November 27, 1989, Patient C was seen for an office visit by Respondent. IV Buprenex, Tegretol and Voltarin were continued and Patient C was scheduled for a bier block. (Dept. Ex. 25, p. 50)

78. On January 4, 1990, Respondent performed a right upper extremity Bier block with 35 cc. of 0.5% Lidocaine, Bretylium 150 mg., and Depomedrol, 40 mg., total volume 43 cc., at the Albany Medical Center Hospital Ambulatory Surgery Center, without significant pain relief. (Dept. Ex. 25, pp. 147-148, 309)

79. On February 1, 1990, Respondent performed a right infraclavicular brachial plexus block and steroid injection at the Albany Medical Center Hospital Ambulatory Surgery Center without significant pain relief. (Dept. Ex. 25, pp. 146, 307)

80. On March 3, 1990, Patient C was seen for an office visit by Respondent who noted three (3) days of relief after the infraclavicular injection and planned two (2) further Bier blocks without steroids. (Dept. Ex. 25, p. 49)

81. On April 16, 1990, Respondent performed a Bier block at the Albany Medical Center Hospital Ambulatory Surgery Center using 40 cc. of 0.5% Lidocain, 300 mgs. of Bretyluem and 40 mg. of Depomedrol, without significant relief. (Dept. Ex. 25, pp. 143, 305)

82. On April 18, 1990, Respondent performed a Bier block at the Albany Medical Center Hospital Ambulatory Surgery Center using the same medications noted in Finding 81, without significant relief. (Dept. Ex. 25, pp. 142, 305)

83. On April 19, 1990, Respondent performed a Bier block at the Albany Medical Center Hospital Ambulatory Surgery Center using the same medications noted in Finding 81, with the exception of the Depomedrol, without significant relief. (Dept. Ex. 25, pp. 141, 305)

84. On June 18, 1990. Patient C was seen for an office visit by Respondent who noted that her pain persisted, Tegretol was helping and that pain wakes her from sleep. (Dept. Ex. 25, p 46)

85. On July 25, 1990, cervical epidural phenol neurolysis was planned for August 27, 1990. (Dept. Ex. 25, p. 45)

86. On August 29, 1990, Patient C was seen for an office visit by Respondent who noted an elevated LDH and changed all medications except IV Buprenex. A continuous cervical epidural block was planned. (Dept. Ex. 25, p. 44)

87. On September 17, 1990, Respondent admitted Patient C to the Albany Medical Center Hospital. The admission note indicates a planned continuous cervical epidural block followed by phenol. After placement of the cervical epidural catheter, six percent (6%) phenol solution was injected on two (2) successive days with questionable transient benefit. On the third day, the catheter was found to be kinked and was removed after injection of dye caused severe pain. Patient C was discharged on September 21, 1990, on IV Buprenex. (Dept. Ex. 25, pp. 133-140, 304)

88. On October 2, 1990, Patient C was seen for an office visit by Respondent who noted that the phenol helped for several hours only, and planned to admit Patient C for either phenol or continuous epidural block in several weeks. (Dept. Ex. 25, p. 43)

89. On October 29, 1990, Respondent admitted Patient C to the Albany Medical Center Hospital for cervical epidural phenol neurolysis. On October 31, 1990, Patient C started having severe pain in her back and started spiking a fever. The catheter was subsequently removed and Patient C was discharged on November 2, 1990. No significant pain relief was obtained from this procedure. (Dept. Ex. 25, pp. 128-132, 302)

90. In 1990, Patient C was 36 years old with a normal life expectancy and chronic non-malignant pain of unclear etiology. The previous attempt at cervical epidural block with a local anesthetic was reported as unsuccessful, and was not repeated. Other less invasive treatment modalities had not been exhausted. Cervical epidural phenol neurolysis was not indicated for Patient C and provided no benefit. (T. 195-197; 203; 214, 11. 16-23; 215)

91. On November 26, 1990, Patient C was seen for an office visit by Respondent who noted severe pain in her entire arm and that IV Buprenex helps most of the time. Buprenex was changed from intermittent to continuous infusion. (Dept. Ex. 25, p. 42)

92. On December 17. 1990, Patient C was seen for an office visit by Respondent and IV Buprenex was increased. (Dept. Ex. 25, p. 41)

93. On January 25, 1991, Patient C was evaluated by Dominic J. Belmonte, M.D. at the request of the State Insurance Fund. Dr. Belmonte diagnosed a moderate disability with no muscle atrophy and marked psycho/physiologic overlay. He agreed that Respondent had little more to offer Patient C and recommended discontinuation of IV Buprenex. (Dept. Ex. 25, pp. 16-19)

94. On June 3, 1991, Patient C was seen for an office visit by Respondent who noted continued pain in the right upper extremity and new onset of pain in the left upper extremity , shoulder and hand following a fall in April, 1990. His impression was chronic RSD of the right upper extremity and possible new onset of RSD to the left upper extremity. Respondent scheduled Patient C to return on June 4, 1991, for stellate ganglion block of the left upper extremity and continued her medications including IV Buprenex. (Dept. Ex. 25, p. 39)

95. On June 24, 1991, Respondent performed a left stellate ganglion block with eight (8) cc's of two percent (2%) Bupivacaine. A possible Horner's Syndrome was noted after the injection. (Dept. Ex. 25, p. 38)

96. On July 22, 1991, Respondent admitted Patient C to the hospital and performed a continuous cervical epidural block with local anesthetic. (Dept. Ex. 25, pp. 124-127)

97. On August 20, 1991, Patient C was seen for an office visit by Respondent who noted that she had been on IV Buprenex for two (2) to three (3) years with "great success." Respondent planned to request approval from the insurance company to continue the use of IV Buprenex. (Dept. Ex. 25, p. 37)

98. On November 20, 1991, Patient C was seen for an office visit by Respondent. A continuous cervical epidural with local anesthesia was planned for January 21, 1992 and Respondent planned to try a continuous infusion of Buprenex noting that, while he had recommended it be done at home, her insurance company refused. (Dept. Ex. 25, p. 36)

99. On January 22, 1992, Patient C was evaluated by Sander Orent, M.D., the Medical Director of the Occupational Health Service at St. Francis Hospital, Poughkeepsie, New York. Dr. Orent was concerned about the diagnosis of RSD, at least to any severe degree, as he found no evidence of temperature changes, no atrophy and no swelling. He felt the patient had chronic pain syndrome, complicated by narcotic addiction. His diagnosis was chronic pain of both arms; he was unable to rule out RSD, but it does not appear to be present to a severe degree. Dr. Orent recommended discontinuation of IV Buprenex, referral to a hand specialist, a long term pain management program and occupational therapy. (Dept. Ex. 25, pp. 21-25)

100. On March 30, 1992, Respondent attempted a cervical epidural block at the Albany Medical Center Hospital. A subarachnoid puncture was noted, the procedure cancelled and Patient C was discharged. (Dept. Ex. 25, pp. 122-123)

101. On April 14, 1992, Patient C was seen for an office visit by Respondent who noted C6-7 pain in the right upper extremity since the subarchboid puncture, severe at first but slowly importing. No post-spinal headache was noted. Respondent's plan was to schedule a continuous epidural block for the middle of June and continue Patient C on IV Buprenex. (Dept. Ex. 25, p. 35)

102. On June 22, 1992, Respondent admitted Patient C to the Albany Medical Center Hospital for continuous epidural block with local anesthetic. Discharge medications included Mexitil and IV Buprenex. (Dept. Ex. 25, pp. 121-122)

103. On July 3, 1992, Patient C was seen for an office visit by Respondent who noted that her pain level was 6-7/10 as compared to 10 plus/10 prior to the most recent block. Respondent's plan was to schedule Patient C for a continuous cervical epidural block in October and continue IV Buprenex as well as Mexitil. (Dept. Ex. 25, p. 34)

104. On October 5, 1992, Respondent admitted Patient C to the Albany Medical Center Hospital for continuous cervical epidural block with a local anesthetic. Patient C was discharged on October 10, 1992. Discharge medications included IV Buprenex. (Dept. Ex. 25, pp. 113-119)

105. On October 19, 1992, Patient C was seen for an office visit by Respondent who noted that the patient described her pain as 10/10 pre-block and 4/10 that day. Respondent planned to schedule Patient C for a continuous cervical epidural block in February and continued IV Buprenex. (Dept. Ex. 25, p. 31)

106. On October 30, 1992, Patient C was evaluated by Charles Kalman, M.D. at the request of the State Insurance Fund. Dr. Kalman felt Patient C was subjectively symptomatic from what appeared to be a mild form of RSD. Her clinical course had not followed the characteristic trend of RSD with no trophic changes, no contractures and her pain had actually increased rather than decreased. He opined that her disability was largely subjective. He did not believe continuous cervical epidural blocks should be scheduled on a regular basis and did not think scheduling them every four (4) to six (6) months was in keeping with the nature of RSD. As she was feeling better at the time of evaluation, Dr. Kalman thought it a perfect opportunity to address her narcotic addiction with detoxification. He believed she should be mentally and physically reconditioned and an alternative means of treatment to try to get her off the IV Buprenex. Dr. Kalman thought it important that Patient C stop the IV Buprenex because of the adverse effect it has on one's mind and body. (Dept. Ex. 25, pp. 198-204, 246-252)

107. On December 9, 1992, Respondent scheduled Patient C for a continuous epidural cervical block on January 25, 1993. This planned procedure was cancelled when the insurance company denied approval pending a second opinion. (Dept. Ex. 25, pp. 25, 205)

108. On January 19, 1993, Patient C was seen for an office visit by Respondent. The patient reported that she was seen by Dr. Kalman that day, who informed her that he would not approve further continuous cervical epidural blocks for RSD, wanted to refer her to another specialist and recommended detoxification. IV Buprenex was continued. (Dept. Ex. 25, p. 30)

109. On January 19, 1993, Patient C was seen by Dr. Kalman for a second consultation. Dr. Kalman found Patient C to be symptomatic from a mild reflex sympathetic dystrophy in both upper extremities and opined that her prognosis was poor unless there was some change in her current treatment protocol. He recommended that she continue to see Dr. Greenhouse, but for some treatment other than continuous cervical epidurals, since they had not altered the long term course of her disease. He felt that she was becoming both psychologically and physically addicted to the blocks in the same fashion that she had become addicted to the IV Buprenex. Dr. Kalman felt that the patient's main problem was physical and mental deconditioning and that these factors played as prominent a role in her condition as the RSD itself. Dr. Kalman recommended no further continuous cervical epidurals at that time and felt that the Patient should be referred to another pain management specialist for evaluation. (Dept. Ex. 25, pp. 241-244)

110. After the cervical epidural phenol neurolysis in September and October of 1990, there was no rational or medical justification for further cervical epidural blocks. All previous blocks had failed. After phenol neurolysis, there was nothing further to be blocked. (T. 198-199, 216)

111. Patient C continues under Respondent's care. On March 22, 1995, she was evaluated by David M. Richlin, M.D. at the Albany Medical College Pain Management Center. At that time Patient C was receiving IV Buprenex and MS Contin from Respondent as her primary therapeutic modality. (Dept. Exs. 24; 25, pp. 5-12; T. 594)

PATIENT D

112. Respondent treated Patient D from on or about May 18, 1988 to on or about October 26, 1993, at the Albany Medical College Hospital Pain Management Center and his office. (Dept. Exs. 26, 27)

113. Patient D was injured while lifting trash bags at work in March, 1988. She saw multiple physicians for complaints related to back pain. The results of diagnostic studies, physical findings and subjective complaints were inconsistent. The symptom complex was most consistent with muscular/myofascial strain with elements of symptom magnification. A myelogram and electrodiagnostic studies were performed in the first part of 1988 and were interpreted as normal. A series of two (2) epidural injections were performed in June, 1988 by Respondent. A second series of epidural injections took place in August, 1988, when the patient experienced a postdural puncture headache and underwent two (2) "blood patches" for treatment. Through the end of 1988 and early 1989, Patient D underwent chiropractic treatments. Attempts to institute a return to work were unsuccessful and the patient did not improve. Further diagnostic studies, including a CT scan, two (2) MRI's and electrodiagnostics were normal. On January 24, 1990, Patient D underwent surgery for bilateral laminotomy, foraminotomies and S1 nerve root decompression with L5-S1 posterolateral fusions. On discharge from the hospital, marked improvement was noted with complete resolution of sciatic symptoms. Within seven (7) weeks of surgery, symptoms recurred. No examiner prior to August, 1990, reported signs or symptoms of RSD. (Dept. Ex. 27, pp. 1-21, 36-42)

114. On August 6, 1990, Patient D was seen for an office visit by Respondent who noted that she was last seen two (2) years ago after a steroid epidural with wet tap and blood patches. Patient D complained of pain in the lower leg with periods of cold and icyness. Respondent noted a finding that the left foot was pale and cold compared to the right. His plan was to perform a steroid caudal injection with local anesthesia. Tylenol #3, one every three (3) hours, and Valium, two (2) mg., two (2) tablets at bedtime, were prescribed. (Dept. Ex. 27, p. 71)

115. On August 6, 1990, Respondent made a diagnosis of lumbar plexopathy and reflex sympathetic dystrophy. (Dept. Ex. 27; pp. 280, 314)

116. A February 24, 1992 consultation report indicates that on August 15, 1990, a caudal steroid epidural was attempted but had to be removed the next day because it leaked. There is no operative report of this procedure in Respondent's records. However, the procedure was reported as unsuccessful. (Dept. Ex. 27, pp. 39, 168-198, 326)

117. On September 24, 1990, Patient D was seen for an office visit by Dr. Vasquez, an associate of Respondent. It was noted that the patient was status/post caudal epidural. She had numbness in her leg, but when the medication wore off the pain returned to her low back, buttocks and leg. Dr. Vasquez found that Patient D had back trigger points and that, when the left sciatic nerve was pressed, pain in her buttock with radiation was elicited. Dr. Vasquez administered trigger point injections with 0.5% Bupivacaine 15 cc. which did not relieve the pain. No signs or symptoms of RSD were noted. Tylenol #3, one (1) every three (3) hours, and Valium, two (2) mg., two (2) tablets at bedtime, were continued. (Dept. Ex. 27, p. 70)

118. On November 1, 1990, Patient D was seen for an office visit by Respondent who noted that the patient was very uncomfortable with painful and cold lower extremities. He noted that all previous steroid epidurals and caudals had failed to achieve much in the way of adequate pain relief. Respondent described Patient D's lower extremities as pale, cold and mottled. Respondent's impression was lumbarplexopathy with reflex sympathetic dystrophy. His plan was to schedule the patient for a continuous lumbar epidural injection for sympathetic blockade. Procardia was prescribed; Tylenol #3 and Valium were continued. (Dept. Ex. 27, pp. 69, 277)

119. On December 17, 1990, Respondent admitted Patient D to the Albany Medical Center Hospital for a continuous lumbar epidural block followed by continuous infusion of sensorcaine. In his discharge summary Respondent wrote "the patient was admitted for placement of a continuous epidural catheter for reflex sympathetic dystrophy." On December 17, 1990, Patient D was brought to the operating room for placement of an epidural catheter. During the attempt at placement of the catheter, several procedures were attempted with little success. It was finally accomplished with a paramedial approach. The discharge summary indicates that the catheter was "threaded" and the patient had good warm legs with good sympathetic block. On December 18, 1990, the patient complained of a severe headache. The discharge summary indicates that leaking around the catheter was noted, an injection of sensorcaine through the catheter afforded immediate relief, that there was much wetness around the catheter, and that it was removed the next day. Progress notes for December 18, 1990 state that the patient complained of a severe headache which he described as typical spinal in nature and that Respondent planned to discontinue the epidural, start IV caffeine, Motrin and IV Buprenex. (Dept. Ex. 27, pp. 182-183, 195-196)

120. On December 18, 1990, Respondent had ordered IV Buprenex for Patient D. On December 19, 1990, Patient D continued to complain of severe post-spinal headache and felt the Buprenex was helping. Respondent ordered continuous Buprenex infusion, discontinuance of Motrin and continuance of caffeine and fluids. On December 20, 1990, Patient D's symptoms continued despite caffeine and fluids. Nausea was noted. A blood patch was discussed, but the patient refused. Respondent ordered that the IV Buprenex be discontinued and IV morphine sulfate started. On December 21, 1990, Patient D's headache was somewhat better, and she was continued on IV morphine sulfate. On December 22, 1990, Patient D's headache was much better and morphine sulfate was continued. On December 24, 1990, Patient D was discharged from the hospital and given prescriptions for Valium and MS Contin, 60 mg., twice a day. (Dept. Ex. 27, pp. 182-183, 195-197)

121. On December 26, 1990, Patient D was seen for an office visit by Respondent who noted continuous recurring headache since the epidural one (1) week ago. Morphine sulfate for intramuscular injection was prescribed and MS Contin was continued. (Dept. Ex. 27, pp. 68, 87, 138)

122. On January 4, 1991, Patient D was seen for an office visit by Respondent who noted improvement of the post-spinal headache. Patient D was "...told to return in three (3) to four (4) weeks for follow-up and discussion of long term of her RSD." 0% efficacy of the epidural block was noted. Fiorcet, Tylenol #3, three (3) times daily and Valium, five (5) mg. twice a day, was prescribed. (Dept. Ex. 27, pp. 67, 323, 325)

123. On February 24, 1991, Respondent prescribed Tylenol #3, two (2) tablets every six (6) hours. No office visit was recorded. (Dept. Ex. 27, pp. 87, 137)

124. On February 26, 1991, Patient D was seen for an office visit by Respondent who noted she was returning for a follow-up visit concerning her low back pain which is 10/10 and is centered in her lower back and radiates to the posterior aspect of her left lower extremity accompanied by numbness and paraesthesia. Respondent noted that she was presently taking Tylenol #3 and Valium five (5) mg. at bedtime. Respondent prescribed Methadone, five (5) mg. by mouth every four (4) hours and Pamelor 25 mg. at bedtime. (Dept. Ex. 27, pp. 66, 87, 135)

125. On March 5, 1991, Patient D was seen for an office visit by Respondent who reported that one (1) week previously the patient felt a snap in her back while lifting something and that the pain in her low back radiating down her legs had been excruciating ever since. Patient D indicated that Methadone did not help. Respondent's plan stated that, since all procedures had failed in the past, it was decided to consider further medication to control the pain. In the interim, Patient D was given MS Contin for one (1) week and "we will try to get approval for a trial of Buprenex for pain control. Patient is agreeable to both of these conditions, script given and Caremark called." A prescription for MS Contin, 30 mgs. twice a day, 15 tablets, was issued. (Dept. Ex. 27, pp. 65, 134)

126. IV Buprenex was started on March 12, 1991 through a peripheral line. (Dept. Ex. 27, pp. 229, 319)

127. On April 19, 1991, Respondent admitted Patient D to the Albany Medical Center Hospital for placement of a Hickman catheter. Patient D was discharged on April 24, 1991 on IV Buprenex, 0.6 mg. every three (3) hours. (Dept. Ex. 27, p. 177)

128. On March 25, 1991, Buprenex was increased to 0.45 mg., four (4) times a day with one (1) extra dose as needed. On April 24, 1991, Respondent increased Buprenex to 0.6 mg. every three (3) hours. On April 25, 1991, MS Contin, 20 mgs. twice a day was added. (Dept. Ex. 27, p. 87)

129. On May 9, 1991, Patient D was seen by Respondent complaining of a burned back from using her heating pad, upper extremity swelling bilaterally and inadequate pain control from the IV Buprenex. Samples of Feldene were given to supplement the IV Buprenex. (Dept. Ex. 27, p. 64)

130. Patient D continued to complain of inadequate pain control with IV Buprenex on May 15, 1991 and the frequency of Buprenex was increased on May 17, 1991. (Dept. Ex. 27, pp. 87, 321)

131. On May 28, 1991, Patient D was seen for an office visit by Respondent. She complained of severe chest and shoulder pain on the right side. Respondent noted that over the past couple of weeks the patient had been complaining of increased pain and had been asking for Demoral or Morphine. Patient D was placed on Roxicodone, two (2) tablets every three (3) hours, and was sent to the emergency room to have the Hickman catheter removed. Respondent planned to have Patient D try oral medications for a few days and then have a peripheral IV line inserted to restart her Buprenex. (Dept. Ex. 27, p. 28)

132. As of June 4, 1991, Patient D was receiving one (1) cc of IV Buprenex every three (3) hours ordered by the Respondent. (Dept. Ex. 27, p. 332)

133. Patient D was continued on IV Buprenex until June 11, 1992, when it was discontinued and Methadone was prescribed. On or about June 17, 1991, a peripheral IV line was restarted by the home care agency. In late June, a Hickman catheter was reinserted. In late August, Patient D was hospitalized for a catheter infection. In September, 1991, the Hickman catheter was discontinued and peripheral IV's restarted. (Dept. Ex. 27, pp. 32-33, 36-42, 50-61, 219, 227)

134. Reflex sympathetic dystrophy (RSD) is a painful condition usually involving one (1), and occasionally both, limbs that follows some traumatic event or surgery. The pain is described in very specific terms which include words like burning, tingling or numbing. It is associated with a variety of specific physical findings that are consistent with vasomotor or sudomotor changes. These involve the autonomic nervous system and include variations in objective temperature of the skin, variations in the color of the skin, changes involving the hair growth, changes involving the nails and changes involving the quality and texture of the skin. It is a diagnosis that requires a considerable amount of workup to confirm or exclude including, most importantly, a thorough history and physical examination that should be repeated over time, consultation with a neurologist to help corroborate findings, and a sympathetic nerve block. In the upper extremity, a stellate ganglion block and in the lower extremity a lumbar sympathetic block, are the most confirmatory tests. None of the list were ordered or carried by Respondent for Patient D. (Dept. Ex. 27, T. 23-28, 75, 77-78)

CONCLUSIONS WITH REGARD TO FACTUAL ALLEGATIONS

PATIENT A:

The Respondent treated Patient A at the Albany Medical Center Hospital's Pain Management Center from January 28, 1991 to August 10, 1992 on referral from Dr. E. J. Ballantine. Finding 8, Dept. Ex. 2, p. 5.

Allegation 2:

It is alleged that the Respondent ordered and administered epidural phenol on March 19, June 4, and October 14, 1991 for Patient A without adequate medical justification.

On the Respondent's first office visit on January 28, 1991, the Respondent was told that previous treatments included stellate, Bier and axillary blocks that provided limited pain relief and that Percocet did provide some pain relief. Finding 10. The Respondent scheduled a continuous axillary block and prescribed Percocet. Finding 10.

The axillary block was provided, without significant relief in early February, and the Patient was continued on Percocet until an office visit on February 25, 1991. At that time, the Respondent scheduled Patient A for the first continuous cervical epidural phenol injection, a phenol neurolysis, on March 20, 1991. One day later, an infection cancelled the treatment. Intravenous (IV) Buprenex was used during hospitalization and scheduled for home use on March 27. There was no pain relief from the phenol neurolysis. Findings 11, 12, 14,15, 16.

Following an April 23, 1991 office visit, the second phenol neurolysis was scheduled for June 4, 1991. On the second day of the procedure the patient developed sympathectomy on the right instead of the left side, and the procedure was discontinued. The IV Buprenex continued; the neurolysis provided no pain relief. Three (3) months later the Respondent had developed

sympathectomy of the right side resulting from the second phenol neurolysis. The fingers of the right hand had numbness and parathesia. The patient's third phenol neurolysis was scheduled and IV Buprenex prescribed as a continuous infusion with IV morphine sulfate added on September 24, 1991. Findings 17, 19, 20, 21, 22.

After an October 14th admission to the hospital, the third neurolysis commenced on October 15, 1991. On October 16th, the catheter was plugged prior to initiation of treatment; further injection was not undertaken. The patient was discharged on IV Buprenex and IV morphine sulfate. Finding 23.

Phenol (carbolic acid) is a neurolytic agent used to destroy nerve fibers. During a phenol neurolysis, phenol is injected by catheter into the ganglion area thought to be responsible for the pain. Sensory and autonomic nerves' fibres are permanently destroyed. Procedural risks include paralysis, paraplegia, quadriplegia, infection, hematoma, deafferentation pain, and creation of unintended sympathectomy to previously unaffected areas. Epidermal phenol neurolysis is indicated for the treatment of severe, chronic, malignant pain in patients with a short life expectancy in whom all other treatment modalities have been tried and failed. Finding 39.

Patient A was approximately 38 years old with a normal life expectancy. His chronic pain was benign, non-cancerous and not malignant. Respondent subjected Patient A to phenol neurolysis less than 60 days after the patient came under his care without exhausting all other treatment modalities. Cervical epidural phenol neurolysis was not indicated for Patient A. Finding 40.

The Hearing Committee concludes that the Respondent ordered and administered epidural phenol on or about March 19, June 4 and October 14, 1991, without medical justification.

Allegation 3:

It is alleged that the Respondent recommended and/or referred Patient A for a surgical sympathectomy without adequate medical justification.

On January 9, 1991, Dr. Edward J. Ballantine referred the medical record of Patient A to the Respondent in his capacity as Director of the Pain Management Center for the Center's review. Dr.

Ballantine requested a report of the Respondent's examination and recommendations. (Dept. Ex. 2, p. 5.; Finding 8). Prior to discharge from the hospitalization for the third phenol neurolysis, the Respondent referred Patient A to a surgeon for consideration of a surgical sympathectomy. Finding 24.

The Hearing Committee concludes that the decision on whether to proceed with a surgical sympathectomy was the decision of the surgeon in conjunction with the patient. Respondent was the consultant who provided the record and a rationale for referral of the case for surgical intervention. The Committee concluded that medical justification can be present for a referral-but it is the responsibility of the surgeon to make the decisions for or against surgery.

Allegation 4:

It is alleged that the Respondent ordered IV Buprenex (buprenorphine) without medical justification.

During Patient A's hospitalization on March 19, 1991, for the first scheduled phenol neurolysis, the Respondent prescribed IV Buprenex. Finding 14. After discharge, the patient was to start continuous IV Buprenex. Findings 14, 16. During the patient's second scheduled phenol neurolysis, the patient was discharged on IV Buprenex. Finding 19. Three (3) months later, the IV Buprenex was changed from an intermittent injection to a continuous infusion. Finding 21. On September 24, the volume of IV Buprenex was increased and IV morphine sulfate added. Finding 22. On October 17, the same two (2) medications were prescribed by the Respondent after discharge from the hospital following the third scheduled phenol neurolysis. Finding 23.

Following a left surgical sympathectomy, IV Buprenex was continued and subsequently increased. Findings 29, 30. After the patient complained of severe pain while taking IV Buprenex, the Respondent substituted IV Dilaudid on December 18, 1991. Finding 32. On January 23, 1992, on the Patient's Dilaudid complaint, the Respondent returned the patient to IV Buprenex. Finding 33.

In mid-May, 1992, the patient complained of intense pain, and the Respondent changed IV Buprenex to a continuous infusion, which was followed by a change to intermittent injections. Finding 34. In August, the patient scheduled a three (3) month European trip. Respondent discontinued the Buprenex and prescribed MS Contin, Percocet and Roxycodine. Finding 35. On the patient's return in November, IV Buprenex was restarted. Finding 36.

In January, 1993, Patient A called to request the start of oral analgesics and the discontinuance of IV Buprenex. Finding 37. In February, the Respondent's office was advised that Patient A was no longer using IV Buprenex; such was confirmed by the home health care agency and the patient. Finding 38.

Buprenex (buprenorphine) is a synthetic narcotic classified as an agonist/antagonist that is associated with a low incidence of physical dependence but is knows to have the potential for psychological dependence. Buprenex has a ceiling effect: once a patient receives a certain dose, no further analgesia can be achieved no matter how much more of the drug is given. It is only available in the United States as an intravenous drug. Finding 42.

The use of Buprenex for chronic pain requires long term intravenous access, with its' associated risks and morbidity. The intravenous mode of treatment has a significant impact on the patient's independence, mobility and autonomy. The surgical procedure for inserting a line for continuous intravenous infusion is associated with risks. The maintenance of the line carries risks for infection, the device falling out, risks of the patient abusing it and giving other drugs through it. The cost is dramatically, by a number of orders of magnitude, different in that the maintenance of this IV treatment at home requires considerable resources in terms of skilled nursing, home care, frequent visits and the provision of these intravenous drugs which are subject to a high mark-up in the absence of any demonstrated advantages over oral treatment. (T. 34) It requires them to become significantly more dependent on the medical system with likely psychological harm and interference with possible rehabilitation. The intravenous route of administration is not indicated unless all oral opioids have been tried and failed, or oral medications cannot be tolerated by the patient. Finding

43.

Before visiting the Respondent, Patient A was being treated with oral medications from August, 1987 to December, 1989. Percocet, limited to 20 per month and Lortab, 7.5 mgs., one (1) every four (4) hours, was prescribed ten (10) days prior to visiting the Respondent. There was neither an adequate trial or a failure of oral medications. Patient A had evidence of his ability to tolerate oral medications. Finding 44.

The Hearing Committee concludes the Respondent ordered IV Buprenex (buprenorphine) without medical justification.

Allegation 5 :

It is alleged that the Respondent falsely stated in an April 9, 1991 letter to Crawford and Company that "All oral medications were either ineffective or caused serious side effects."

The letter to Crawford and Company is included in the record as Dept. Ex. 2, pp. 159-160. The quotation is in the last sentence of paragraph 3, p. 159.

The Respondent's position is that the quoted statement reflected his best judgement. He determined that Percocet was no longer effective and methadone resulted in side effects. At that time the Respondent had a "hierarchy" for prescribing pain medication: from Percocet to IV Buprenex to the narcotics. He believes Buprenex to be a very safe medication. There was no intentional misrepresentation by the Respondent. T. 337-338.

The Hearing Committee concludes the Respondent was being candid. The record does not cast doubt on his statement.

PATIENT B

The Respondent treated Patient B from on or about May, 1985 to on or about November 1, 1992, at the Albany Medical Center Hospital and at Respondent's office at 3 Columbia Circle, Albany, New York. Finding 45.

Allegation 1:

It is alleged the Respondent arranged, recommended and/or ordered a bilateral surgical lumbar sympathectomy on or about June 13, 1985, without adequate medical justification.

On May 30, and June 3, 1985, the Respondent performed a left paravertebral lumbar sympathetic block on Patient B and performed a second left, and a right block on Patient B on June 3, 1985. Finding 49.

On June 6, 1985, the Respondent, in his consultative capacity to Dr. Kite, reviewed the results of his procedures with Dr. Kite, the referring surgeon, and several options that could be considered including a surgical sympathectomy. The patient and his two (2) surgeons, Drs. Kite and Denton, determined that the surgery should be performed. Finding 50; See T. 461-463, 463, 11. 6-11)

The lumbar sympathectomy was performed by Dr. Denton on June 13, 1985.

The Hearing Committee concludes that the medical justification determination on performance of the surgical sympathectomy on Patient B was not made by the Respondent.

Allegation 2:

It is alleged the Respondent performed, recommended and/or ordered implantation of a permanent thoracic epidural catheter and port-a-cath infusion well on or about August 23, 1985, without medical justification.

The Respondent agreed that the use of the permanent catheter may have been premature, but he had had some success in using the method previously. He would not use the method today. Finding 54.

The Hearing Committee concludes that the implantation of the permanent thoracic epidural catheter and port-a-cath infusion well on August 23, 1985 was medically justifiable at the time.

Allegation 3:

It is alleged the Respondent ordered and/or performed caudal epidural phenol injections on

or about July 21, 22 and/or 23, 1986, without medical justification.

On July 21 and 23, 1986, Respondent initiated two (2) Patient B phenol neurolysis at Albany Medical Center Hospital. Finding 60.

As a result of the caudal epidural phenol neurolysis in July, 1986, Patient B suffered permanent impotence and incontinence of bladder and bowel. Finding 61.

Phenol neurolysis for Patient B in July, 1986 was contraindicated. The patient was 39 years old and had a life expectancy of 78 years. Caudal epidural phenol neurolysis carries a high risk of urinary and fecal incontinence and impotence as well as sensory loss, paraplegia and paralysis. Patient B's pain was caused by arachnoiditis, which cannot be treated with neurolysis. As demonstrated by the Respondent's previous attempts, Patient B's epidural space was compromised by multiple prior surgeries, including spinal fusions. Such demonstrated that the appropriate nerves could not be neurolyzed via the epidural space. Findings 46, 47, 62, 57.

The Hearing Committee concludes the Respondent ordered and performed caudal epidural phenol injections on July 21 and July 23, 1986 without medical justification.

Allegation 4:

It is alleged that the Respondent ordered IV Buprenex beginning in August, 1986, without adequate medical justification.

From about June 20 to about October 18, 1986, Patient B was prescribed IV Buprenex by the Respondent. Finding 58. During the period, after a limited pause in IV Buprenex medication, the Respondent restarted the medication on August 6, 1986.

Oral opioids, especially Percocet and Methadone, had been used to treat Patient B for only short periods of time when the epidural catheter and port-a-cath were not working. Prior to referral to the Respondent, the patient had not been under medical care for two (2) years. There was neither an adequate trial, or a showing that the patient was unable to tolerate oral pain medications. The use of Buprenex for chronic pain requires long term intravenous access with the risks and morbidity associated therewith. There is a significant impact on the patient's independence, mobility and

autonomy, requiring the patient to become significantly more dependent on the medical system with likely psychological harm and interference with possible rehabilitation. The IV and IM routes of administration are not indicated unless all oral opioids have been tried and failed, or oral medications cannot be tolerated by the patient. The Respondent did not want to use morphine or "Heavy duty drugs" on Patient B in 1986 and 1987 because it was frowned upon to use these narcotics in the treatment of non-malignant pain. Dept. Ex. 11, pp. 278-279; Finding 59.

The Hearing Committee concludes the Respondent ordered IV Buprenex beginning in August, 1986, without adequate medical justification.

PATIENT C

The Respondent treated Patient C from on or about March 14, 1989 to on or about October at the Albany Medical Center Hospital and his office. Finding 64.

Allegation 2:

It is alleged the Respondent ordered and/or performed cervical epidural blocks on September 17, 1990; October 29, 1990; July 22, 1991; March 30, 1992; June 22, 1992; October 5, 1992 and January 25, 1993, without medical justification.

The Respondent was aware of Patient C's history of major depression at her initial visit requiring hospitalization in 1983 and her continuing psychiatric treatment to the time of her injury in 1988. Finding 68. At the patient's initial office visit to the Respondent in March, 1989, the Respondent diagnosed RSD of the upper right extremity and increased the frequency of Percocet use. Finding 67.

On September 17, 1990 Patient C entered Albany Medical Center Hospital (hereinafter:"AMCH") for a continuous cervical epidural block followed by phenol. The continuous block was not performed. After placement of the cervical epidural catheter, a six percent (6%) phenol solution was injected on two (2) successive days with questionable transient benefit. Finding 87.

On October 29, 1990, Respondent admitted the patient to AMCH for a cervical epidural phenol neurolysis. On October 21, 1990, the patient had a severe back pain and started spiking a fever. There was no significant pain relief. Finding 89.

On July 22, 1991, the Respondent admitted the patient to AMCH and performed a continuous cervical epidural block. Finding 96.

On March 30, 1992, Respondent admitted the patient to AMCH and attempted a cervical epidural block. A subarachnoid puncture was noted, and the procedure was cancelled. Finding 100.

On June 22, 1992, Respondent admitted the patient to AMCH for a continuous epidural block. Local anesthesia was used. Finding 102.

On October 5, 1992, Respondent admitted the patient to AMCH and performed a continuous cervical epidural block. Finding 104.

On December 9, 1992, Respondent scheduled the patient for a continuous epidural cervical block for January 25, 1993 at AMCH. The procedure was cancelled when the insurance company denied approval pending a second opinion. Finding 107.

At a June 3, 1991 office visit, Patient C noted continued pain in the right upper extremity and a new onset of pain in the left upper extremity, shoulder and hand. Respondent's "impression" was chronic RSD of the right, and possible RSD of the left, extremities. Finding 94

On January 22, 1992, Patient C was evaluated by the medical director of Occupational Health of St. Francis Hospital, Poughkeepsie, New York. A basic concern was the Respondent's diagnosis of RSD. He found no evidence of temperature changes, no atrophy and no swelling. He judges the patient had chronic pain syndrome, complicated by narcotic addition. He did not rule out RSD in a minor degree. His recommendation: discontinuation of IV Buprenex, referral to a hand specialist, a long term pain management program, and occupation therapy. Finding 99.

On October 30, 1992, Patient C was evaluated by Dr. Kalman for the State Insurance Fund. The patient appeared to be subjectively symptomatic from what appeared to be a mild form of RSD absent trophic changes, contractures and a decrease in pain. He believed continuous cervical epidural blocks should not be regularly scheduled; scheduling them ever four (4) to six (6) months

was not in keeping with the nature of RSD. The patient needed mental and physical reconditioning and detoxification from the IV Buprenex addiction, because of the adverse effect it had on the mind and body. Finding 105, Finding 109.

After the cervical epidural phenol neurolysis in September and October, 1990, there was no rational or medical justification for further cervical epidural blocks. All previous blocks had failed. After phenol neurolysis, there was nothing further to be blocked.. Finding 110.

The Hearing Committee concludes the Respondent ordered a cervical epidural block on September 17, 1990, ordered and performed such block on July 22, 1991, ordered and initially performed such block until cancelled on June 22, 1992, and ordered and performed such block on October 5, 1992, without adequate medical justification.

Allegation 3:

It is alleged the Respondent ordered and/or administered epidural phenol on September 17, 1990 and October 29, 1990, without adequate medical justification.

On September 17, 1990, Respondent admitted Patient C to the AMCH. Despite the admission note indicating a planned continuous cervical epidural block followed by phenol, the continuous epidural block was not performed. After placement of the epidural catheter, six percent (6%) phenol solution was injected on two (2) successive days with transient benefit that was questionable. Finding 87.

On October 2, 1990, Patient C was seen for an office visit by Respondent, who noted that the phenol helped for several hours only. He planned to admit Patient C for either phenol or a continuous epidural block in several weeks. Finding 88.

On October 29, 1990, Respondent admitted Patient C to the AMCH for a cervical epidural phenol neurolysis. On October 21, Patient C started having severe pain in her back and a spiking fever. No significant pain relief was obtained from the procedure. Finding 89.

In 1990, Patient C was 36 years old with a normal life expectancy and chronic non-malignant pain of unclear etiology. The previous attempt at cervical epidural block with a local anesthetic was reported as unsuccessful, and was not repeated. Other less invasive treatment modalities had not been exhausted. Cervical epidural phenol neurolysis was not indicated for Patient C, and provided no benefit. Findings 90, 110.

The Hearing Committee concludes the Respondent ordered and administered epidural phenol on September 17, 1990 and October 29, 1990, without adequate medical justification.

Allegation 4:

It is alleged the Respondent treated Patient C by ordering IV Buprenex without adequate medical justification.

From June 30, 1989 to March 22, 1995, over a dozen findings of the Hearing Committee document the consistent use of IV Buprenex as the primary treatment modality of the Respondent. Findings 74, 77, 86, 87, 91, 92, 94, 98, 101, 102, 103, 104, 105, 111.

On August 20, 1991, the Respondent noted that Patient C had been prescribed IV Buprenex for two (2) to three (3) years with "great success". Finding 97. The Respondent requested approval from the insurance company to continue the use of IV Buprenex for Patient C despite a prior evaluation and recommendation by Dr. Dominic J. Belmonte on January 25, 1991 that IV Buprenex be discontinued. Findings 93, 97.

On November 30, 1991, the Respondent noted he planned to try a continuous infusion of Buprenex in a scheduled hospitalization on January 21, 1992. Finding 98.

On January 22, 1992, Patient C's medical program was evaluated by Dr. Sander Orent. He identified narcotic addiction and recommended that IV Buprenex be discontinued and a long range management program be instituted. Finding 99.

On December 9, 1992, a continuous epidural cervical block was scheduled by the Respondent for January 25, 1993. The procedure was cancelled when the insurance company denied approval pending a second opinion. Finding 107.

On January 19, 1993, Dr. Charles Kalman saw Patient C for a second consultation. The continuous cervical epidural was not recommended because previous ones had not altered the long term course of the patient's disease. Dr. Kalman's judgement was that the patient was becoming addicted to the blocks. Findings 109, 110.

Patient C continues under the Respondent's care. On March 22, 1995, the patient was evaluated by Dr. David Richlin. She was receiving IV Buprenex and MC Contin from the Respondent as her primary therapeutic modality. The comprehensive evaluation included a diagnosis list and a list of recommendations. Noting that IV Buprenex has been the Respondent's main medication modality over the past five (5) years, the evaluation recommends that the addiction receive prompt treatment. Finding 111; Dept. Ex. 25, pp. 5-12.

Patient C was a 35 year old woman suffering from chronic, non-malignant pain. IV Buprenex was not indicated for Patient C. Finding 75; See T. 201, 1.3;202, 1.2;132-134.

The Hearing Committee concludes that the Respondent ordered IV Buprenex without adequate medical justification.

PATIENT D

The Respondent treated Patient D from on or about May 18, 1988 to on or about October 26, 1993 at the AMCH and his office. Respondent's care and treatment of Patient D failed to meet acceptable standards of medical care in that:

Allegation 1:

The Respondent is alleged to have diagnosed reflex sympathetic dystrophy without adequate medical justification.

Patient D saw multiple physicians for complaints relating to back pain resulting from a lifting accident at work during March, 1988. The results of diagnostic studies, physical findings and subjective complaints were inconsistent. The symptom complex was most consistent with muscular/myofacial strain with elements of symptom magnification. A myelogram and electrodiagnostic studies were normal. In June and August, 1988. the Respondent performed two (2) series of epidural injections with no improvement. Further diagnostic studies including a CT scan, two (2) MRI's and electrodiagnostics were normal. January, 1990 surgery resulted in the recurrence of Patient D's symptoms within seven (7) weeks. None of the examining physicians reported signs or symptoms of RSD prior to August, 1990. Finding 113.

On August 6, 1990, Patient D was seen by the Respondent at his office complaining of lower leg pain with periods of cold and icyness. Respondent found patient's left foot pale and cold compared to right foot. Respondent made a diagnosis of lumbar plexopathy and reflex sympathetic dystrophy (RSD). Findings 114, 115.

On August 15, 1990, a caudal steroid epidural was attempted and removed the next day. The procedure was reported as unsuccessful. Finding 116.

On September 24, 1990, Dr. Vasquez found back trigger points. Pressure on the left sciatic nerve resulted in pain in patient's buttock with radiation. Trigger point injections with Bupivacaine did not relieve the pain. No signs or symptoms of RSD were noted. Finding 117.

On November 1, 1990, Patient D was seen for an office visit by the Respondent who described the patient's lower extremities as pale, cold and mottled. Respondent's impression was lumbarplexopathy with RSD. He noted that all previous steroid epidurals and caudals had failed to achieve adequate pain relief. Finding 118.

On December 17, 1990, Respondent admitted Patient D to the AMCH for a continuous lumbar epidural block followed by continuous infusion of sensorcaine. Respondent's discharge summary states the patient was admitted for placement of a continuous epidural catheter for reflex sympathetic dystrophy, the catheter was "threaded" and the patient had good warm legs with good sympathetic block. On December 18, 1990, the patient complained of a severe headache and a

sensorcaine injection afforded relief, until the following day when the patient complained of a severe post-spinal headache, and stated that IV Buprenex was helping. Finding 119.

On January 4, 1991, the headache had improved and Patient D was "...told to return in three (3) to four (4) weeks for follow-up and discussion of long term of the RSD." 0% efficacy of the epidural block was noted. Fiorcet, Tylenol #3 and Valium were prescribed. Finding 122.

On February 24, 1991, Respondent prescribed Tylenol #3. Two (2) days later, the patient returned for a follow-up visit concerning the low back pain which was 10/10, centered in the lower back, radiating to the posterior of the left lower extremity, and accompanied by numbness and paraesthesia. Respondent prescribed Methadone and Pamelor. Findings 123, 124.

RSD is a painful condition usually involving one (1), and occasionally both, limbs that follows some traumatic event or surgery. The pain is described in very specific terms which include words like burning, tingling or numbing. It is associated with a variety of specific physical findings that are consistent with vasomotor or sudomotor changes. These involve the autonomic nervous system and include variations in objective temperature of the skin, variations in the color of the skin, changes involving the hair growth, changes involving the nails, and changes involving the quality and texture of the skin. It is a diagnosis that requires a considerable amount of workup to confirm or exclude including, most importantly, a thorough history and physical examination that should be repeated over time, consultation over time with a neurologist to help corroborate findings, and a sympathetic nerve block. In the upper extremity, a stellate ganglion block and in the lower extremity a lumbar sympathetic block, are the most confirmatory tests. None of the list were ordered or carried out by the Respondent for Patient D. Finding 134.

The Hearing Committee concludes the Respondent diagnosed reflex sympathetic dystrophy without adequate medical justification.

Allegation 2:

It is alleged the Respondent failed to order a confirmatory or diagnostic workup for reflex sympathetic dystrophy.

About a dozen specific findings, conditions and tests are set forth in the last substantive paragraph of Allegation 1, above, to support a diagnosis of reflex sympathetic dystrophy. None of the listed confirmatory or diagnostic items were ordered by the Respondent. Finding 134.

The Hearing Committee concludes the Respondent failed to order a confirmatory or diagnostic workup for reflex sympathetic dystrophy.

Allegation 3:

It is alleged the Respondent ordered IV Buprenex without adequate medical justification.

On December 18, 1990, the Respondent ordered IV Buprenex for Patient D. A day later the patient continued to complain of severe post-spinal headache and felt the Buprenex was helping. On December 20, patient's symptoms continued and nausea was noted. Respondent discontinued the Buprenex and ordered IV morphine sulfate. Two (2) days later the headache was much better. On December 24, 1990, Patient D was discharged from the hospital with prescriptions for Valium and MS Contin. Finding 120.

Following the December hospitalization, the Respondent adjusted Patient D's pain medication to treat recurring headaches during December, January and February. Findings 121, 122.

On March 5, 1991, Patient D reported she felt a snap in her back while lifting. The lower back pain radiated down her legs; it was excruciating. Previously prescribed Methadone did not help. The Respondent prescribed MS Contin for one (1) week, and suggested IV Buprenex for pain control. The patient agreed. IV Buprenex was started on March 12, 1991 through a peripheral line. Findings 125, 126.

On April 19, 1991, Respondent admitted Patient D to the AMCH for placement of a Hickman Catheter. Patient D was discharged on April 24th on IV Buprenex. On March 25, and

April 24 continuing IV Buprenex orders were adjusted by the Respondent. From time to time additional pain medications were added. Findings 127, 128.

Patient D reported a burned back to the Respondent in early May and complained three (3) times during the month that there was inadequate pain control from the IV Buprenex. Near the end of the month, the patient complained of severe chest and shoulder pain on the right side. The patient was sent to the emergency room for removal of the Hickman catheter. The Respondent planned to use oral medications temporarily. Findings 129, 130, 131.

At a May 28, 1991 office visit, Patient D reiterated requests for Demerol or Morphine to relieve the pain. After removal of the Hickman catheter, a peripheral IV line was restarted and IV Buprenex ordered. By June 17th the peripheral line was in place. In late June, a Hickman Catheter was reinserted; in late August Patient D was hospitalized for her second catheter infection. In September, the Hickman catheter was removed and peripheral IV's were restarted. Findings 131, 132, 133.

The Hickman catheter is made of durable material, and it requires surgical placement in an operating room under sterile conditions. It is mostly used for administration of chemotherapy, feedings and, in a few cancer patients, pain medication. It is placed under the collar bone in a large vein or, occasionally, in the neck. Compared to oral medication, additional risks are associated with use of the Hickman. There are acute risks from the placement in surgery: risks from anesthesia, artery puncturing, lung collapsing. After placement: risks from infection, dislodging and bleeding exist. T. 44.

For patients with chronic, non-malignant pain, such as Patient D, where such pain is of unclear etiology, a thorough set of psychological interviews, testing and evaluation, and a thorough physical examination and assessment of the patient's functional status, and a consideration of less invasive, less risky treatment are needed. If an intravenous drug is considered, there should be thorough trials of an oral agent and demonstration that adequate pain relief could not be achieved by a simpler, safer means. T. 46-47.

The criteria outlined above were not met in the care and treatment of Patient D. The ordering and administration of IV Buprenex in Patient D did not meet acceptable standards of medical care. T. 47.

The Hearing Committee concludes that the Respondent ordered IV Buprenex without adequate medical justification.

CONCLUSIONS WITH REGARD TO SPECIFICATION

GROSS NEGLIGENCE

FIRST SPECIFICATION:

Having unanimously sustained the allegations in Paragraphs A. and A.2., the Hearing Committee concludes the Respondent practiced with gross negligence by ordering and administering phenol neurolysis during Patient A's first hospitalization, March 19, 1991, and second hospitalization, June 4, 1991, and ordering phenol neurolysis on Patient A's third hospitalization, October 14, 1991.

SECOND SPECIFICATION:

Having unanimously sustained the allegations in Paragraphs B. and B.3, the Hearing Committee concludes the Respondent practiced with gross negligence by ordering and administering two (2) phenol neurolyses on July 21 and July 23, 1986 on Patient B.

THIRD SPECIFICATION:

Having unanimously sustained the allegations in Paragraphs C. and C.3., the Hearing Committee concludes the Respondent practiced with gross negligence by ordering and administering two (2) Patient C phenol neurolysis on hospitalizations on September 17 and October 29, 1990.

FOURTH SPECIFICATION:

The Hearing Committee has unanimously not sustained the allegations of gross negligence set fourth in the Fourth Specification.

GROSS INCOMPETENCE

SIXTH, SEVENTH, EIGHTH AND NINTH SPECIFICATIONS:

The Hearing Committee has unanimously not sustained the allegations of gross incompetence set forth in the Sixth, Seventh, Eighth and Ninth Specifications.

NEGLIGENCE ON MORE THAN ONE OCCASION

ELEVENTH SPECIFICATION:

Having unanimously sustained the allegations in Paragraphs A. and A.2., A.4., B., B.3, B.4., C., C.2., C.3., C.4., D., D.1., D.2. and D.3., the Hearing Committee concludes the Respondent practiced with negligence on more than one (1) occasion in violation of N.Y. Education Law Section 6530(3) (McKinney Supp. 1995) in that the Respondent has practiced with negligence on the ten (10) occasions set forth in the allegations noted above.

INCOMPETENCE ON MORE THAN ONE OCCASION

TWELFTH SPECIFICATION:

The Hearing Committee has unanimously not sustained the allegations of incompetence on more than one (1) occasion set forth in the Twelfth Specification.

FRAUDULENT PRACTICE OF MEDICINE

THIRTEENTH SPECIFICATION:

The Hearing Committee has unanimously not sustained the allegation of the Fraudulent Practice of Medicine set forth in the Thirteenth Specification.

SUMMARY OF CONCLUSIONS

In the judgement of the Hearing Committee, the Respondent's professional practice has generally been a dedicated one. He has been candid in his testimony, and has been willing to admit some mistakes he has made. Beyond questions, he has been well trained. He has shared his knowledge with fellow professionals, in the training of staff and in continuing education.

In the unanimous judgement of the Hearing Committee, however, the Respondent has also evident significant problems in several facets of his practice. The use of phenol neurolysis for some non-malignant patients that were relatively young was evidenced in Patient A, B and C.

Phenol neurolysis involves the permanent destruction of sensory and autonomic nerve structures. Procedural risks include paralysis, paraplegia, quadriplegia, infections, hematoma and the creation of unintended sympathectomy to previously unaffected areas.

Epidural phenol neurolysis is indicated for the treatment of a severe, chronic, malignant pain in patients with a short life expectancy in whom all other treatment modalities have been tried and failed. The multiple use of phenol neurolysis in Patient A-three (3) phenol injections-and Patient B and C-two (2) phenol injections each-did not meet these basic requirements. Each instance of phenol neurolysis, as well as all instances in each patient considered separately, represent egregious conduct amounting to a minimum of the three (3) separate instances of gross negligence alleged herein. The Committee sustained the three (3) allegations.

The Respondent testified that he no longer does epidural phenol neurolysis and that it has fallen out of favor in pain management circles. The Committee believes he would not perform the procedure again.

The Respondent has also evidenced judgmental problems in the use of permanent catheters for Intravenous Buprenex injections outside the hospital setting. The use of IV Buprenex for chronic pain requires long term intravenous access with its' associated risks and morbidity. Despite its primary use for the administration of chemotherapy, feedings and, in a few cancer patients, pain medication, a Hickman catheter is frequently used by the Respondent. Surgical placement is

required in an operating room with its attendant risks.

True, there is a significant impact on the patient's independence, mobility and autonomy requiring the patient to become significantly more dependent on the medical system with likely psychological dependence that may interfere with possible rehabilitation. The intravenous route is not indicated unless all oral opioids have been tried and failed, or oral medications cannot be tolerated by the patient.

Coupled with the problems associated with the intravenous route that is the only method of administration available in the United States for Buprenex, are the characteristics of the drug itself. Buprenex is a synthetic narcotic classified as an agonist/antagonist that is associated with a low incidence of physical dependence, but is known to have the potential for psychological dependence. Once a patient receives a certain dose of Buprenex, no further analgesia can be achieved no matter how much more of the drug is given. All four (4) of the patients considered herein were prescribed Buprenex.

In each instance there was neither an adequate trial of, or a failure of all available, oral medications, or an inability of the patients to tolerate oral medications.

The Hearing Committee concluded that the Respondent ordered IV Buprenex for Patients A, B, C and D without medical justification, and that, in each instance, such is a separate occasion of negligence in the medical treatment of each patient.

On consecutive days in September, 1990, the Respondent performed two (2) cervical epidural phenol injections on Patient C. On October 29, 1990, a phenol neurolysis was performed on Patient C. During the period from July 22, 1991 through January 25, 1993, the Respondent ordered five (5), and performed four (4), cervical epidural blocks on Patient C.

After the phenol neurolysis in September and October, 1990, there was no rational or medical justification for further cervical epidural blocks. All previous blocks had failed. After phenol neurolysis, there was nothing further to be blocked.

The Hearing Committee concluded that the Respondent negligently ordered and performed the cervical epidural blocks on Patient C.

Patient D saw multiple physicians after back pain resulting from a lifting accident in March, 1988. The results of diagnostic studies, physical findings and subjective complains were inconsistent. The complex of symptoms was most consistent with muscular/myofacial strain with elements of symptom magnification. None of the several physicians treating Patient D reported signs or symptoms of RSD.

In August, 1990, Patient D was seen by the Respondent. He diagnosed lumbar plexopathy and reflex sympathetic dystrophy (RSD). In August, the Respondent attempted an unsuccessful caudal steroid epidural. The next month, Dr. Vasquez did not note signs or symptoms of RSD.

On November 1, 1990, the Respondent resumed treatment for RSD. Treatments continued monthly through February, 1991, with pain continuing and the diagnosis of RSD remaining.

Ten or more specific tests for RSD are available. Involved are tests for variations in the objective temperature of the skin, color of the skin, changes in hair growth, nails, and the quality and texture of the skin. A thorough history and physical examination repeated over time, a neurological consult, and a sympathetic nerve block are tests as well. In the upper extremity, a stellate ganglion block, and in the lower extremity, a lumbar sympathetic block are the most confirmatory tests.

None were ordered or carried out by the Respondent.

The Hearing Committee concluded that the Respondent negligently diagnosed reflex sympathetic dystrophy without adequate medical justification.

The Hearing Committee further concluded that the Respondent negligently failed to order a confirmatory or diagnostic workup for reflex sympathetic dystrophy.

ORDER

In accordance with the provisions of Sections 230, Subdivision 10, Paragraph (g) and 230-a, Subdivision 2, Paragraph (b) of the Public Health Law, the Hearing Committee unanimously orders that the license to practice medicine in the State of New York of BERNARD BARRY GREENHOUSE, M.D. be, and hereby is, **SUSPENDED.** A stay of such suspension shall be granted if the licensee is granted admission to the remediation program for anesthesiologists of the New York State Society of Anesthesiologists for the duration of such retraining program. The training program is to be in pain management only.

After the New York State Society of Anesthesiology determines that the licensee has satisfactorily completed the retraining program in pain management, the licensee shall apply for admission to the physicians monitoring program of the Office of Professional Medical Conduct for a two (2) year period with bimonthly reports to be submitted to the Office of Professional Medical Conduct by the approved monitor. A stay of the licensee's suspension herein shall be granted during the two year period of such retraining monitoring.

After the Office of Professional Medical Conduct determines that the licensee has satisfactorily completed the monitoring program, the suspension of the subject license shall be terminated.

DATED: **Albany, New York**
Nov 13 , **1995**

Therese G Lynch MD
THERESE G. LYNCH, M.D.
Chairperson

ROBERT A. MENOTTI, M.D.
TRENA DE FRANCO

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

ATTACHMENT I

IN THE MATTER :

OF :

BERNARD BARRY GREENHOUSE, M.D. :

AMENDED STATEMENT OF CHARGES

BERNARD BARRY GREENHOUSE, M.D., the Respondent, was authorized to practice medicine in New York State on October 31, 1962, by the issuance of license number 089671 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A (patients are identified in the attached appendix) at Albany Medical Center Hospital (AMCH) from on or about January 28, 1991, to on or about August 10, 1992. Respondent's care and treatment of Patient A failed to meet acceptable standards of medical care, in that:

1. Respondent ordered and/or administered cervical epidural blocks on or about February 4, 1991, March 19, 1991, June 4, 1991, and October 14, 1991, without adequate medical justification.

T. 94

2. Respondent ordered and/or administered epidural phenol on or about March 19, 1991, June 4, 1991 and October 14, 1991, without adequate medical justification.

3. Respondent recommended and/or referred Patient A for a surgical sympathectomy without adequate medical justification.

4. Respondent ordered IV Buprenex (buprenorphine) without adequate medical justification.

5. Respondent falsely stated in an April 9, 1991 letter to Crawford and Company that "All oral medications were either ineffective or caused serious side effects."

B. Respondent treated Patient B from on or about May of 1985 to on or about November 1, 1993, at AMCH and his office, 3 Columbmia Circle, Albany, New York. Respondent's care and treatment of Patient B failed to meet acceptable standards of medical care, in that:

1. Respondent arranged, recommended and/or ordered a bilateral surgical lumbar sympathectomy on or about June 13, 1985, without adequate medical justification.

2. Respondent performed, recommended and/or ordered implantation of a permanent thoracic epidural catheter and port-a-cath infusion well on or about August 23, 1985, without adequate medical justification.

3. Respondent ordered and/or performed caudal epidural phenol injections on or about July 21, 22, and/or 23, 1986, without adequate medical justification.

T.268-269 4. Respondent ordered IV Buprenex beginning in August of 1987, without adequate medical justification.

C. Respondent treated Patient C from on or about March 14, 1989, to on or about October of 1993, at AMCH and his office. Respondent's care and treatment of Patient C failed to met acceptable standards of medical care, in that:

1. ~~Respondent diagnosed reflex sympathetic dystrophy without adequate medical justification.~~

T. 94

2. Respondent ordered and/or performed cervical epidural blocks on September 17, 1990, October 29, 1990, July 22, 1991, March 30, 1992, June 22, 1992, October 5, 1992 and January 25, 1993, without adequate medical justification.
3. Respondent ordered and/or administered epidural phenol on September 17, 1990 and October 29, 1990, without adequate medical justification.
4. Respondent ordered IV Buprenex without adequate medical justification.

D. Respondent treated Patient D from on or about May 18, 1988, to on or about October 26, 1993, at AMCH and his office. Respondent's care and treatment of Patient D failed to meet acceptable standards of medical care in that:

1. Respondent diagnosed reflex sympathetic dystrophy without adequate medical justification.
2. Respondent failed to order a confirmatory or diagnostic workup for reflex sympathetic dystrophy.

3. Respondent ordered IV Buprenex without adequate medical justification.

T.9,94 ~~4. Respondent requested authorization for a spinal cord stimulator without adequate medical justification.~~

T.93 E. Respondent treated Patient E from on or about April of 1991, to on or about October 7, 1993, at AMCH and his office. Respondent's care and treatment of Patient E failed to meet acceptable standards of medical care, in that:

1. Respondent failed to perform and/or record an adequate neurological examination.
2. Respondent prescribed escalating doses of opioid analgesics without sufficient attempts to use adjuvant medications.
3. Respondent failed to coordinate the care and treatment of Patient E with the Whitney Young Community Health Center Methadone Program.

SPECIFICATIONS

FIRST THROUGH FIFTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with gross negligence in violation of N.Y. Educ. Law §6530(4)(McKinney Supp. 1995) in that, Petitioner charges:

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

SIXTH THROUGH TENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with gross incompetence in violation of N.Y. Educ. Law §6530(6)(McKinney Supp. 1995) in that, Petitioner charges:

6. The facts in Paragraphs A and A.1, A.2, A.3, A.4, and/or A.5.
7. The facts in Paragraphs B and B.1, B.2, B.3, and/or B.4.
8. The facts in Paragraphs C and C.1, C.2, C.3, and/or C.4.
9. The facts in Paragraphs D and D.1, D.2, D.3, and/or D.4.

10. The facts in Paragraphs E and E.1, E.2, and/or E.3.

ELEVENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with negligence on more than one occasion in violation of N.Y. Educ. Law §6530(3)(McKinney Supp. 1995) in that, Petitioner charges two or more of the following:

11. The facts in Paragraphs A and A.1, A.2, A.3, A.4, A.5; B and B.1, B.2, B.3, B.4; C and C.1, C.2, C.3, C.4; D and D.1, D.2, D.3, D.4; and/or E and E.1, E.2, E.3.

TWELFTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with incompetence on more than one occasion in violation of N.Y. Educ. Law §6530(5)(McKinney Supp. 1995) in that, Petitioner charges two or more of the following:

12. The facts in Paragraphs A and A.1, A.2, A.3, A.4, A.5; B and B.1, B.2, B.3, B.4; C and C.1, C.2, C.3, C.4; D and D.1, D.2, D.3, D.4; and/or E and E.1, E.2, E.3.

THIRTEENTH SPECIFICATION

FRAUDULENT PRACTICE OF MEDICINE

The Respondent is charged with practicing the profession fraudulently in violation N.Y. Educ. Law §6530(2)(McKinney Supp. 1995) in that, Petitioner charges:

13. The facts in Paragraphs A and A.5.

DATED: , 1995
Albany, New York

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct

David A. Solomon
ATTORNEY AT LAW
2366 ALGONQUIN ROAD
SCHENECTADY, NEW YORK 12309
TELEPHONE 518 372-8688

September 12, 1995

ATTACHMENT II

M E M O R A N D U M

TO: Record

FROM: Administrative Officer

SUBJECT: Matter of Dr. Greenhouse
Entry of Exhibits B-1 through B-10

Ten physicians affidavits were submitted by the Respondent in lieu of testimony by August 21, 1995, the date set forth in the record. T. 646.

For proper identification, the affidavits are identified as Exhibits . They are entered in the record as Resp. Exs. B-1 through B-10. Notice was provided to the parties and the Hearing Committee by the attached letter dated September 11, 1995.

David A. Solomon
ATTORNEY AT LAW
2366 ALGONQUIN ROAD
SCHENECTADY, NEW YORK 12309
TELEPHONE 518 372-8688

September 11, 1995

Leonard W. Krouner, Esq.
Two Greyledge Drive
Albany, NY 12211-2054

Kevin C. Roe, Esq.
Associate Counsel
State of New York
Department of Health
Corning Tower-Empire State Plaza
Albany, NY 12237

RE: Matter of Greenhouse, M.D.

Counselors:

Confirming our telephone conference call of September 6, 1995, prior and subsequent letters of both parties and additional communications, the following determinations are provided:

1. At the request of Mr. Krouner, the original exhibits were delivered to Mr. Butler's office on September 7th for review during office hours at the Bureau of Adjudication until 1:00 p.m. on September 19, when they will be picked up for delivery to Utica for the Panel's Deliberation Conference.

2. Mr. Jones forwarded affidavits of physicians by letters dated 8/14/95 and 8/21/95. Thereafter, further affidavits were forwarded. The closing date for submission is August 21. Affidavits submitted thereafter are not part of the record. The Administrative Officer is admitting into evidence the following affidavits only, with the remainder being returned to him; The admissions are as follows:

Resp. Ex. B-1: Dr. MacDowell
Resp. Ex. B-2: Dr. Smith
Resp. Ex. B-3: Dr. Spargas
Resp. Ex. B-4: Dr. Beebe
Resp. Ex. B-5: Dr. Lazaro
Resp. Ex. B-6: Dr. Fuchs
Resp. Ex. B-7: Dr. Uhl
Resp. Ex. B-8: Dr. Sheikh
Resp. Ex. B-9: Dr. Swartz
Resp. Ex. B-10: Dr. Jacobs

See, Transcript, p. 646

David A. Solomon
ATTORNEY AT LAW
2366 ALGONQUIN ROAD
SCHENECTADY, NEW YORK 12309

TELEPHONE 518 372-8688

3. Mr. Roe requested admission into evidence of (a) a January 24, 1992 letter from Respondent to C. Blanchard of Caremark, Inc. and (b) an examination before trial transcript of Patient A dated May 2, 1995 titled Watson v. Chang and Albany Medical Center. Both requests were denied by the Administrative Officer. Other than the exhibits listed in paragraph 2, above, the record in the matter was closed on August 9, 1995. See, Transcript, pp. 643-647. The letter and the E.B.T. transcripts are being returned to the Administrative Officer.

4. Requests for extentions of time to prepare final briefs by Mr. Krouner were denied as requested. The briefs of both parties may be delayed until September 15, 1995 provided such are sent for next day delivery to the members of the Hearing Panel and the Administrative Officer to permit the deliberations conference to proceed on September 20th. The Panel has agreed to the delay with the specific understanding that the time schedule will be met. See, Transcript, p. 643.

The rationale for the prompt completion of each Professional Medical Conduct Hearing is twofold. The Respondent should receive a prompt determination. Section 210 of the Public Health Law includes a legislative mandate to provide protection to the public promptly.

Sincerely,

DAVID A. SOLOMON
Administrative Officer

DAS/aw
Pcs. Hearing Panel
Bureau of Adjudication

Rec'd ExB — 1-B7C 8/15/95 Attached on. In Evidence. 9/11/95

ATTACHMENT II

Law Offices

E. Stewart Jones

E. Stewart Jones, Jr.
W. Farley Jones
Jeffrey K. Anderson
David J. Taffany
Peter J. Moschetti, Jr.

Jones Building - 28 Second Street
Troy, New York 12181
Telephone 518 - 274 - 5820
Fax 518 - 274 - 5875

Abbott H. Jones
(1873-1939)

Of Counsel
E. Stewart Jones
Arthur L. Rosen

August 14, 1995

Hon. David A. Solomon, Esq.
2366 Algonquin Road
Schenectady, New York 12309

Re: Bernard Barry Greenhouse, M.D.
Our File No. 95-3-38 S

Dear Judge Solomon:

I am enclosing from the below named physicians, affidavits submitted by each of them in support of Dr. Greenhouse. I am providing the originals to you. I am sending a copy of each to each of the three panel members at the addresses listed below. I am also forwarding a copy to Mr. Roe.

It is my understanding that there are additional affidavits, and those will be forwarded to you as soon as I receive them.

The enclosed affidavits are from the following physicians:

1. Richard T. MacDowell, M.D.
2. Howard Smith, M.D.
3. Paul E. Spurgas, M.D.
4. Richard T. Beebe, M.D., M.A.C.P.
5. Reynaldo P. Lazaro, M.D.
6. Marc D. Fuchs, M.D.

Respectfully yours,
E. STEWART JONES

E. Stewart Jones, Jr.

ESJ,JR./ml
Enclosure.

Law Offices

E. Stewart Jones

E. Stewart Jones, Jr.
W. Farley Jones
Jeffrey K. Anderson
David J. Taffany
Peter J. Moschetti, Jr.

Jones Building - 28 Second Street
Troy, New York 12181

Telephone 518 - 274 - 5820
Fax 518 - 274 - 5875

Abbott H. Jones
(1873-1939)

Of Counsel
E. Stewart Jones
Arthur L. Rosen

August 21, 1995

Hon. David A. Solomon, Esq.
2366 Algonquin Road
Schenectady, New York 12309

Re: Bernard Barry Greenhouse, M.D.
Our File No. 95-3-38 S

Dear Judge Solomon:

Supplementing my letter to you of August 14, 1995, enclosed please find original affidavits from the below named physicians:

1. Richard L. Uhl, M.D.

2. Farhan Sheikh, M.D.

3. Donald P. Swartz, M.D.

4. Richard L. Jacobs, M.D.

Also enclosed is a copy of Dr. Greenhouse's CV.

Sincerely yours,

E. STEWART JONES

E. Stewart Jones, Jr.
Signed in Absence of
Writer to Avoid Delay

ESJ,JR./ml
Enclosure.

cc: Therese G. Lynch, M.D.
Robert A. Menotti, M.D.
Ms. Trena DeFranco
Kevin C. Roe, Esq.

P. 1

REED REFERENCE PUBLISHING

ATTACHMENT III
(Official Notice)

Sandra S. Barnes
Vice President
Publisher

September 7, 1995

Leonard W. Krouner
2 Greyledge Drive
Albany, NY 12211

Dear Mr. Krouner:

I, Sandra S. Barnes, am a Vice President of Reed Reference Publishing and Publisher of the ***Marquis Who's Who*** titles which include **The *Official* ABMS Directory of Board Certified Medical Specialists.**

The attached pages are from the **1995 27th Edition of The *Official* ABMS Directory of Board Certified Medical Specialists** per your request.

Sincerely yours,

Sandra S. Barnes
Vice President
Publisher, ***Marquis Who's Who***

SSB/emk

Attach.

NEW YORK STATE DEPARTMENT OF HEALTH 19

Ann Marie Roycroft

ANN MARIE ROYCROFT
A Notary Public of New Jersey
My Commission Expires Mar. 20, 1997

The *Official* ABMS Directory of Board Certified Medical Specialists®

1995

27th Edition

Volume 1
Allergists and Immunologists
Anesthesiologists
Colon and Rectal Surgeons
Dermatologists
Emergency Medicine Physicians
Family Physicians
Internists
(A–Miss.)

Formed by the merger of the Marquis Who's Who *Directory of Medical Specialists* and the *ABMS Compendium of Certified Medical Specialists*

MARQUIS Who's Who
A Reed Reference Publishing Company
New Providence, NJ

Tables

TABLE 1 *(Continued)*

Subcertification

American Board of	Certificates of Added Qualifications	Certificates of Special Qualifications	Date Approved by ABMS	First Issued	Time Limited Certificates: First Issued Month/Year	Time Limited Certificates: Duration Years
Allergy & Immunology	Clinical & Laboratory Immunology[6]		1989	1986	--	
Anesthesiology	Pain Management		1991	1993	10/1993	10
		Critical Care Medicine	1985	1986		
Colon & Rectal Surgery						
Dermatology		Dermatopathology	1973	1974	--	
		Clinical & Laboratory Dermatological Immunology[5]	1983	1985	--	
Emergency Medicine		Pediatric Emergency Medicine	1991	1993	2/1993	10
		Medical Toxicology	1992	††		
	Sports Medicine		1992	1993	12/1993	10
Family Practice	Geriatric Medicine		1986	1988	4/1988	10
	Sports Medicine		1989	1993	9/1993	10
Internal Medicine	Adolescent Medicine		1992	††		
		(Allergy & Immunology)[4]	†			
		Cardiovascular Disease	†	1987	11/1991	10
			1989	1992	11/1992	10
	Cardiac Electrophysiology		1985	1987	11/1987	10
		Critical Care Medicine	1983	1988	--	
	Clinical & Lab. Immunology[6]		1971	1972	11/1991	10
		Endocrinology Diabetes and Metabolism[5]	1985	1988	4/1988	10
	Geriatric Medicine		†	1988	11/1991	10
		Gastroenterology	1971	1972	11/1990	10
		Hematology	1971	1972	11/1990	10
		Infectious Disease	1972	1973	11/1990	10
		Medical Oncology	1971	1973	11/1990	10
		Nephrology	†	1987	11/1990	10
		Pulmonary Disease	1971	1972	11/1990	10
		Rheumatology	1992	1993	9/1993	10
	Sports Medicine					
Medical Genetics[3]						
Neurological Surgery						
Nuclear Medicine						
Obstetrics & Gynecology	Critical Care Medicine		1985	1991	12/1991	10
		Gynecologic Oncology	1972	1974	12/1987	10
		Maternal & Fetal Medicine	1973	1974	12/1987	10
		Reproductive Endocrinology	1973	1974	12/1987	10
Ophthalmology						
Orthopaedic Surgery	Hand Surgery		1988	1989	2/1989	10
Otolaryngology		Otology/Neurotology	1992	††		
		Pediatric Otolaryngology	1992	††		

Tables

General Certification

TABLE 1

American Board of	Incorp. Year	Approved as Member Board	Certificates	First Issued[1]	Time Limited Certificates First Issued[1] Month/Year	Duration Years
Allergy & Immunology	1971	1971	Allergy & Immunology	1972	10/1989	10
Anesthesiology	1938	1941	Anesthesiology	1938	--	
Colon & Rectal Surgery	1935	1949	Colon & Rectal Surgery	1940	1/1991	8
Dermatology[2]	1932	1933	Dermatology	1932	11/1991	10
Emergency Medicine	1976	1979	Emergency Medicine	1980	6/1980	10
Family Practice	1969	1969	Family Practice	1969	3/1970	7
Internal Medicine	1936	1936	Internal Medicine	1937	1/1990	10
Medical Genetics[3]	1980	1991	Clinical Genetics - M.D.	1982	9/1993	10
			Medical Genetics	1982	9/1993	10
			Clin Biochem Genetics	1982	9/1993	10
			Clinical Cytogenetics	1982	9/1993	10
			Clinical Biochem/ Molecular Genetics	1990 (only)	--	
			Clin Molecular Genetics	1993	9/1993	10
Neurological Surgery	1940	1940	Neurological Surgery	1940	--	
Nuclear Medicine	1971	1971	Nuclear Medicine	1971	1/1992	10
Obstetrics & Gynecology[2]	1930	1933	Obstetrics & Gynecology	1930	1/1986	10
Ophthalmology[2]	1917	1933	Ophthalmology	1916	1/1992	10
Orthopaedic Surgery	1934	1935	Orthopaedic Surgery	1935	7/1986	10
Otolaryngology[2]	1924	1933	Otolaryngology	1925	--	

Which Medical Specialist For You

DESCRIPTION OF RECOGNIZED SPECIALTIES AND SUBSPECIALTIES

ALLERGY AND IMMUNOLOGY (A&I)

An allergist-immunologist is a certified internist or pediatrician expert in the evaluation, physical and laboratory diagnosis, and management of disorders potentially involving the immune system. Selected examples of such conditions include asthma, anaphylaxis, rhinitis, eczema, urticaria, and adverse reactions to drugs, foods, and insect stings as well as immune deficiency diseases (both acquired and congenital), defects in host defense, and problems related to autoimmune disease, organ transplantation or malignancies of the immune system. The scope of this specialty is ever-widening as our understanding of the immune system develops. Selected experts may receive special certification in "Diagnostic Laboratory Immunology" after additional training in the various laboratory procedures required to analyze both the function and malfunction of the immune system.

Dual certification programs are now available at some training centers for preparation of candidates with expertise in allergy/immunology and adult rheumatology and allergy/immunology and pediatric pulmonology.

Diagnostic Laboratory Immunology (DLI): This is a subspecialty field in which laboratory tests and complex procedures are used to diagnose and treat disorders characterized by defective responses of the body's immune systems.

ANESTHESIOLOGY (Anes)

The anesthesiologist is a physician-specialist who, following medical school graduation and at least four years of postgraduate training, has the principal task of providing pain relief and maintenance, or restoration, of a stable condition during and immediately following an operation, an obstetric or diagnostic procedure. The anesthesiologist assesses the risk of the patient undergoing surgery and optimizes the patient's condition prior to, during, and after surgery. Anesthesiologists diagnose and treat acute and long-standing pain problems. Anesthesiologists diagnose and treat patients who have critical illnesses or are severely injured. Anesthesiologists direct resuscitation in the care of patients with cardiac or respiratory emergencies including the provision of artificial ventilation. They also supervise and teach others involved in anesthesia, respiratory and intensive care. Anesthesiologists may specialize in Critical Care Medicine as practiced in critical care and intensive care units, post-anesthesia recovery rooms, and other settings.

Critical Care Medicine (CCM): The anesthesiologist who specializes in Critical Care Medicine is a physician who after completion of anesthesiology training must receive additional training in critical care because the requisite knowledge and skills extend beyond anesthesiology training and cross traditional specialty lines. The primary work place is an intensive or critical care unit. Anesthesiologists trained in critical care are qualified to diagnose, treat and support patients with multiple organ dysfunction. In addition, they may have administrative responsibilities for intensive care units and may participate in the training and medical direction of essential health care professionals such as nurses, respiratory therapists, and physicians in training. The critical care anesthesiologist, in addition to providing direct patient care, may also facilitate and coordinate patient care among the primary physician, the critical care staff, and other specialists.

Pain Management (PM): The anesthesiologist who specializes in pain management is a physician who must receive additional training in pain management after the completion of anesthesiology training. Certification in pain management will recognize those physician anesthesiologists who, through special examination in pain management, have documented competence to provide a high level of care either as a primary physician or consultant for patients experiencing problems with acute or chronic pain in both hospital and ambulatory settings and coordinate a multidisciplinary approach toward pain management. The additional training in pain management prepares the anesthesiologist to treat patients within the entire range of painful disorders with mastery of an additional body of knowledge required for the diagnosis and management of patients with pain.

The pain management specialist in anesthesiology, in addition to providing direct patient care, may also coordinate the patient care needs with other primary care physicians and other specialists.

COLON AND RECTAL SURGERY (CRS)

A Board certified colon and rectal surgeon has completed at least five years of residency training in general surgery and one additional year devoted entirely to colon and rectal surgery. He or she has then passed both the Written (Qualifying) and Oral (Certifying) Examinations given by the American Board of Colon and Rectal Surgery. As a result of their extensive training and experience, colon and rectal surgeons develop the knowledge and skills necessary to diagnose and treat various diseases of the intestinal tract, colon, rectum, anal canal and perianal area by medical and surgical means. They are also able to deal surgically with other organs and tissues (such as the liver, urinary and female reproductive system) involved with primary intestinal disease.

A colon and rectal surgeon has the expertise to diagnose and often manage anorectal conditions such as hemorrhoids, fissures (painful tears in the anal lining), abscesses and fistulae (infections located around the anus and rectum) in the office.

Colon and Rectal Surgeons also treat problems of the intestine and colon and perform endoscopic procedures to detect and treat conditions of the bowel lining. Endoscopy involves the passage of lighted tubes through the bowel to evaluate and treat problems such as cancer, polyps, (pre-cancerous growths) and inflammatory conditions. The names used to describe these procedures include proctoscopy ("procto"), proctosigmoidoscopy, flexible sigmoidoscopy, and colonoscopy. Polyps can often be removed during endoscopy without abdominal surgery. If cancers are detected, colon and rectal surgeons are able to plan the surgical treatment program based on their first hand visualization of the tumor, and follow up with endoscopic techniques.

Colon and rectal surgeons perform abdominal surgical procedures involving the small bowel, colon and rectum. These include treatment of inflammatory bowel diseases such as chronic ulcerative colitis and Crohn's disease, as well as diverticulitis and cancer. Because of their expertise, colon and rectal surgeons are often able to treat cancer of the rectum without a colostomy. The management of intestinal infections such as diverticulitis, bacterial colon infections and intestinal parasites is also within the proficiency of the colon and rectal surgeon.

Training in colon and rectal surgery also provides the specialist with an in-depth knowledge of intestinal and anorectal physiology required for the evaluation and treatment of problems such as constipation and incontinence (loss of bowel control).

Colon and rectal surgeons are committed to the highest standards of care for patients with diseases affecting the lower gastro-intestinal tract.

DERMATOLOGY (D)

A dermatologist is a physician who has expertise in the diagnosis, and treatment of pediatric and adult patients with benign and malignant disorders of the skin, mouth, external genitalia, hair and nails, as well as a number of sexually transmitted diseases. Dermatologists have extensive training and experience in the diagnosis and treatment of skin cancers, melanomas, moles, and other tumors of the skin, contact dermatitis and other allergic and non-allergic disorders and in the recognition of the skin manifestations of systemic (including internal malignancy) and infectious diseases. The dermatologist also has expertise in the management of cosmetic