STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Dennis P. Whalen
Executive Deputy Commissioner

July 13, 1999

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Robert Bogan, Esq.
NYS Department of Health
433 River Street
Hedley Park Place – 4th Floor
Troy, New York 123180

Niles Frederick Greenhouse, M.D.
537A South Main Street
Central Square, New York 13036

Michael J. Vavonese, Esq.
108 West Jefferson Street – Suite 500
Syracuse, New York 13202

RE: In the Matter of Niles Frederick Greenhouse, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No.99-165) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

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 penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

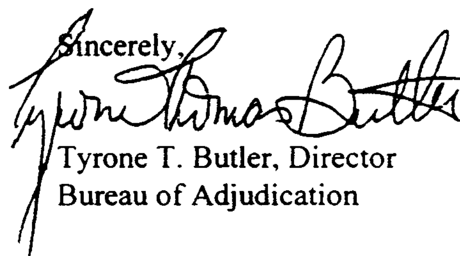
All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

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
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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:mla
Enclosure

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

COPY

IN THE MATTER OF NILES F. GREENHOUSE, M.D.	DETERMINATION AND ORDER BPMC 99-165

LEMUEL ROGERS, M.D., Chairperson, **JOSEPH G. CHANATRY, M.D.** and **MS. CLAUDIA GABRIEL**, duly designated members of the State Board for Professional Medical Conduct appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **JEFFREY ARMON, ESQ.**, served as Administrative Officer for the Hearing Committee. After consideration of the entire record, the Hearing Committee submits this Determination.

SUMMARY OF APPEARANCES

Notice of Hearing and Statement of Charges: August 27, 1998

Department of Health appeared by: Henry M. Greenberg, General Counsel
NYS Department of Health

BY: **ROBERT BOGAN, Esq.**
Associate Counsel
NYS Department of Health
Empire State Plaza, Corning Tower
Albany, New York 10001-1803

Respondent appeared by: **MICHAEL J. VAVONESE, Esq.**
108 West Jefferson Street, Suite 500
Syracuse, New York 13202

Witness for the Department of Health: Richard J.Bonanno, M.D.

Witnesses for the Respondent:

William D. Nugent, M.D.;
Jennifer Daniels, M.D.
C. P.
Michael Klein, M.D.
Niles F. Greenhouse, M.D.
(Respondent)

LEGAL ISSUES AND AMENDMENTS TO THE STATEMENT OF CHARGES

During the proceeding, the Administrative Law Judge made the ruling that allegations contained in Paragraph K of the Statement of Charges, relating to Patients Nine through Thirteen, were cumulative and repetitive and that evidence regarding those allegations would not be received. Charges in Paragraph K related to Respondent's maintenance of adequate medical records and the performance of adequate histories and/or physical examinations. These allegations so closely resembled those charges related to the other eight patients that, even if sustained by the Committee, their probative value would be outweighed by their cumulative and repetitive nature. The Committee was instructed to make no inference as to the Department's ability or inability to prove the allegations in Paragraph K.

Paragraph B. 5. of the Statement of Charges was amended to specify that the period of time in question was "During the period of August and September, 1989". Paragraph C. 4. was similarly amended to specify the same period of time.

Paragraphs E. 3. and F. 3. were each amended by deleting the reference to "hydrocodone" and substituting "contolled substances".

Numbers in parenthesis refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. All Hearing Committee findings were unanimous unless otherwise specified.

NOTE: Petitioner's Exhibits are designated by Numbers.

Respondent's exhibits are designated by Letters.

T = Transcript

GENERAL FINDINGS OF FACT

The Respondent was authorized to practice medicine in New York on September 12, 1980 by the issuance of license number 143576 by the New York State Education Department.

FINDINGS OF FACT RELATED TO ALLEGATIONS A AND B

1. On or about January 28, 1994, Respondent pled guilty to one count of a misdemeanor violation of New York Penal Law § 175.30, Offering a False Instrument for Filing in the Second Degree in the Justice Court of the Village of Central Square, Oswego County, New York. Respondent received a Conditional Discharge and was required to pay a fine of $1,000, to perform 420 hours of Community Service and to maintain a medical practice in the Village of Central Square for at least one year thereafter. (Ex. 53; T.1368-71)

2. On or about December 16, 1985, the State Board for Professional Medical Conduct (hereinafter "the Board") prepared a Statement of Charges alleging that Respondent had committed acts constituting professional misconduct. On or about April 15, 1986, Respondent entered into an Application for Consent Order with the Board wherein he admitted to guilt to two Specifications contained in the Statement of Charges. The New York State Education Department granted the Application for Consent Order on or about July 14, 1986. (Ex. 54)

3. The terms of the Consent Order included the suspension of Respondent's license to practice as a physician with respect to the practice of obstetrics and gynecology until his successful completion of a minimum of twenty credits of continuing medical education in obstetrics and gynecology and the submission of proof thereof to the New York Education Department. (Ex. 54)

4. In a letter from the Director of the Office of Professional Medical Conduct, dated September 26, 1989, Respondent was informed that he had been found to have complied with all Terms of Probation and that his period of probation had been terminated. (Ex. H)

FINDINGS OF FACT RELATED TO PATIENT I

5. Respondent treated Patient I, a 24 year old female, from August, 1989 through February, 1990 for evaluation and management of pregnancy. (Ex. 4, pp.2-3, 5; T. 41, 544)

6. Respondent took a history and performed a physical examination of Patient I at her initial office visit on August 15, 1989. He performed a pap smear and obtained vaginal and blood cultures for laboratory analysis. He provided her with a prescription for prenatal vitamins and requested that she return for a follow-up visit two weeks thereafter. (Ex. 4, pp.2-3, 5; T. 543, 547-550)

7. Although Respondent recorded that her next visit was to be two weeks thereafter, Patient I did not return to his office until September 20, 1989, by which time Respondent had obtained and recorded the results of a pap smear and laboratory work. There were no copies of laboratory results contained in the medical record for Patient I. (Ex. 4; T. 43, 563, 573)

8. Respondent recorded a note in the medical record " called every OB in Syracuse and all OB clinics. No one will see this patient now or in the future." There was no documentation in the record to indicate what doctors or clinics were called or on what date they were called. (Ex.4; T. 61)

9. Patient I returned to Respondent's office for a third, and final time, on January 2, 1990. A few notes of a general physical examination were recorded, including the position of the fetus. Respondent again recorded that no clinic or obstetrician would see the patient. (Ex. 4, p.4; T. 565-6)

10. On January 10, 1990, Patient I presented at St. Joseph's Hospital Health Center in labor and gave birth to a healthy baby girl. A letter to Respondent from the Director of Emergency Services at St. Joseph's Hospital, dated January 30, 1990, indicated that the Director was not aware of any arrangement made between Respondent and the hospital's Department of Emergency Services for coverage of obstetrical care for Respondent's patients. (Ex. 4, p.16, Ex. 6, pp.17-8)

FINDINGS OF FACT RELATED TO PATIENT II

11. Patient II, a 17 year old female, presented at Respondent's office on November 14, 1990 with a complaint of abdominal pain. Respondent recorded findings related to blood pressure and type, pulse, respiration, urine and temperature in the medical record and noted an immediate referral of the patient to a hospital obstetric clinic, that no pregnancy was observed and a diagnosis of secondary amenorrhea. A handwritten record of this office visit subsequently provided by Respondent included additional findings related to his examination of the patient's breasts and abdomen and impressions of toxemia and amenorrhea. (Ex. 5, 7)

12. Respondent did not note the patient's last menstrual period and did not order and/or perform a pregnancy test or other diagnostic test. (Ex. 5,7; T. 619, 624)

13. Patient II presented to the hospital's labor and delivery suite on the following day without an appointment, medical records or a referral from Respondent to a hospital physician. She was evaluated and found to not be pregnant. (Ex. 8)

FINDINGS OF FACT RELATED TO PATIENT III

14. Respondent treated Patient III, a 41 year old female, from about March, 1990 through about November, 1992 for neck and lower back pain incurred in a work-related injury and obesity. (Ex. 9, pp.3, 42; T. 1136-7, 1141-2)

15. The medical record maintained by Respondent for Patient III was inadequate in that it contained no documentation of physical examinations or medical history other than that recorded at the initial office visits in March and April, 1990. Although Patient III had numerous office visits during this period, the only documentation of these visits was reflected on Worker Compensation forms contained in the chart. There was no evidence of a treatment plan for the patient in the record. (Ex. 9; T.149-55, 157-8)

16. In March, 1991, Patient III was treated at a psychiatric facility on an in-patient basis for approximately one month. Her admitting diagnosis included major depression and mixed substance abuse in remission except for continuous use of marijuana..Her history included abuse of alcohol, marijuana and pain-killers. (Ex. 11, p.5)

17. In September, 1992, Patient III was readmitted to the same psychiatric facility. She provided a long-standing history of abuse of alcohol, marijuana, Valium, codeine, diet pills and prescription medications and admitted to a continuing abuse of codeine, Valium and pain medication. (Ex. 12, p.4)

18. Respondent regularly prescribed controlled substances as treatment for Patient III's pain without evidence of a physical examination or history which were not justified by her medical and/or psychiatric condition. (Ex. 9, 11-16; T.151-8, 161-4)

19. There was no evidence in the medical record that Respondent adequately monitored or followed-up the patient's condition or that he altered his treatment despite evidence of her substance abuse. (Ex. 9; T. 176-9)

FINDINGS OF FACT RELATED TO PATIENT IV

20. Respondent treated Patient IV, a 51 year old male, from about October, 1988 through about October, 1992 for back pain, gastric ulcers and anxiety. Patient IV was the husband of Patient III. (Ex. 18, pp. 3-4; T. 235, 1191-3)

21. There was little documentation in the medical record maintained for Patient IV of history and physical examinations other than a note dated August 2, 1991. (Ex. 18; T. 236)

22. Respondent prescribed Tylenol with Codiene, Vicodin and Valium as treatment for the patient's pain and anxiety. In an entry in the medical record dated November 11, 1991, Respondent noted Patient IV's drug dependency and indicated that he was weaning the patient off medications. (Ex. 18, p. 19)

23. Respondent noted on several instances in the record that Patient IV was able to work with pain. He referred the patient to drug dependency programs on March 9 and September 14, 1992. The record indicates that Patient IV was regularly non-compliant with referrals to other medical providers. (Ex. 18, Ex. P)

FINDINGS OF FACT RELATED TO PATIENT V

24. Patient V, a 41year old female, was treated by Respondent from about August, 1990 until August, 1997 for chronic neck and back pain, asthma, insomnia and carpal tunnel syndrome. (Ex. 26; T. 289)

25. The records of Patient V as maintained by Respondent contain no documentation of a history or evidence of a physical examination conducted by him. (Ex. 26; T. 296, 323, 326)

26. Respondent prescribed methylprednisolone, an anti-inflammatory, as treatment for Patient V's bronchial asthma, which may have been indicated as appropriate treatment.(T. 311)

27. Respondent prescribed Zovirax, an anti-viral medication commonly used to treat a herpes viral infection, as treatment for canker sores. Respondent did not document a complaint of cold or canker sores in Patient V's medical record. (Ex. 18; T. 297-9)

28. Respondent prescribed codeine for Patient V's pain, which was indicated and may have been appropriate. (Ex. 18; T.297)

29. Respondent prescribed phenobarbital as treatment for Patient V's insomnia, which may have been appropriate. (Ex. 18; T. 306)

FINDINGS OF FACT RELATED TO PATIENT VI

30. Respondent treated Patient VI, a 34 year old female, from about October, 1991 until about March, 1992 for pancreatitis, asthma, diabetes and alcohol abuse. (Ex. 31, p 10; T. 342-3)

31. Respondent noted in the medical record at Patient VI's initial office visit that she had a history of diabetes for which she was taking insulin. Respondent increased the dosage of insulin without recording a reason for such change. (Ex. 31, p.10; T. 347-9)

32. There was no evidence in the record that Respondent ordered blood sugar and blood tests for kidney function as should have been ordered for a patient with a history of diabetes. (Ex. 31; T. 344-7)

33. Respondent prescribed Zovirax, on December 17, 1991 as treatment for canker sores. Respondent did not document a complaint of cold or canker sores in Patient VI's medical record. (Ex. 31; T. 357, 1335-6)

34. Respondent frequently prescribed Tylenol with Codeine for Patient VI's complaints of pain. She was diagnosed with a narcotics addiction following a hospital admission in February, 1992. At an office visit on March 9, 1992, Respondent prescribed Tylenol with Codeine and Valium for Patient VI. (Ex. 31, pp. 4-6, 42, Ex. R)

35. Respondent prescribed methylprednisolone as treatment for Patient VI's asthma. A cortisone medication such as methylprednisolone can increase the blood sugar in a diabetic which would necessitate monitoring of blood sugar levels. The patient was following such levels at home and was being monitored by other physicians.(Ex. 31, pp. 10, 42-3; T. 364-5, 1327-30)

36. Patient VI's care was assumed by another physician on February 21, 1992 subsequent to her hospital admission. (Ex.31, pp. 42-3)

FINDINGS OF FACT RELATED TO PATIENT VII

37. Respondent treated Patient VII, a 34 year old female, from about April, 1990 through about May, 1993 for a number of chronic conditions, including headaches, anxiety, depression, sinus infections and bronchitis. Patient VII had a long history of alcohol abuse and had been diagnosed as bipolar. (Ex. 35; T. 1376-8)

38. The medical records of Patient VII as maintained by Respondent contain no documentation of a history or physical examination after June, 1990 and include prescriptions for controlled substances which are not supported by the medical record. (Ex. 34, 35; T.399-408)

39. Respondent prescribed Valium and Codeine as treatment for Patient VII's pain in amounts which were not excessive and which enabled her to continue employment as a nurse's aide. (Ex. 34, 35; T. 1030-1)

40. Respondent saw Patient VII on a frequent basis during the course of his treatment of her which adequately enabled him to follow her condition and to monitor whether she was abusing her medications. (Ex. 34, 35; T. 1030-1)

FINDINGS OF FACT RELATED TO PATIENT VIII

41. Respondent treated Patient VIII, a 40 year old female, from about February, 1992 until about February, 1996 for complaints of abdominal and back pain and chronic headaches. (Ex. 39, pp. 176-7; T. 421-2)

42. Respondent's medical record maintained for Patient VIII was inadequate and did not reflect his performance of a physical examination other than that performed at the initial office visit. The nature of Patient VIII's headaches was not adequately documented and justification for the continued prescribing of controlled substances as treatment was not included in the record. (Ex. 39: T. 420-2, 1066)

43. Respondent regularly prescribed Stadol, an analgesic, as treatment for Patient VIII's complaints of headaches. Stadol is an appropriate medication for headaches and Respondent's prescibing of it was within acceptable standards of practice. (Ex. 39: T. 420, 1061)

44. Respondent prescribed Valium for Patient VIII on numerous occasions. Patient VIII was treated for a complaint of migraine headache at a hospital emergency room on January 29, 1996. The physician's note indicated a likelihood of substance abuse and recommended a referral for a detoxification assessment. (Ex. 35, p. 94)

45. Respondent saw Patient VIII on a frequent and consistent basis during the period in which he provided treatment. He referred her to other physicians for evaluations and, in a note in the medical record dated February 6, 1996, referred Patient VIII to the SUNY at Syracuse Pain Clinic. (Ex. 39, p. 37)

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. Unless otherwise noted, all conclusions resulted from a unanimous vote of the Hearing Committee.

The Hearing Committee concluded that the following Factual Allegations should be **SUSTAINED**. The citations in parentheses refer to the Findings of Fact which support each Factual Allegation:

Paragraph A. :	(1);
Paragraphs B. 1., B. 2., B. 4. :	(2);
Paragraph B. 3. :	(3);
Paragraph C. 1. :	(7-9);
Paragraph C. 2. :	(6);
Paragraph C. 3. :	(8-10);
Paragraphs D. 1., D. 2., D. 3. :	(11-13);
Paragraph D. 4. :	(13);
Paragraphs E. 1., E. 2. :	(15, 18-9);
Paragraphs E. 3., E. 4. :	(16-8);
Paragraph E. 5. :	(15-18);
Paragraph E. 6. :	(19);
Paragraphs F. 1., F. 2. :	(21);
Paragraphs G. 1., G. 2. :	(25);
Paragraph G. 3. (in part only) :	(27);
Paragraphs H. 1., H. 2. :	(31-32);
Paragraph H. 3. :	(33);
Paragraphs H. 4., H. 5.:	(34);
Paragraphs I. 1., I. 2. :	(38);
Paragraphs J. 1., J. 2. :	(42);
Paragraph J. 4. :	(44).

The Hearing Committee determined that all other Factual Allegations should **NOT** be sustained.

The Hearing Committee concluded that the following Specifications of Professional Misconduct should be **SUSTAINED** based on the Factual Allegations which were sustained as set out above:

First Specification;

Third through Tenth Specifications;

Thirteenth through Twentieth Specifications;

Twenty-second through Twenty-nineth Specifications;

Thirty-first through Thirty-eighth Specifications;

Fortieth through Forty-seventh Specifications.

The Hearing Committee determined that all other Specifications of Professional Misconduct should **NOT BE SUSTAINED.**

DISCUSSION

Respondent was charged with multiple Specifications of Charges alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of actions which constitute professional misconduct, but does not provide definitions of such categories of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for certain types of professional misconduct.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Gross Incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine.

The Committee relied upon these definitions in considering the Specifications of professional misconduct.

The Committee recognized that it was essential to determine the acceptable standard of medical practice for each case at issue. It was therefore necessary to evaluate the credentials and testimony of each expert witness to determine his credibility and the appropriate weight to be assigned to each witness' testimony.

Dr. Bonanno was considered by the Committee to be very familiar and experienced with the family practice of medicine. His testimony was considered to be objective and his opinions were based on open-minded thinking and were not seen as dogmatic. He was not always in full agreement with the Department's positions and was honest and persuasive. The Committee found his testimony to be most credible and relied heavily on his expert opinions, particularly those concerning the acceptabilty of the medical records.

Dr. Nugent was acknowledged to have significant expertise in the area of pain management as a result of his association with the pain clinic at St. Joseph's Hospital. His testimony on that subject was assigned substantial weight by the Committee. However, the Committee members felt that he was less objective than Dr. Bonnano on other matters including the quality of Respondent's medical records and that he sometimes made questionable statements in an effort to support certain acts of the Respondent. Those opinions were accorded less significance by the Committee.

CONCLUSIONS RELATED TO PATIENTS I AND II

Respondent's treatment of these two patients was considered to significantly deviate from acceptable standards of practice. While the non-compliance by Patient I with prenatal care recommendations was noted, the Committee felt that Respondent's treatment of her during her infrequent visits was woefully inadequate. The record indicates that a pap smear and certain blood

work was performed for laboratory analysis by Respondent at Patient I's initial office visit. There were no reports of the results in the chart and little evidence of findings from any physical examinations that he may have conducted during the patient's two follow-up visits.

The Committee found Respondent's testimony that he could not obtain obstetrical care for the patient to not be credible. There is no notation in the record as to which specific providers were contacted. The January 30, 1990 letter from the Director of the St. Joseph's Hospital Emergency Department, in which the Director stated that he was unaware of any arrangement made by that Department to provide coverage for obstetrical care to Respondent's patients, was accepted as being accurate. That letter also indicated that it was not accurate for Respondent to have considered that the Emergency Department agreed to see any of his patients. The Committee believed Patient I should not have been referred to the hospital's Emergency Room and that appropriate care could have been obtained elsewhere for the delivery of the baby.

The Committee did not conclude that Respondent provided obstetrical care to Patient I during August and September, 1989. The initial visit of August 15, 1989 was the result of an unscheduled walk-in by the patient. Respondent performed a physical examination, which was completely appropriate. The subsequent visit on September 20, 1989 was only one week prior to the termination of Respondent's probation. No specific obstetrical services were provided. The Committee felt that in light of the OPMC's letter of September 26, 1989 which ended Respondent's probation and which the Department was unaware of when the Charges in this matter were prepared, allegations that Respondent violated the terms of his probation in his treatment of Patient I were extremely frivolous. Factual Allegations B. 5. and C. 4. were not sustained.

The Committee concluded that Respondent's treatment of Patient II was also substandard. He relied on the patient who told him she thought that she was pregnant based on positive results of home pregnancy tests without independently verifying a pregnancy. The documented history in the medical record does not indicate the duration of the amenorrhea or her sexual history. The Committee considered the documented findings to be inconsistent with a complaint of severe abdominal pain and concluded that Respondent should have had the supplies necessary to perform a

pregnancy test.

The Committee accepted as accurate the letter dated December 17, 1990 from the St. Joseph's Hospital Professional Affairs Coordinator to Respondent which detailed the circumstances by which Patient II presented unscheduled to the hospital's labor and delivery suite. It concluded that Respondent should have made a greater attempt to provide hospital staff with a copy of the patient's medical record. Even if the patient did not go directly to the hospital, as referred by Respondent, he had an obligation to provide the records and notice of such a referral to hospital personnel. The Committee felt it unacceptable for the patient to present unannounced without further arrangement by Respondent. Factual Allegations D. 1. through D. 4. were each sustained.

CONCLUSIONS RELATED TO PATIENTS III AND IV

The Committee determined the medical records maintained by Respondent for this husband and wife were significantly below acceptable standards. Respondent treated Patient III for a work-related back injury for over two years without indicating a plan of treatment. Following the initial office visits in March and April, 1990, Respondent recorded no findings from any physical examination nor did he document any additional history. The records related to Patient IV were similarly deficient in meeting acceptable standards.

Respondent's continued prescribing of controlled substances was seen to be inappropriate in light of the diagnoses made while Patient III was treated at a psychiatric facility. Respondent was, or should have been, aware of the reports of her abuse of alcohol, codeine, Valium and pain medications. His failure to alter his treatment of her was seen as unacceptable, particularly when the patient's psychiatric history was considered. While the Committee considered Dr. Nugent's testimony that the treatment of pain with controlled substances for an extended period has become more accepted, it was determined that Respondent's prescription of such medications for a period of over two years was not justified. Factual Allegations E. 3. through E. 6. were sustained.

The Committee felt that factors in Respondent's treatment of Patient IV made such treatment

more acceptable than that provided to his wife. The Committee noted entries in the patient's medical record indicating an attempt by Respondent to reduce the patient's dependency on pain medications and reflecting referrals to drug treatment programs. The continued noncompliance by the patient with these actions was considered. There were also notations stating that Patient IV was able to continue working with the use of medications. This provided some basis for the repeated prescriptions for Tylenol with Codeine, Vicodin and Valium. The Committee therefore gave greater weight to Dr. Nugent's testimony that Respondent's treatment of Patient IV was acceptable and did not sustain Factual Allegations F. 3. Through F. 6.

CONCLUSIONS RELATED TO PATIENTS V THROUGH VIII

The Committee felt that Respondent's treatment of Patients V, VI, VII and VIII were similar. His records and documentation of histories and physical examinations were considered to be significantly inadequate. There was no documentation to support his continued prescribing of controlled sustances to Patient V. Respondent changed the dosage of Patient VI's insulin without noting a reason and did not order diagnostic tests which would have been necessary for a diabetic patient. There was no evidence of any physical examination of Patient VII after June, 1990 even though Respondent continued to treat her for several years thereafter. Justifications for the routine prescription of controlled substances were not found in the records of Patients VII or VIII. The Committee sustained allegations relating to Respondent's prescribing Zovirax for Patients V and VI because there was no documentation of complaints of cold or canker sores in either medical record.

Factual Allegations H. 4. and H. 5., relating to the prescribing of excess Codeine for Patient VI, were sustained. The Committee considered such prescribing to be not medically justified by the patient's complaints of general pain. In addition, Respondent continued to prescribe Codeine and Valium to the patient even after she had been diagnosed by another physician as being addicted to narcotics. Allegation J. 4. was sustained for Respondent's similar treatment of Patient VIII with Valium, notwithstanding the likelihood of her abuse of that medication. The Committee did not

sustain Factual Allegations I. 3. and I. 4. and accepted Dr. Nugent's testimony that Respondent's treatment of Patient VII with Codeine and Valium was appropriate because the dosages were in small amounts and enabled the patient to continue her employment.

SPECIFICATIONS OF PROFESSIONAL MISCONDUCT

Being convicted of a crime under New York state law

This Specification was sustained based on Respondent's guilty plea January, 1994 in the Central Square, New York, Justice Court to a misdemeanor violation of Offering a False Instrument for Filing in the Second Degree.

Practicing the profession while license is suspended/ Abandoning and neglecting a patient

These Specifications relate to Respondent's treatment of Patient I and neither was sustained. As discussed above, the Committee did not conclude that Respondent provided obstetrical and/or gynecological services to Patient I during her initial office visit, which was the only time he provided care to her while he was on probation. The Committee believed he did not abandon Patient I by failing to make appropriate arrangements for the delivery of her baby. It reasoned that Respondent believed he could not provide obstetrical services to the patient and that he was not treating her for the purpose of delivering the baby. While the Committee felt that Respondent's efforts to obtain obstetrical care did not meet acceptable practice standards, it did not feel that those inadequate efforts constituted abandonment of the patient.

Practicing with moral unfitness

The Committee did not conclude that the many instances of Respondent's failure to meet acceptable standards of medical practice was the equivalent of moral unfitness to practice. The changing practice standards of pain management was noted in regards to his continued prescribing of controlled substances to his patients. There was no evidence that the patients were selling the medications that were being prescribed, or if some were being sold, that Respondent was aware of such fact. The misdemeanor conviction was also not viewed as evidence of moral unfitness, but rather as an additional example of Respondent's poor record keeping practices.

Record keeping/ Gross Negligence/ Gross Incompetence

All Factual Allegations and Specifications related to the records maintained by Respondent were sustained. The Committee believed that the records were such a deviation from acceptable standards that all Allegations of failures to maintain adequate medical records and failures to perform and obtain adequate physical examinations and histories were determined to constitute practice of the profession with gross negligence and gross incompetence.

Respondent's own testimony indicated a lack of understanding as to the purpose and necessity of maintaining adequate medical records for each patient. While a point was made by Respondent as to the sheer volume of each chart, he appeared unaware of what information was required to be contained within the record. Virtually all coherent information in each chart came from other medical providers and there was little evidence that Respondent acted on such outside information. No plans of treatment were documented for patients for whom Respondent provided frequent treatments over extended periods of time. While Respondent testified as to his referral of patients to other providers or to pain or drug treatment clinics, these referrals were often not documented. He had difficulty explaining many of the entries in his own records. The Committee concluded that the records were grossly inadequate and substandard.

Negligence and Incompetence

The Committee determined that all other sustained Factual Allegations constituted the practice of the profession with negligence and with incompetence on more than one occasion. While these Allegations were viewed as serious deviations from acceptable standards of practice, mitigating evidence or circumstances resulted in those deviations not being considered as rising to the level of gross negligence and/or gross incompetence. Mitigating factors included the testimony of Respondent's expert, non-compliant actions by the patients and changing standards of acceptable practices.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set out above, unanimously determined that Respondent's license to practice medicine in New York State should be revoked. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

This determination was based on the serious nature of the sustained charges in conjunction with Respondent's 1986 Consent Order with the Board and his 1994 criminal conviction. It was clear to the Committee that Respondent did not improve his practice subsequent to the discipline imposed pursuant to the Consent Order. He continued to demonstrate poor medical judgement and to exhibit little insight of the requirements for adequate record keeping. The Committee felt that Respondent squandered the second opportunity he was provided by the Board and that he clearly demonstrated that he was not qualified to hold a license to practice medicine in New York.

ORDER

Based on the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The following Specifications of professional misconduct as set forth in the Amended Statement of Charges (Ex. 1A) are **SUSTAINED:**

    a. First Specification;

    b. Third through Tenth Specifications;

    c. Thirteenth through Twentieth Specifications;

    d. Twenty-second through Twenty-nineth Specifications;

    e. Thirty-first through Thirty-eighth Specifications;

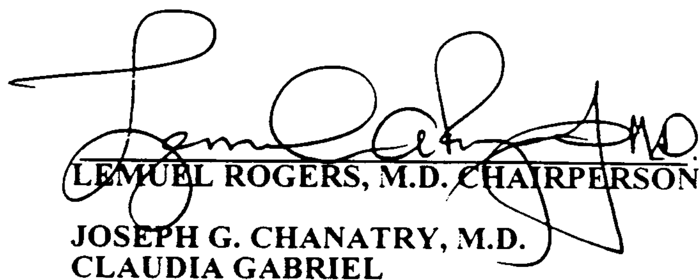
    f. Fortieth through Forty-seventh Specifications.

2. The license of Respondent to practice medicine in New York State be and hereby is **REVOKED.**

3. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: Albany, New York

7/8, 1999



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APPENDIX I

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

IN THE MATTER	:	STATEMENT
OF	:	OF
NILES FREDERICK GREENHOUSE	:	CHARGES

NILES FREDERICK GREENHOUSE, M.D., the Respondent, was authorized to practice medicine in New York State on September 12, 1980, by the issuance of license number 143576 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about January 28, 1994, Respondent was convicted of Offering a False Instrument For Filing In The Second Degree in violation of New York Penal Law section 175.30 in the Justice Court, Village of Central Square, County of Oswego, State of New York.

B. 1. On or about December 16, 1985, the State Board For Professional Medical Conduct, Department of Health, State of New York prepared a Statement of Charges charging the Respondent with professional misconduct.

2. On or about April 15, 1986 the Respondent entered into an Application For Consent Order with the State Board For Professional Medical Conduct, Department of Health, State of New

York as a result of the Statement of Charges described in paragraph B.1 above, wherein he admitted to guilt to two specifications therein.

3. The Application for Consent Order included among other penalties that the Respondent's license to practice as a physician with respect to the practice of obstetrics and gynecology be suspended until the Respondent successfully completed a minimum of twenty credits of continuing medical education in obstetrics and gynecology and submitted proof thereof to the Education Department of the State of New York.

4. On or about July 14, 1986, the State Education Department granted the above described Consent Order.

During the period of Aug and Sept 1989

JA 1/21/99

5. [On or about 1989 to on or about 1991] the Respondent practiced obstetrics and/or gynecology while his license to practice obstetrics and gynecology was suspended.

C. Respondent treated Patient I (patients are identified in Appendix) from on or about August 1989 to on or about February 1990 at his office located at 537 A South Main Street, Central Square, New York 13036 (hereinafter "his office.") Respondent's care and treatment failed to meet acceptable standards of medical care, in that:

1. Respondent did not maintain an adequate medical record for Patient I.

2. Respondent did not obtain appropriate medical screens and tests for Patient I.

3. Respondent did not make appropriate arrangements for Patient I's delivery of her unborn child.

1/21/99 JCR

4. Respondent provided obstetrical care to Patient I while his license to provide such care was suspended. during the period of August and September, 1989.

D. Respondent treated Patient II from on or about November 1990 to on or about January 1991 at his office. Respondent's care and treatment failed to meet acceptable standards of medical care in that:

1. Respondent did not maintain an adequate medical record for Patient II.

2. Respondent did not perform an adequate initial history and/or physical examination of Patient II.

3. Respondent did not obtain appropriate medical screens and/or tests for Patient II.

4. Respondent did not provide hospital ER personnel pertinent information about Patient II for what he believed was an emergency situation.

E. Respondent treated Patient III from on or about May 1989 to on or about September 1992 at his office. Respondent's care and treatment failed to meet acceptable standards of medical care in that:

1. Respondent did not maintain an adequate medical record for Patient III.

2. Respondent did not perform adequate histories and/or physical examinations of Patient III.

10/14/98 JCR

3. Respondent prescribed excessive medication for Patient III, namely [Hydrocodone] Controlled substances

4. Respondent prescribed potentially habit forming medications for Patient III, despite suspected substance abuse.

5. Respondent failed to alter his treatment of Patient III despite clear evidence of substance abuse.

6. Respondent did not provide a consistent and/or adequate follow-up of Patient III's medical conditions.

F. Respondent treated Patient IV from on or about July 1991 to on or about October 1992 at his office. Respondent's care and treatment failed to meet acceptable standards of medical care in that:

1. Respondent did not maintain an adequate medical record for Patient IV.

2. Respondent did not perform adequate histories and/or physical examinations of Patient IV.

10/14/98 ja

3. Respondent prescribed excessive medication for Patient IV, namely [Hydrocodone] controlled substance

4. Respondent prescribed potentially habit forming medication for Patient IV, despite suspected substance abuse.

5. Respondent failed to alter his treatment of Patient IV despite clear evidence of substance abuse.

6. Respondent did not provide a consistent and/or adequate follow-up of Patient IV's medical conditions.

G. Respondent treated Patient V from on or about October 1990 to on or about August 1997 at his office. Respondent's care and treatment failed to meet acceptable standards of medical care in that:

1. Respondent did not maintain adequate medical records for Patient V.

2. Respondent did not perform adequate histories and/or physical examinations of Patient V.

3. Respondent inappropriately prescribed methylprednisolone, codeine, Zovirax, and/or phenobarbital to Patient V without sufficient documentation and/or justification.

H. Respondent treated Patient VI from on or about October 1991 to on or about March 1992 at his office. Respondent's care and treatment failed to meet acceptable standards of medical care in that:

1. Respondent did not maintain adequate medical records for Patient VI.

2. Respondent did not perform adequate histories and/or physical examinations of Patient VI.

3. Respondent inappropriately prescribed Zovirax, for Patient VI without sufficient documentation and/or justification.

4. Respondent prescribed excessive medication for Patient VI, namely codeine.

5. Respondent prescribed potentially habit forming medication for Patient VI, despite suspected substance abuse.

6. Respondent prescribed Methylprednisolone for Patient VI without addressing her chronic diabetic condition.

7. Respondent did not provide a consistent and/or adequate follow-up of Patient VI's medical conditions.

I. Respondent treated Patient VII from on or about April 1990 to on or about May 1993 at his office. Respondent's care and treatment failed to meet acceptable standards of medical care, in that:

1. Respondent did not maintain adequate medical records for Patient VII.

2. Respondent did not perform adequate histories and/or physical examinations of Patient VII.

3. Respondent prescribed excessive medication for Patient VII, namely valium/diazepam and/or codeine.

4. Respondent prescribed potentially habit forming medications for Patient VII, despite suspected substance abuse.

5. Respondent did not provide a consistent and/or adequate follow-up of Patient VII's medical conditions.

J. Respondent treated Patient VIII from on or about February 1992 to on or about February 1996 at his office. Respondent's care and treatment failed to meet acceptable standards of medical care, in that:

1. Respondent did not maintain adequate medical records for Patient VIII.

2. Respondent did not perform adequate histories and/or physical examinations of Patient VIII.

3. Respondent prescribed excessive medication for Patient VIII, namely Stadol.

4. Respondent prescribed potentially habit forming medications for Patient VIII, despite suspected substance abuse.

5. Respondent did not provide a consistent and/or adequate follow-up of Patient VIII's medical conditions.

K. Respondent treated Patients IX, X, XI, XII, and/or XIII from on or about December 1991 to on or about May 1992 at his office. Respondent's care and treatment failed to meet acceptable standards of medical care in that:

1. Respondent did not maintain an adequate medical record for Patients IX, X, XI, XII, and/or XIII.

2. Respondent did not perform adequate histories and/or physical examinations of Patients IX, X, XI, XII, and/or XIII.

SPECIFICATIONS OF MISCONDUCT

FIRST SPECIFICATION

BEING CONVICTED OF CRIME UNDER NEW YORK STATE LAW

Respondent is charged with being convicted of committing an act constituting a crime under New York State Law in violation of N.Y. Educ. Law §6530 (9)(a)(i) (McKinney Supp. 1997) in that the Petitioner charges:

1. The facts in paragraph A.

SECOND SPECIFICATION

PRACTICING THE PROFESSION WHILE LICENSE IS SUSPENDED

Respondent is charged with practicing the profession while his license was suspended in violation of New York Educ. Law §6530(12) in that Petitioner charges:

2. The facts in paragraph B and B.1, B.2, B.3, B.4, and/or B.5.

THIRD THROUGH ELEVENTH SPECIFICATIONS
RECORD KEEPING

Respondent is charged with failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient in violation of New York Educ. Law §6530 (32) in that petitioner charges:

3. The facts in paragraph C and C.1.

4. The facts in paragraph D and D.1.

5. The facts in paragraph E and E.1.

6. The facts in paragraph F and F.1.

7. The facts in paragraph G and G.1.

8. The facts in paragraph H and H.1.

9. The facts in paragraph I and I.1.

10. The facts in paragraph J and J.1.

11. The facts in paragraph K and K.1.

TWELFTH SPECIFICATION
ABANDONING AND NEGLECTING A PATIENT

Respondent is charged with abandoning and/or neglecting a patient under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care, in violation of New York Education Law §6530 (30) in that the Petitioner charges:

12. The facts in paragraph C and C.3.

THIRTEENTH THROUGH TWENTY-FIRST SPECIFICATIONS
NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion in violation of New York

Education Law §6530 3 in that the Petitioner charges:

13. The facts in paragraph C and C.1, C.2, and/or C.3.

14. The facts in paragraph D and D.1, D.2, D.3 and/or D.4.

15. The facts in paragraph E and E.1, E.2, E.3, E,4, E.5 and/or E.6.

16. The facts in paragraph F and F.1, F.2, F.3, F.4, F.5 and/or F.6.

17. The facts in paragraph G and G.1, G.2, and/or G.3.

18. The facts in paragraph H and H.1, H.2, H.3, H.4, H.5, H.6 and/or H.7.

19. The facts in paragraph I and I.1, I.2, I.3, I.4, and/or I.5.

20. The facts in paragraph J and J.1, J.2, J.3, J.4 and/or J.5.

21. The facts in paragraph K and K.1 and/or K.2.

TWENTY-SECOND THROUGH THIRTETH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence in violation of New York Education Law §6530 (4) in that the Petitioner charges:

22. The facts in paragraph C and C.1, C.2, and/or C.3.

23. The facts in paragraph D and D.1, D.2, D.3 and/or

D.4.

24. The facts in paragraph E and E.1, E.2, E.3, E,4, E.5 and/or E.6.

25. The facts in paragraph F and F.1, F.2, F.3, F.4, F.5 and/or F.6.

26. The facts in paragraph G and G.1, G.2, and/or G.3.

27. The facts in paragraph H and H.1, H.2, H.3, H.4, H.5, H.6 and/or H.7.

28. The facts in paragraph I and I.1, I.2, I.3, I.4, and/or I.5.

29. The facts in paragraph J and J.1, J.2, J.3, J.4 and/or J.5.

30. The facts in paragraph K and K.1 and/or K.2.

THIRTY-FIRST THROUGH THIRTY-NINTH SPECIFICATIONS
INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with incompetence on more than one occasion in violation of New York Education Law §6530 (5) in that the Petitioner charges:

31. The facts in paragraph C and C.1, C.2, and/or C.3.

32. The facts in paragraph D and D.1, D.2, D.3 and/or D.4.

33. The facts in paragraph E and E.1, E.2, E.3, E,4, E.5 and/or E.6.

34. The facts in paragraph F and F.1, F.2, F.3, F.4,

F.5 and/or F.6.

35. The facts in paragraph G and G.1, G.2, and/or G.3.

36. The facts in paragraph H and H.1, H.2, H.3, H.4, H.5, H.6 and/or H.7.

37. The facts in paragraph I and I.1, I.2, I.3, I.4, and/or I.5.

38. The facts in paragraph J and J.1, J.2, J.3, J.4 and/or J.5.

39. The facts in paragraph K and K.1 and/or K.2.

FORTIETH THROUGH FORTY-EIGHTH SPECIFICATIONS
GROSS INCOMPETENCE

Respondent is charged with practicing the profession with gross incompetence in violation of New York Education Law §6530 (6) in that the Petitioner charges:

40. The facts in paragraph C and C.1, C.2, and/or C.3.

41. The facts in paragraph D and D.1, D.2, D.3 and/or D.4.

42. The facts in paragraph E and E.1, E.2, E.3, E,4, E.5 and/or E.6.

43. The facts in paragraph F and F.1, F.2, F.3, F.4, F.5 and/or F.6.

44. The facts in paragraph G and G.1, G.2, and/or G.3.

45. The facts in paragraph H and H.1, H.2, H.3, H.4,

H.5, H.6 and/or H.7.

46. The facts in paragraph I and I.1, I.2, I.3, I.4, and/or I.5.

47. The facts in paragraph J and J.1, J.2, J.3, J.4 and/or J.5.

48. The facts in paragraph K and K.1 and/or K.2.

FORTY-NINTH THROUGH FIFTY-SEVENTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with practicing the profession with moral unfitness in violation of New York Education Law §6530 (20) in that the Petitioner charges:

49. The facts in paragraph A.

50. The facts in paragraph B and B.5.

51. The facts in paragraph C and C.3, and/or C.4.

52. The facts in paragraph D and D.4.

53. The facts in paragraph E and E.4.

54. The facts in paragraph F and F.4 and/or F.5.

55. The facts in paragraph G and G.3.

56. The facts in paragraph H and H.3, H.4 and/or H.5.

57. The facts in paragraph I and I.3. and I.4.

58. The facts in paragraph J and J.3. and J/4.

DATED: August 27, 1998
Albany, New York

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