State of New Hampshire
Supreme Court

NO. 2019-0009

2019 TERM

JULY SESSION

Appeal of Aaron Geller, M.D.

RULE 10 APPEAL OF FINAL DECISION OF THE
NEW HAMPSHIRE BOARD OF MEDICINE

BRIEF OF RESPONDENT/APPELLANT
AARON GELLER, M.D.

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QUESTION PRESENTED

I. Did the Board of Medicine err in imposing discipline?

Preserved: Hearing transcripts, *passim*; Motion for Rehearing, *C.R.* at A172.

STATEMENT OF FACTS

I. Aaron Geller, M.D[*]

Until about 30 years ago, opioids were by regulation unavailable for doctors treating chronic non-cancer pain.[1] Starting in the 1990s, medical organizations endorsed opioids for chronic pain, and instituted guidelines to protect patients from adverse effects, ensure monitoring, and guide cessation when treatment goals were unmet.[2] In 2008, the New Hampshire Board of Medicine condoned "use of controlled substances to manage pain."[3]

There is no consensus on whether pain relief alone – without demonstrable functional benefits such as employment – is an acceptable outcome. There is little agreement on what appropriate doses are, or how to calculate equivalencies among opioids.[4] Ralph Beasley, the Board's expert, testified the "pendulum swung" too far toward acceptance of high dosing for chronic pain,[5] but acknowledged "there is no standard of care with regard to chronic pain management."[6] He explained "insurance companies used to pay for" pain techniques doctors have been "doing … for 20 years [but] [t]he research was not written up," and now "insurance companies are saying … it's experimental and, therefore, we do not have to cover it."[7] The Board acknowledged that doctors who prescribe opioids "walk[] a tenuous path."[8]

Aaron Geller, M.D., now 54 years old, graduated from the University of

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[*]Due to the number of citations to the voluminous record, in-line citations are cumbersome and distracting, and footnote citations on some pages would occupy most or entire pages. Accordingly, citations to the record are in the appendix, and at 12,172 words, not included in word-count.

Patient-Notes and similar entries in individual patient medical files, generated when a clinician consults with a patient, are called "Patient-Note." Citations to the certified record are indicated by "*C.R.*" Patient numbers are specified in the appendix only when references appears out of patient context.

Non-record citations are conventionally cited, and legal citations are conventionally located.

Pennsylvania Medical School in 1991. He completed a three-year residency in Physical Medicine & Rehabilitation (PM&R), treating chronic pain at Tufts and Harvard.[9] His career has been treating chronic pain, and lecturing on safe opioid prescribing,[10] including the content of Board-endorsed "SCOPE of Pain" course, teaching safe prescribing to over 40,000 doctors.[11]

In 2001 Geller established Nashua Pain Management, dedicated to outpatient treatment of chronic pain, including nerve blocks, and opioid and non-opioid medications,[12] with a patient-load of 120 to 150. Geller employs his wife Sharon Geller, who holds a masters degree in physical therapy. She manages scheduling, triaging, compliance, and participation in the State-run Prescription Drug Monitoring Program (PDMP). They invoice through a billing company, and refuse cash customers.[13]

Geller's philosophy, supported by scientific research throughout his records, is that opioids are viable for some chronic pain patients, and screening techniques can help discriminate. Safe prescribing to Geller necessitates non-branded medications having low street values, and characteristics discouraging abuse.[14] He believes the purpose of pain therapy is to increase function and not merely decrease pain, and that function is often determined by the ability to engage in full-time employment.[15]

Based on credible medical science,[16] Geller understands "incapability of working is for many chronic pain patients the beginning of a social reroute."[17] Unemployed people with chronic pain drift toward obesity, diabetes, and depression, often not appreciating the health benefits of work until after they have abandoned it.[18]

Geller takes seriously patient education, monthly monitoring, and opioid agreements.[19] He prescribes generic and abuse-resistant formulations to hinder diversion,[20] and only one month's supply to minimize quantities patients possess.[21] Geller was an early-adopter of the PDMP,[22] and calls pharmacies

when he has suspicions.[23] His records routinely demonstrate encouragement of non-opioid options,[24] medication combinations to reduce total dosage,[25] gradually modulating dosages to avoid unpredicted results,[26] not prescribing for undeserving conditions,[27] and refusing to prescribe dangerous medications.[28] Of the 24 patient-records the Board examined, only two showed high doses.[29] In a "pill-mill," Geller suggests, "everybody's going to have high dosing."[30]

Even Beasley, Geller's harshest critic, credits Geller for doing "a good job,"[31] and "trying to be extra safe for his patients with respect to his prescribing habits."[32] Patients sometimes self-discharge upon Geller denying opioid requests,[33] but none have overdosed due to his prescribing.[34]

Because his field is relatively new, Geller viewed medical charts as an opportunity to teach, expressing his philosophy in patient-notes, often verbosely, with abundant citations to medical literature, repeated reference to comparative treatments, and frequent justification of on-going therapies – appearing sometimes as much polemical as informational.[35] Geller now omits superfluous material.[36]

Geller often notes stressors in patients' personal lives, such as Patient-4's daughter's death and son's departure for military service,[37] or Patient-5 exiting an abusive relationship.[38] Each of Geller's patient-notes end with a blurb listing earned certifications, and indicating which professionals the record was copied to.

II. Patient Summaries

As part of an investigation into three patient complaints, the Board requested 24 patient records from Geller's office. In disciplinary proceedings, it relied on nine (three complainants plus six others), which it randomly numbered.[*] The patients are referenced herein by that assigned number. They are presented in the general order in which Geller encountered them.

[*]The Board ordered "the identities of all patients shall remain confidential and … each patient shall be referred to by their respective patient numbers." NOTICE OF HEARING (Nov. 19, 2015) at 23. Patient names and initials nonetheless appear in the record. For convenience, but to maintain confidentiality, patient numbers, initials, and names have been correlated in a separately-filed sealed cross-reference.

A. Patient-4

As a result of workplace repetitive motion, Patient-4 experienced neck, shoulder, and elbow pain. In 2002, when she was 41, she was referred to Geller after other treatments were ineffective. Patient-4 kept regular monthly half-hour or longer appointments with Geller for over 15 years, and remains his patient.[39]

Clinically indicated testing early in Geller's care revealed Patient-4's ingestion was appropriate.[40] Geller's assessment showed no physical or behavioral manifestations of misuse. Patient-4 was truthful about medications, never lost any, consumed few pills,[41] entered an opioid contract,[42] never presented to emergency rooms, did not request particular formulations as addicts and criminals tend, and was working, "contributing to society despite her … injury."[43] Geller thus determined no need for further testing.[44] His treatment included trigger point injections,[45] suprascapular nerve blocks,[46] non-opioid analgesics,[47] anti-inflammatories,[48] anti-depressants,[49] medications to counter side-effects,[50] and recommendations for low-impact therapies.[51]

In December 2002, Geller started Patient-4 on opioids. With occasional adjustments, she continued on progressively lower doses for many years.[52] Believing that understanding pain can help reduce it, Geller educated Patient-4 about safe pain management and risk avoidance.[53] In 2007 and 2011, Patient-4's insurance carrier threatened to stop paying. Geller defended his treatments, and both times preserved workers' compensation benefits.[54]

At the time the Board seized Geller's records, Patient-4 was 52, still his patient, still successfully managing her condition, and employed.[55] She made no complaint against Geller.

B. Patient-7

Patient-7 suffered workplace injuries in 2001, and after four shoulder operations, surgeons could do no more.[56] She experienced chronic neck, shoulder, and back pain, compromising her work, sleep and moods.[57] Doctors tried narcotic and non-narcotic painkillers with frustrating results. Spurning opioids without a treatment plan, they referred her to pain management,[58] and Geller began seeing Patient-7 in 2006, when she was 49. Patient-7 was a bookkeeper in her husband's business, and after becoming widowed, maintained function by gardening, caretaking elderly family, and carrying firewood.[59]

Over many years, Geller met monthly with Patient-7, and recorded education, observations, and assessment. There was no evidence of opioid misuse, nor typical behaviors of an addict, such as losing prescriptions, requesting additional doses, retaining unfilled prescriptions, or appearing at emergency rooms.[60] Patient-7 entered opioid agreements, in which she committed to safe opioid practices, abstention from listed substances, and maintenance of medical transparency; and consented to random testing, pill-counting, and reporting to authorities in event of breach.[61] Consequently, Geller identified no need for urine testing.[62] Geller ensured Patient-7 got treatment for depression, recommended she not take benzodiazepines to avoid interaction dangers,[63] and suggested she quit smoking to reduce pain.[64]

Geller routinely provided Patient-7 suprascapular nerve blocks – anesthetic injections adjacent to the nerve to alleviate shoulder pain. While Geller's records do not specify exact location and depth of injections, they detail the anatomy of the shoulder and suprascapular nerve, traumas and conditions that cause it injury, and muscles it innervates. The records discuss dangers of incorrect injection and dosing, and specify the quantity of medication.[65]

Geller continued Patient-7's prior opioid prescription, then adjusted it several times,[66] trying a half-dozen different opioids, and sometimes increasing

for heightened pain during colder months.[67] The treatments helped maintain Patient-7's functioning and employment capacity.[68] In 2007, after an operation, Patient-7 filled post-surgery prescriptions through Geller rather than the surgeon, and Geller followed-up by phone. In 2009, Geller performed a morphine equivalency assessment to establish whether Patient-7's opioid dose was too high, and determined it was not.[69]

In 2009, Patient-7's insurance carrier challenged validity of long-term pain therapy, value and frequency of Geller's injections, and legitimacy of opioid combining.[70] After it stopped covering some medications,[71] Geller defended the patient and his work.[72] In concession to the carrier, he reduced the frequency of injections, but when pain increased[73] and the Labor Department sided with the patient,[74] returned to recommended intervals.[75] In 2012, it happened again, with the same result.[76] In 2013, Patient-7 was admitted to the hospital with confusion,[77] and while it was determined that opioids were not the cause,[78] again Geller adjusted doses.

Patient-7 made no complaint.

C. Patient-9

Patient-9 was in a work-related collision in 2007 when he was 57 years old, which exacerbated pre-existing problems, caused chronic neck, shoulder, and upper-body pain, and hobbled his gait. Surgeries provided no relief.[79]

At monthly appointments, Geller performed suprascapular nerve blocks, discussed the anatomy of the nerve and how treatments might address Patient-9's objective pain pathology, and recorded doses injected.[80] Geller prescribed a non-opioid analgesic, a pain-relieving topical cream, and medications to reduce side effects.[81] Over time, Geller adjusted Patient-9's injections,[82] encouraged cognitive behavioral therapy and quitting smoking,[83] and provided extensive education.

Drug testing conducted by the VA showed appropriate results.[84] Geller did not order additional screening until it became mandatory in 2015, because Patient-9 was in obvious pain, did not show signs of abuse, had many years of stable dosage, was content with Geller's injections, did not request the most easily abusable formulations, and disclosed leftover medications.[85] Geller adjusted dosing, trialled different opioids, and despite Patient-9's increasingly stressful home situation, prescribed an overall declining dose.[86]

In 2011, Patient-9's workers' compensation carrier threatened to discontinue covering Geller's treatments,[87] resulting in having to switch to a less effective opioid.[88] Geller defended his prescriptions and frequency of injections.[89]

In 2016, Patient-9 left Geller's practice, after years of treatment, because Geller had lowered his dosage, and because the carrier made it impossible for Geller to affordably prescribe the safest and most effective medication.[90] Patient-9 reported that Geller's treatments decreased his pain, and improved his function and quality of life.[91] Patient-9 made no complaint about Geller.

D. Patient-6

Patient-6 injured his lower back shoveling snow, but surgery could not cure pain, tingling, and weakness. His defense-industry job involved installing wiring in small spaces and carrying tools and ladders, requiring lifting, bending, and twisting. Pain interfered with function.[92] Before being referred to Geller, Patient-6's doctor had prescribed a variety of medications, including opioids.[93]

At their initial two-hour appointment, when Patient-6 was 30 years old in May 2011, Geller prescribed no opioids, but recommended less risky options.[94] Geller also listened to Patient-6 talk, a low-impact pain technique, discussing non-opioid options for managing pain, insomnia, and fatigue.[95] Throughout several years of monthly monitoring, Geller performed suprascapular nerve block injections,[96] and provided education.

Geller determined drug screening was unnecessary, because Patient-6 passed workplace random drug testing for 14 years, and because Geller observed and assessed him as low risk, noting he was employed, had not lost medications or doctor-shopped, lacked personal and family histories of substance abuse, did not magnify symptoms, expressed relief from non-opioid treatments, self-reported left-over opioids from another doctor, and signed an opioid agreement.[97] Geller prescribed, in part, 10 pills per month for ingestion in the morning on an as-needed basis, because Geller knew Patient-6's wiring job, on some days, required "strenuous manipulation of his body,"[98] and trusted Patient-6 to self-regulate because he used fewer pills than prescribed.[99]

In addition to encouraging non-medication approaches, Geller several times switched opioids and adjusted dosages to better match treatment with ongoing reassessment of persistent pain, address new injuries, and avoid surgery.[100] Geller's treatments succeeded in maintaining Patient-6's job function.[101]

Patient-6 remained in Geller's care for five years, until 2016.[102] He brought no complaint against Geller.

E. Patient-5

Patient-5 was a ballet dancer, injured in an unrelated fall, with degenerative spine disease, resulting in chronic pain in her back, neck and shoulder. She had tried many medications, including opioids, which were not working, so was referred to a pain specialist. Geller noted that in her prior records she had failed a pill count, though it was not her fault.[103] Geller began seeing Patient-5 in August 2011 when she was 38.[104]

During a two-hour consultation, Geller assessed Patient-5, determining the opioid dose the non-specialist had prescribed was not appropriate for her situation.[105] Geller listed a 22-point plan to address underlying health issues, including testing, avoiding certain medications, local injections, maintaining employment, and considering opioids later.[106]

Physical examination revealed no evidence of drug abuse. She had no arrests or DWI stops, no doctor-shopping, no ER visits, no solicitation of additional pills. She was content with abuse-resistant formulations, aware of risks, signed an opioid agreement, and was employed full-time.[107] While Geller understood Patient-5 had some risk factors, such as substance abuse in her family and when she was much younger,[108] she was an acceptable opioid candidate. Unlike the non-specialist who gave her Percocet "max 8/day,"[109] Geller resolved to limit his prescribing to unbranded Percocet, twice daily, to minimize diversion value.[110]

Geller did not order a urine screen because risk assessment did not indicate it was necessary, and the standard of care at the time did not require it.[111] He applied the Opioid Risk Tool (ORT), endorsed by the Board, which is designed for doctors to numerically score a patient's likelihood of abuse, and downgraded her risk to low.[112] Beasley later intuited her risk was higher, but vacillated, and did not properly perform an ORT.[113]

Monthly, Geller gave Patient-5 trigger point and suprascapular nerve

block injections.[114] Geller encouraged non-medication approaches, and introduced Patient-5 to combinations of opioids with lower total dosage,[115] which remained stable for almost six months.[116]

In February 2012, Geller was informed by a hospital that Patient-5 had been admitted for heroin detoxification.[117] She had been using IV heroin for two-and-a-half months, attempting to cope with an abusive husband.[118]

Geller immediately stopped opioids.[119] At their next visit, Geller met with Patient-5 and her mother, and discussed family support.[120] Later they discussed counseling, AA,[121] exercise, and a pain psychologist.[122] Geller continued providing injections and pain management education, but no opioids.[123]

After ten months, confident in her recovery, Geller again prescribed opioids to manage chronic pain and maintain full time employment, starting with far smaller amounts than before.[124] Patient-5 signed another opioid agreement.[125]

Geller deliberately did not order a urine screen immediately upon resumption, because that would not be random, but conducted one at the very next visit, and six times thereafter,[126] consistently finding no evidence of abuse. He also counted her pills.[127]

Because her heroin use was related to exiting the abusive relationship, Geller determined Patient-5 was not an addict.[128] He observed her unsuccess with non-opioid options, and concluded benefits outweighed opioid risks.[129] Given ongoing compliance and repeated[130] acceptable[131] drug test results[132] (using the most exacting method[133] of testing), Geller gradually increased the number of pills prescribed, peaking at a low dose.

Patient-5 maintained function, was still employed, and still Geller's patient, at the time of the hearing in 2017.[134] She filed no complaint.

F. Patient-8

Patient-8, a full-time parole officer, suffered a farm injury as a young man, and had lately been in an accident which reignited his pain, resulting in functional limitations. There were no surgical solutions, and a variety of treatments, including opioids, were ineffective. In December 2012 at age 61, he was referred to Geller.[135]

After a three-hour examination, Geller established a treatment plan for Patient-8, which included continuing employment, weight-loss and exercise, non-opioid analgesics, consideration of opioids, and suggestions for coping with side effects.[136] Geller performed monthly trigger point injections and suprascapular nerve blocks.[137]

Geller assessed Patient-8 and determined his fitness for opioids. Despite having been addicted to cigarettes and using marijuana when he was younger, Patient-8 worked full time, did not magnify symptoms or doctor-shop, had not lost prescriptions or requested early refills, did not have personal or family histories of substance abuse, had painful pathologies verified by X-ray and MRI, and had been previously prescribed opioids for chronic pain.[138] Geller also determined drug screening was unnecessary,[139] because Patient-8 had improvement on low and stable opioid doses, maintained employment, did not engage in suspect behaviors, and signed opioid agreements.[140]

Geller prescribed a variety of medications, including opioids, adjusting formulations and doses.[141] Geller treated Patient-8 for a year-and-a-half, providing the same thorough education as with others.

Geller believed treatment was successful because Patient-8's dose was low and, until Patient-8 retired for unrelated reasons,[142] he maintained function through full-time work.[143] Patient-8 made no complaint about Geller.

G. Patient-1

Patient-1, a data-entry clerk at a technology company, had experienced pain for most of her life[144] in most of her body, including her neck, shoulder, elbows, wrists, hands, fingers, back and lower back, hips, knees, and ankle.[145] It could be traced to poor balance inducing stumbles and falls, being overweight, riding horses, repetitive motion at work, or causes unknown.[146] Pain limited her daily function, worsening when she carried or gripped things, input data, or walked her dog.[147]

A variety of tests[148] had attained no firm diagnosis,[149] and there was no surgical solution.[150] She had tried physical therapy, opioid[151] and non-opioid medications, and workstation modifications,[152] with little lasting success.[153] In 2009, Patient-1 had sought workers' compensation, but an IME declared her pain not work-related, and she returned to full-time work.[154] She was referred[155] to chronic pain management,[156] and began seeing Geller in March 2011 when she was 47 years old.

1. Treatment

In Patient-1's first four monthly visits,[157] Geller administered suprascapular nerve blocks and analgesic injections, which she said helped her.[158] Geller provided education, and recommended muscle relaxants, insomnia aids, electrical nerve stimulation, physical therapy, sleep splints and pillows, elbow braces, an ergonomic workstation, avoiding heavy lifting, and losing weight.[159] Geller told her he thought carrying water buckets for horses[160] contributed to her pain,[161] that she had continued capacity for sedentary work,[162] and that employment was the best therapy. He recommended:

> Continue full time work as the distraction afforded by work decreases pain and mood depression while also decreasing risks for addiction as patients focus on work duties, not on pain or narcotics. Pain in no way supports disability and the disabled patient

> suffers from misdirected compassion when endorsed by the clinician as the absence of socialization, presence of daytime napping, absence of distraction, and decreased caloric expenditure will predictably increase risks for early mortality. Society is injured as well as the individual who seeks disability as less financial resources remain for the truly disabled in terms of the blind, schizophrenic, paraplegic, quadriplegic, elderly, [] such that life expectancy for the silent truly disabled may be compromised if chronic pain patients inappropriately achieve disability funds.[163]

Geller assessed her opioid risk,[164] listing benefits and drawbacks, including having been jailed for assault,[165] and disinterest in non-opioid treatments. He determined she was high risk,[166] and never prescribed opioids.[167]

After June 2011, Patient-1 saw other providers,[168] returned to Geller in February 2012 for injections,[169] and then returned to her other providers.[170] Starting in August 2012, her orthopedist provided work excusals, under workers' compensation or disability, and she was not working.[171] After injuring herself carrying wet laundry, Patient-1 made an appointment with Geller, forwarding records from her orthopedist before the visit.[172]

On September 3, 2012, Patient-1 returned for the last time to Geller and again got an examination, injections, and education, but no opioids.[173]

2. Disclosure

Also on September 3, Patient-1 delivered additional medical records to Geller[174] seeking his evaluation.[175] That evening after the appointment, while reading them and preparing patient-notes, Geller noted inconsistencies, causing him to be skeptical of Patient-1's reportage of pain: "discrepanc[ies] between her perceived disability and her pathology," diverging dates of claimed work-related injuries, assertions of pain and activities exacerbating it which conflicted with his observations, declination of pain-mitigating treatments, dubious

omissions in medical records, and avoiding employment when she appeared capable. Thus, in addition to his regular notes, Geller typed an "Addendum" describing his doubts at length and in detail.[176]

Geller added the Addendum to his patient record, and also sent it to Patient-1's other doctors because, to ensure continuity of care, Geller believed it was his duty to apprise a patient's entire medical team of potential problems he perceived.[177] He also sent the Addendum to what appears to be two insurance companies: a named claims adjuster at Chubb Insurance, and: "United vs. ? NH work comp."[178]

Though he later conceded he may have been mistaken,[179] for several reasons Geller understood there was a Chubb workers' compensation claim.

First, when Patient-1 visited Geller on September 3, she told him she was out of work related to workers' compensation;[180] the medical records she gave him that day appeared to be related to evaluation of workers' compensation eligibility;[181] and those records listed a Chubb insurance claim,[182] which even the Board understood "handled [her] old workers' compensation claim."[183] Second, Geller had received records from Patient-1's orthopedist a week before, which contained references to Chubb and workers' compensation,[184] and those records indicated they were being forwarded to Geller to explore "treatment options,"[185] which Geller understood to normally include workers' compensation.[186] Third, the "Prudential work comp form,"[187] which he was to complete, specifically asked for evaluation of capacity-to-work, thus appearing to indicate a workers' compensation issue.[188] Geller also knew from Patient-1's records she had been on workers' compensation two weeks before her initial visit, which is where he got the carrier's contact information.[189]

Because, as Geller knew,[190] workers' compensation mandates broad statutory disclosure by doctors to insurers,[191] he understood he was required to disclose to Chubb. Geller's understanding was bolstered by a privacy waiver

Patient-1 had signed upon intake, which allowed disclosure for treatment, continuity of care, workers' compensation, and in the patient's best interest.[192] Geller recalled several conversations with Patient-1 requesting he send the material to her insurers, which Geller understood was plural,[193] and Patient-1 herself provided Geller the carriers' contact information he used.[194] Geller also believed his oath of beneficence mandated disclosure because it was in Patient-1's best interest.[195] To the extent Geller mistakenly disclosed to the wrong carrier, it was ambiguous which carrier covered which aspect of Patient-1's situation.[196] Attempting to timely react to her demand for expedited action may have contributed some confusion, an oversight for which Geller contemporaneously apologized.[197]

On September 5, Geller received a questionnaire from Prudential, which required Geller to check-box his opinion of Patient-1's percentage fitness for a range of everyday activities, which he completed.[198]

A few days later, on Monday, September 10, Geller found two letters signed and dated by Patient-1 slipped under his door, saying:

> I give … Gellar [sic] permission to share my/release my medical records, note, test results, etc with the following: 1) Prudential Insurance 2) United Health Care
> For purposes of medical claim reimbursement and/or insurance claims processing.
>
> Please fill out any insurance claims request right away, as my short term disability claim needs to be approved ASAP or I won't have any income at all. Thank you.[199]

The letters prompted Geller to note, in Patient-1's medical chart, that he believed her request to sign disability forms "ASAP or I won't have any income," rather than because she was in pain, was an indication of abuse of benefits. Geller's office called Patient-1 to inform her of compliance with her

instructions.[200]

On Wednesday, September 12, Patient-1 called Geller's office to cancel her next-day's appointment, purportedly because her mother was ill. But Geller suspected she was seeking alternatives from "her Boston pain consultants."[201]

Two days later, Geller's office called Patient-1 to schedule another appointment. After a year-and-a-half of sporadic treatment, she told his office she was discharging herself from Geller's services because the injections had not helped. But knowing from her history that they had, Geller did not believe her, reiterated he would not prescribe her opioids,[202] and suspected she was seeking narcotics.[203]

3. Complaint

Some time the next month, Patient-1 learned of Geller's September 3 Addendum, and on November 20, called Geller to "loudly voice her displeasure that her privacy rights were violated."[204] That evening, Geller memorialized their conversation in a seven-page comment added to her file, which he sent to Patient-1 and her primary doctor.[205]

Geller evaluated her as capable of employment,[206] and believed Patient-1 tried to use him to provide an excuse, based on workers' compensation[207] or disability,[208] from working at a job she did not like.[209] Geller told her the best therapies were curtailing her horse hobby and returning to work.[210] Having strong views about abuse of social programs, the role of the medical system in facilitating such abuses, and his own rectitude, Geller transparently and zealously expressed his distrust, averring "premeditated fraud."[211] Geller regarded as "fabricated" any grievance over his mistaken disclosure to Chubb, and alleged that Patient-1's actual motivation was anger at him[212] for not condoning a benefits scam.[213]

On December 11, in 39 single-spaced pages, Patient-1 filed a complaint with the Board detailing everything she perceived as negative in Geller's

November 20 comment, in his September 3 Addendum, and in his records of their prior sessions. She alleged his records were wrong about many things; suggested he falsified records to justify his views; said his office was unprofessionally administered, poorly lighted, and malodorous; and insinuated he was an unethical pill-pusher.[214] Geller penned an equally-long response to the Board; he listed 111 ways he prescribes safely, rebutted Patient-1's allegations, called her untruthful, and denied pushing pills – manifested by his refusal to prescribe her opioids.[215]

H. Patient-2

Patient-2 had a long history of injuries related to his active physical life.[216] In 2011 he fell shoveling snow,[217] and in 2012 fractured a bone practicing martial arts.[218] He had chronic pain in his neck and upper extremities, and reduced range of motion in his shoulder.[219] Doctors had him on six Percocet daily.[220] In July 2012 when he was 54 years old,[221] he was referred to Geller,[222] who immediately reduced his dose to one Percocet daily.[223]

Patient-2 was, for 16 years, Patient-1's housemate and sometimes boyfriend, and they shared the same referring doctor.[224]

Geller initially prescribed no opioids to Patient-2, but performed suprascapular nerve blocks and other injections; discussed benefits of weight loss; and suggested non-prescription medications to address pain, insomnia, and side-effects.[225] At their appointment a month later, Geller listed a treatment plan including continued full-time employment, a very low opioid dose,[226] and comprehensive patient education.

Patient-2 signed an opioid agreement.[227] Geller noted that Patient-2's social and medical histories did not suggest a high risk for opioid abuse.[228] While performing injections, Geller observed that Patient-2's eyes, nose, mouth, demeanor, and gait betrayed no evidence of abuse,[229] and determined drug screening was unnecessary.[230] Patient-2 maintained the same treatments and prescriptions at his third and fourth visits on September 5 and October 2, and reported that injections helped.[231]

On October 19, *Patient-1* called Geller's office to cancel *Patient-2*'s next visit,[232] and on November 26, Patient-2 called and, after four months with Geller, discharged himself from Geller's care, now saying "the injections were not working."

Geller was surprised by the cancellation because he believed they had established a rapport,[233] and was dubious[234] about Patient-2's explanation

because it contradicted earlier reporting of substantial pain reduction. Geller was concerned Patient-2 would seek more opioids rather than Geller's program of injections with fewer opioids,[235] and felt it was important for Patient-2's other doctors to know Patient-2 had made conflicting statements on opioid-related matters.[236] Thus, in Geller's November 26 notes, he wrote: "Either the patient is embracing falsification at this time as he asserts to inefficacy or he was being untruthful," and therefore "his veracity is questionable as an occult agenda appears to be an unstated motivator." Geller forwarded the notes to Patient-2 and his referring doctor.[237]

In January 2013, *Patient-2* filed a complaint,[238] alleging Geller was unprofessional and his records inaccurate.[239] Patient-2 referred to untreated back pain,[240] though he had consulted Geller for only his neck and shoulder.

The complaints by Patient-1 and Patient-2 are related: in *Patient-1*'s December 2012 complaint to the Board, *Patient-2* is repeatedly mentioned as a corroborator of *Patient-1*'s allegations, and Patient-1 referred to Patient-2's "joint complaint." Geller also understood the complaints were related because Patient-2 and Patient-1 were intimate roommates, and their complaints were filed just a month apart.[241] Geller filed a response with the Board defending the accuracy of his records, and suggesting Patient-2's complaint was motivated by Patient-1.[242]

I. Patient-3

Patient-3[243] had a work injury and was on workers' compensation.[244] Back operations in 2009 and 2010 left him with chronic back and neck pain,[245] but doctors determined further surgery would not help.[246] He had tried several injections, opioid and non-opioid medications, and physical therapy,[247] but only opioids worked.[248] His primary doctor had ideas for possible treatments, but lacked capability to administer them,[249] so referred Patient-3 to a pain specialist.[250] In July 2012 at age 53, Patient-3 made an appointment with Geller.

They never met. Through a clerical error, Geller's office was closed when Patient-3 came for his appointment, and Patient-3 did not show up on July 23, 2012 for the substitute appointment.[251] Awaiting his arrival, Geller reviewed Patient-3's medical chart.[252] Because it was a workers' compensation case, when Patient-3 did not appear, Geller understood his role was a record review,[253] which he had done from time to time.[254] When he noticed important items missing, Geller contacted the workers' compensation carrier for additional portions.[255]

Geller's 16-page report made some conclusions and recommendations,[256] qualifying his comments because he lacked Patient-3's full record and had not conducted in-person observation.[257] Geller noticed Patient-3 was ingesting a potentially lethal combination of opioids and benzodiazepine, and his dosage was too high.[258] Geller offered a polemic on the value of employment,[259] asserted Patient-3 "100% has the ability to return to at least full time sedentary work, 8 hours a day, 5 days a week," but recommended a formal capacity evaluation.[260]

Geller listed 33 recommendations,[261] including alternative remedies,[262] vocational rehabilitation, and finding a job.[263] Geller did an assessment of whether Patient-3 was a viable candidate for opioids, and concluded he was not.[264] Geller discussed opioid equivalencies[265] and side-effects,[266] and risk

factors for opioid-related problems.[267] He suggested non-opioid medications,[268] and less abusable opioids should any be prescribed.[269]

Geller sent the report to Patient-3, his other doctors, and to the workers' compensation carrier.[270]

A year later, Patient-3 filed a complaint with the Board. He asserted that Geller's records made it sound like he was remiss and dishonest, and that Geller's report was responsible for denial of disability benefits to which he believed he was otherwise entitled.[271] Geller filed a response explaining he appropriately conducted a record review, and stood by his comments and conclusions.[272]

STATEMENT OF THE CASE

In December 2012 and January 2013, Patients-1 and -2 filed complaints, to which Geller responded in January and February 2013.[273] In January, the Medical Review Subcommittee ("MRSC"), the investigatory branch of the Board,[274] subpoenaed Geller's records regarding the complainants,[275] and commissioned experts to investigate.

Regarding Patient-1, MRSC's expert summarized the complaint and response, and suggested that Geller "appears to over react to criticism," but found no conduct outside the standard of care.[276] Regarding Patient-2, a different MRSC expert suggested Geller interpreted the records to show Patients-1 and -2 had conspired against him, but also found no negligence.[277]

In May 2013, the Board received a complaint from Patient-3, to which Geller responded.[278] The MRSC again employed an expert, who found that Geller had addressed the cause of the scheduling snafu, engaged in no misconduct, and had little impact on denial of disability.[279]

In July 2013, an investigator posed as a cash patient, and confirmed that Geller's practice summarily declined such high-risk cases.[280] In August, investigators conducted an inspection, and took pictures of Geller's office and appointment books.[281] They also seized six random files, which, in addition to the three complainants, established the nine numbered patients referenced in this matter.[282] During the inspections, with which Geller cooperated,[283] the Board learned Geller stored old records off-site and expressed its disapproval; Geller immediately removed them to his office.[284]

In June 2014, the Board posed 19 interrogatory-type questions to Geller, which he answered in July.[285] In September, apparently unsatisfied with the MRSC experts who concluded no duties were breached in the complainant cases, the Board engaged Beasley.[286] He was a recently retired anesthesiologist with a background in surgical numbing and sedation.[287] Beasley reviewed charts

of the nine patients – records between 2002 and 2013 – and some investigatory materials.[288]

In April 2015, Beasley communicated his conclusions to the Attorney General, via "Expert Review,"[289] which has never been shared with Geller.[290] In August, the Attorney General summarized Beasley's opinions in a Report of Investigation authored by Attorney Heaton, who was later the State's prosecutor.[291] The Heaton/Beasley report found things to praise about Geller, but listed disagreements with his approach toward several patients.[292]

In November, the Board issued a Notice of Hearing, constituting notice of disciplinary charges.[293] After reciting alleged facts, paragraphs A through Z brought 26 allegations of misconduct, both general and denoting particular patients, pursuant to statutes, rules, and ethics codes,[294] and ordered commencement of disciplinary proceedings.

The nine numbered patients and all allegations are tabulated on page 36.

In a March 2016 prehearing conference, the parties indicated they were attempting joint stipulations to "streamline and shorten the length of the hearing," but anticipated it "will take at least two days of hearing time to fully direct and cross examine the experts and other witnesses."[295]

Geller submitted to a review by Boston medical consulting firm Affiliated Monitors, Inc. (AMI), selected by the Board.[296] AMI designed the review "to provide … Geller with an opportunity to demonstrate his skills through an evaluation of his written and stated patient care and to address issues identified by the … Board."[297] AMI designed the assessment, which it described as:

> includ[ing] two clinically-based interviews, conducted by physiatrists with experience in interventional pain management, reviews of Dr. Geller's patient care charts, and evaluation of [his] experience and professional education activities. AMI identified, and the Board approved, two physiatrists with experience in pain medicine to serve as the evaluation monitors.[298]

During summer 2016, the two AMI doctors collectively reviewed 13 of Geller's files (different from the numbered nine) picked from Geller's appointment book over a range of time, and interviewed Geller for hours, one by videoconference and the other in person. AMI's assessment focused on three broad topics: clinical knowledge, clinical reasoning and application of knowledge to practice, and medical recordkeeping.[299] On clinical topics, AMI determined Geller "demonstrated a breadth of knowledge that was complete in many areas," suggested some "in which he would benefit from further review," but found no conduct below the standard of care. On recordkeeping, AMI critiqued Geller's current documentation system.[300]

In mid-2016, Beasley became a member of MRSC,[301] a paid position. His duties were reviewing complaints made to the Board, investigating, writing a report, and presenting conclusions to fellow MRSC members.[302]

As part of this proceeding, Geller engaged expert physiatrist Andrew Forrest.[303] In October 2016, Forrest filed an expert report in anticipation of testimony, in which he disputed and rebutted allegations made by Heaton/Beasley regarding the nine patients, contested the State's characterization of the standard of care, and asserted Geller had met the standard for all patients.[304]

In November, Heaton filed the State's prehearing brief. The parties had not agreed on stipulated facts "therefore [making] all of the facts … in dispute." Heaton grouped allegations in two broad categories: knowledge/competence

and disclosures/recordkeeping.[305] The parties exchanged witness and exhibit lists.[306]

At a November 18 prehearing conference, the parties discussed the scope of trial and time necessary for presenting their cases. Heaton planned to examine her investigator, Beasley, and Geller.[307] Geller's lawyer, James Bello of Boston, indicated he would call Geller and Forrest.[308] Bello urged Heaton to consolidate issues, but Heaton insisted on presenting evidence on all nine patients.[309] The Board noted "it's just going to be a full blown hearing."[310] The parties then calculated the time necessary for all witnesses,[311] with Bello estimating a week[312] and Heaton suggesting four days.[313]

On December 1, the Board's procedural order urged parties to keep presentations short.[314] December 7, the first half-day of hearing, comprised openings, investigator testimony, and direct examination of Beasley. At the end of the day, the Board indicated it planned four additional dates – two in January and two in March,[315] and a few days later the Board's scheduling order memorialized those four dates.[316]

A month later, however, on January 11, 2017, without any further proceedings, the Board issued an amended procedural order. Reciting members' calendaring difficulties, it scheduled two hearing days in January, but announced "no further dates will be scheduled."[317]

The remainder of the hearing took place on January 30 and 31, 2017. Testimony addressed all nine numbered patients. It compared the seven expert opinions (Iber – twice, Conway, Feeney, Kishner, Forest, and Geller), which all found that Geller's conduct met the standard of care, against Beasley's opinion that (where standards existed) it did not.[318] With no time for Forrest's testimony, parties waived closings,[319] and the hearing concluded.

Over a year-and-a-half later, on October 5, 2018 – nearly six years after Patient-1 filed her complaint and during which the Board expressed no

quandary with Geller's continuing practice – a decision issued. The Board recited the State's allegations and investigations, and listed the parties' numerous and voluminous exhibits. It rejected allegations attacking Geller's knowledge and competence,[320] but found sufficient evidence on twelve issues, mainly related to frequency of drug screening and maintenance and disclosure of medical records.[321]

The Board imposed reprimand, its lowest discipline. It fined Geller $2,000, mandated education and recordkeeping modifications identified by AMI, and ordered Geller "work with a monitor, who shall be a Board Certified Pain Specialist," until March 2021.[322] Geller appealed.

The standard of review on appeal is:

> Upon the hearing the burden of proof shall be upon the party seeking to set aside any order or decision of the commission to show that the same is clearly unreasonable or unlawful, and all findings of the commission upon all questions of fact properly before it shall be deemed to be prima facie lawful and reasonable; and the order or decision appealed from shall not be set aside or vacated except for errors of law, unless the court is satisfied, by a clear preponderance of the evidence before it, that such order is unjust or unreasonable.

RSA 541:13.

SUMMARY OF ARGUMENT

Geller first discusses the Board's retained clinical allegations. He shows he knew and understood anatomy and morphine equivalence, and demonstrates he diligently assessed, prescribed for, monitored, and tested all his patients, within the standard of care.

Geller than addresses the non-clinical allegations, regarding disclosures and documentation. He violated no rule or standard.

Finally, Geller shows that in the process of truncating the hearing, the Board prevented his expert from testifying. This resulted in a lopsided explanation of the standards of care, as the only remaining expert had an interest in the prosecution.

Overall, it appears the Board disciplined Geller, not because it found him incompetent or unethical, but in reaction to the opioid epidemic, and because it disagreed with his observation, emphatically expressed, that some people use pain to avoid work, when work may provide the best passage through pain.

Table of Patients, Retained & Rejected Allegations

BOM ¶	Substance of Allegations	Patient Number								
		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
NON-CLINICAL ALLEGATIONS, RETAINED										
E	Disclosed medical information without authorization	X								
K	Wrote report with "blended social theories"			X						
Y	Stored medical records offsite *									
W	Misrepresented board certifications *									
CLINICAL ALLEGATIONS, RETAINED										
C	Improperly described suprascapular nerve *									
	Morphine equivalency (appears in order, not allegations) *							?		
U,V	Prescribed opioids with inadequate monitoring							X		X
P	Prescribed opioids without reviewing records or drug screening					X				
Q	Restarted opioids after heroin, without screening					X				
R	Inadequate monitoring after restarting opioids					X				
M	Inadequate drug screening *									
REJECTED ALLEGATIONS										
A	Performed nerve blocks using Celestone	#								
B	Did not recognize/discuss risks/side effects of injections	#								
D	Did not consult with allergist	#								
F,G	Did not respect patient's rights and best interests	#	#							
L	Lacked knowledge/competence to prescribe opioids for chronic pain *									
N	Lacked knowledge/competence for injections *									
O	Counseled that certain opioids are abuse-resistant *									
S	Prescribed methadone on as-needed basis						#			
T	Addressing patient's emotional distress						#			
H	Disclosed information to insurance carrier without consent			#						
I	Received/used/disclosed medical records without authorization			#						
J	Provided medical records to third party without consent			#						
X	Referenced letters as publications (rejected but affected credibility) *									
Z	Whether Geller subject to discipline for any of above +									

LEGEND

X = *retained allegation*

= *rejected allegation*

***** = *allegation not patient-specific*

+ = *no specific finding, but BOM imposed discipline*

? = *unclear whether finding relates to Patient-7*

ARGUMENT

Clinical Allegations

I. Geller Accurately Described Suprascapular Nerve

Geller performed suprascapular nerve blocks – analgesic injections proximate to the suprascapular nerve – over many years, on all numbered patients (except Patient-3 with whom he had no clinical contact). The only complaints were from Patient-1, who reported they caused her temporary itchiness[323] (a common and generally benign side-effect), and Patient-2, who said they wore off in three weeks[324] (the expected duration). While injections are not a cure, it is well-known they relieve pain, and are an accepted,[325] non-addictive,[326] low-risk remedy.[327]

Allegation-C charges[328] Geller with "professional misconduct by improperly *describing* the suprascapular nerve."[329] The Board did not specify in what context the allegedly improper description occurred.

Basic anatomy shows, and Geller obviously does not dispute, that the suprascapular nerve innervates the "peri-scapular supraspinatus and infraspinatus peri-scapular tissue" – which is how Geller repeatedly and accurately described it.[330] Geller understands, in accord with accepted medical science, that blocking the suprascapular nerve may relieve pain in areas beyond the muscles it innervates. He described how, when the suprascapular nerve is blocked, it addresses pain originating in the rhomboid muscles. Geller never said the suprascapular innervates the rhomboids.[331]

Forrest's report explains the difference between innervation and pain blocking, and had there been time for him to testify, Forrest would have been able to make the distinction clear to the Board:

> Beasley is unreasonably critical of Dr. Geller's use of the term "suprascapular nerve blocks." While it is accurate that the rhomboids are innervated by the dorsal scapular nerve rather than the

> suprascapular nerve, the effects of suprascapular nerve blocks would be expected to cover the area of the posterior shoulder, posterior capsule of the shoulder, and skin overlying the scapula which would be most commonly perceived by patients as the back of the shoulder. As such, the use of the term "suprascapular nerve block" with patients in practice does not rise to the level of "professional misconduct" or "lack of basic medical knowledge" as Dr. Beasley suggests.[332]

Everybody – Beasley, Geller, MRSC experts, AMI reviewers, Forrest, and the Board[333] – described the medical facts similarly. They all agreed that performing suprascapular nerve blocks for the purpose Geller used it (provided the clinician knows the anatomy, which Geller indisputably demonstrated[334]) is within the standard of care.[335] The Board appropriately found no violation regarding Geller's injections and follow-up, Allegations-A, -B, and -D.

There was no suggestion Geller's injections were substandard or misplaced,[336] belying any allegation that he lacked anatomical knowledge; the Board appropriately determined Allegation-N was rejected.[337]

The Board nonetheless found that Geller's "improper describing of the suprascapular nerve amounts to a display of medical practice which is incompatible with the basic knowledge of competence."[338] It is undisputed that blocking the suprascapular nerve relieves pain in an area broader than the specific muscles it innervates.[339] There is no evidence that Geller ever inaccurately or improperly *described* the suprascapular nerve – the substance of Allegation-C.

Accordingly, the Board erred in reprimanding on this basis, and this court should reverse.

II. Geller Explained Morphine Equivalency

Though not appearing among the allegations in the Notice of Hearing, in its order the Board found Geller "could not explain the morphine equivalency."[340]

Equivalency is an attempt to enable comparison among opioids, find an "equianalgesic dose ratio" for differing opioids, and determine total opioid ingestion.[341] Morphine is the common opioid reference, and equivalency calculators are expressed as milligrams of morphine.[342]

There are several equivalency calculators, and no consensus or rule on which is best.[343] They produce "major variability" in conversion ratios,[344] and some opioids, especially fentanyl,[345] cannot be reliably converted.[346] At most, the calculators are considered guidelines, and the only way to truly determine dosing is clinical monitoring.[347] Although the Board now recommends using its on-line calculator, it was not yet adopted at the time.[348]

Forrest thus criticized Beasley's calculations of the morphine-equivalent dosages Geller prescribed.

> I have had the opportunity to review the various morphine dose equivalences referenced by Dr. Beasley. It should be noted that several dose equivalence calculators exist in the literature which can produce different numbers and no specific calculator is endorsed by the New Hampshire Board of Medicine.… In light of the different assumptions each physiatrist may make regarding the cross-sensitivity of different opioids, the resulting morphine equivalences can produce different dosing calculations. As such, it is unclear how to best address Dr. Beasley's calculations and conclusions in light of the varying methodologies that exist that may produce different results.[349]

AMI also recognized Geller was aware of relative potency and toxicity.[350]

Throughout his records, Geller commented on opioid equivalency, and

the dosing issues equivalency presented for his patients,[351] demonstrating his understanding. For instance, Geller suggested Patient-7's[352] situation "implicate[d] morphine and morphine equivalent dosing,"[353] considered whether "200mg of morphine equivalent [was] a 'high dose,'"[354] and described one medication as "20-30 times the analgesic potency of morphine."[355]

Geller testified that the various conversion guidelines are "still in a huge state of flux,"[356] how some calculators are more reliable for some medications, and that equivalency can vary among patients. Regarding Patient-9, for example, Geller explained that there is "no uniform agreement amongst … experts in pain management with respect to transition from one opioid to another."[357]

It is thus unsurprising the Board rejected Allegation-L, whether Geller had knowledge and competence to prescribe opioids for chronic pain; Allegation-O, whether he understood abuse properties of various opioids; and Allegation-S, whether he appropriately prescribed opioids to Patient-6 on as-needed basis.[358]

But contrary to the Board's finding, it is apparent Geller could fully "explain … morphine equivalency."[359] Had Forrest testified, the Board would have been educated on various equivalency calculators, strengths and weaknesses of each, lack of consensus regarding how they are used, and confusion stemming from the existence of multiple calculators.

Geller's records show he regularly adjusted dosing, and prescribed different opioids as needed. There is no allegation Geller harmed any patient by prescribing the wrong quantity or formulation of any medication, showing he fully understood and regularly accounted for morphine equivalency in his practice.[360] Geller now uses the Board's calculator for all patients,[361] and routinely documents equivalency.[362]

Accordingly, the Board's finding that Geller could not explain morphine equivalency is erroneous, and this court should reverse.

III. Geller Satisfactorily Monitored and Tested Opioid Patients

The Board based its reprimand, in part, on six allegations (U, V, P, Q, R, M)[363] that Geller insufficiently monitored and drug-screened opioid patients.

A. Drug Screening at Doctor's Discretion

Treatment of patients in this case occurred between December 2002 and July 2014. Complaints were filed in December 2012 and January 2013.

Before 2013, there were no rules directly regulating opioid prescribing. Instead,[364] the rules guided doctors to the standard of care, N.H. ADMIN. R. MED 502.01(i) (July 18, 2007) (Document #8945),[365] *Appx.* at 40, embodied in several policy guidelines.[366]

The 2004 Federation of State Medical Boards policy, updated in 2012, expounded 11 standard of care recommendations, including drug screening, which said:

> Periodic drug testing may be useful in monitoring adherence to the treatment plan, as well as in detecting the use of non-prescribed drugs. Drug testing is an important monitoring tool because self-reports of medication use is not always reliable and behavioral observations may detect some problems but not others. Patients being treated for addiction should be tested as frequently as necessary to ensure therapeutic adherence, but for patients being treated for pain, *clinical judgment trumps* recommendations for frequency of testing.[367]

In 2009 the American Pain Society (APS) and the American Academy of Pain Medicine (AAPM) promulgated similar guidelines, providing:

> In patients on [chronic opioid therapy] who are at high risk or who have engaged in aberrant drug-related behaviors, clinicians should periodically obtain urine drug screens or other information to confirm adherence. In patients … not at high risk

> and not known to have engaged in aberrant drug-related behaviors, *clinicians should consider* periodically obtaining urine drug screens or other information to confirm adherence.[368]

The 2009 APS/AAPM guidelines noted that while urine tests "can be useful supplements," and that "[p]eriodic urine drug screening can be a helpful tool to monitor patients, … no evidence exists that demonstrates that screening improves clinical outcomes"[369] or curtails abuse.[370] At the time, only 7 percent of chronic opioid patients were being screened.[371]

Effective May 8, 2013, new rules provided:

> When prescribing any controlled substance for use in pain control, licensees shall … [u]tilize appropriate treatment standards for the treatment of chronic pain, including … [a]ppropriate toxicology screening, *if indicated*.

N.H. ADMIN. R. MED 501.02(i)(2)(f) (Apr. 12, 2011, readopted May 1, 2013), Exh. DDDD (emphasis added), *C.R.* at H574, *Appx.* at 44.

Thus, in the time period covered by this case, no guidelines or standard of care mandated testing, or even endorsed comprehensive testing, and clinicians had broad discretion to screen or not, depending upon their assessment.[372]

Although Beasley claimed that Geller's allegedly sparse testing fell below the standard of care,[373] he conceded that during the time covered by this case, the guidelines did not require screening, the standard of care was fluid and imprecise, and that screening does not necessarily improve outcomes.[374] Forrest accordingly wrote:

> I disagree with Dr. Beasley's generalized conclusion that failure to periodically drug test in any way deviated from the standard of care. … [T]his entire issue is in flux and as time progresses, clearer recommendations and guidelines based on scientific studies will become

> prominent. The issue of drug screenings has only recently come to the forefront of the practice of chronic pain management.[375]

Screening carries risks of both false negatives and false positives,[376] and therefore results may be inaccurate or misleading, simultaneously blinding clinicians to people misusing opioids, or causing termination of legitimate patients.[377] Both Beasley[378] and the Board recognized this problem, cautioning clinicians against "dismissing a patient, perhaps improperly."[379] Also, scheduled tests can be manipulated.[380] Both AMI physicians confirmed Geller valued the importance of "substance abuse screening, and monitoring – namely urine toxicology."[381] Before the rules changed, in accord with then-prevailing standards, Geller regarded screening as wasteful when not otherwise indicated,[382] though Beasley disagreed.[383]

In 2015, three years after Geller's actions here, emergency rules were promulgated, N.H. ADMIN. R. MED 501.02(i)(2) (Sept. 4, 2015) (Document #10969), *Appx.* at 48, becoming effective in January 2017 – coincident with the hearings in this matter. Addressing the opioid epidemic, for the first time they "[r]equire random and periodic urine drug testing at least annually for all patients" on long-term opioids. N.H. ADMIN. R. MED 502.05(l) (Jan. 1, 2017) (Document #11090), *Appx*. at 56. Board members expressed rueful familiarity with the just-rewritten rules.[384]

Since annual drug testing became mandatory, Geller has complied,[385] and conceded that the rule improved his practice.[386]

B. Geller Acted Within Standard of Care

Throughout the period covered by this case, Geller acted within the standard of care.

The guidelines direct that identifying patients who are not appropriate opioid recipients is the critical first step to safe prescribing.[387] Geller characteristically spent two to three hours with each patient at intake, and then more after patients departed, assessing and preparing notes.[388]

Geller prescribed opioids to only a "very small subset of patients" – not those with incomplete records, unstable medical situations, brittle mental health, struggles with abuse or addiction, or the unemployed.[389] For those passing his triage, Geller's records show he closely weighed benefits and risks of opioid and non-opioid treatments.

Geller's records show his monitoring included comprehensive examinations, searching for physical, mental, and emotional signs of addiction, diversion, or other aberrant behaviors. After assessment intake, Geller established treatment plans for each patient, did not prescribe opioids without evaluating other options first, and started with low doses. He observed all patients at monthly half-hour follow-ups, reviewing whether treatments were achieving functional goals, and re-triaging before doses were escalated.[390] All of Geller's opioid patients entered opioid agreements.

Geller inquired about patients' families, jobs, stresses, and activities. He was an early participant in PDMP, communicated with pharmacies and patients' providers to ensure they received comprehensive care and could not obtain opioids from multiple sources, and shunned the most easily abused formulations. Geller educated his patients about opioid risks, and the value of maintaining functional lifestyles. When he determined opioids were inappropriate, he did not prescribe them (Patient-1), or canceled them (Patient-5).

Patient-8's chart, for example, shows Geller's 3-hour initial session, reviewing prior records to authenticate pathologies and previous interventions, and recording physical condition, areas of pain, motion and speech, and mental acuity. Geller compared "favorable terms of opioid candidacy" against "unfavorable concerns regarding opioid candidacy," and concluded certain opioids could not be safely prescribed. Geller listed a 22-point treatment plan, and educated the patient about his options. Geller started with injections, and opioids only later. Geller determined testing was unnecessary because Patient-8 showed improvement on low and stable doses, maintained employment, and had no suspect behaviors.[391] Geller similarly paid careful attention to Patient-4's and Patient-6's mental and emotional health, and referred Patient-5 to a psychologist – leading the Board to reject Allegation-T.

Although his patients were not subject to the frequency of today's rules, Geller tested appropriately. Of the seven who received opioids, three (Patients -4, -9, and -6) were drug-tested, one at intake, two annually by others. Given Geller's assessment and monitoring, he determined three patients (Patients -7, -8, and -2) did not warrant screening. Geller did not initially test Patient-5, but ordered screening when she resumed. Geller did not test Patients -1 and -3 because he never prescribed opioids to them.

Geller did not conduct routine testing because his evaluation system and regular assessments scrutinized for signs of malconsumption, most of his patients were employed, and the standard of care allowed discretion.[392] Geller recalled an unrelated patient who presented with dilated pupils, prompting immediate testing, which showed cocaine.[393] Beasley acknowledged Geller is "extremely cautious in prescribing opioids."[394]

C. Monitoring Patient-7, Allegation-U

The Board said Geller did not sufficiently monitor Patient-7. But he closely audited her, as with all his patients, and she exhibited no concerning behaviors or physical indications. Patient-7 had already undergone four unsuccessful surgeries before finding Geller, showing both a documented basis for pain and willingness to try other treatments. In March 2007, Patient-7 asked Geller to increase her injections but not her opioid dose. In December 2010, when she visited Geller's office ahead of schedule (because insurance-mandated diminished frequency of injections was unsustainable), she disclosed unused pills.

Although Patient-7's dose increased over time, Geller documented why: her condition worsened, she was trying to avoid surgery, she experienced seasonal changes in pain, and she had assumed more physical labor after her husband died. When another physician prescribed Percocet, Geller ensured she received opioids from only one source, and followed-up with the other doctor to monitor the additional prescription.

Geller did not drug screen Patient-7, because he regularly physically observed her, he was aware of her activities at work and home, she had never done anything aberrant, and she gave Geller no clinical concern for her safety.[395]

The record shows constant and close monitoring of Patient-7, and this court should reverse Allegation-U.

D. Monitoring Patient-9, Allegation-V

Geller's records demonstrate, in monthly half-hour meetings continuing for years, thorough monitoring of Patient-9.

Patient-9 underwent surgeries and spinal stimulator implantation, demonstrating pain pathology and willingness to try other treatments. Geller noted Patient-9, unlike abusers,[396] did not balk at FDA-reformulated abuse-deterrent OxyContin. When he suffered an injury causing new and additional pain, Geller added injections, but noted Patient-9 did not request increased opioids.[397] Because Patient-9 passed VA drug screens, Geller discerned no need to test. When Patient-9 had a week of leftover medication, Geller prescribed fewer tablets. Geller continually assessed Patient-9, saw no concerning behavioral changes, educated him, and encouraged other treatments and improvement of overall health. When Geller decreased doses, he noted Patient-9 did not discharge – until workers' compensation refused to pay.

The record shows constant and close monitoring of Patient-9, and this court should reverse Allegation-V.

E. Monitoring and Screening Patient-5, Allegations -P, -Q, & -R

As to Allegation-P, Geller made the initial decision to prescribe opioids to Patient-5 after a lengthy initial consultation and formal assessment. She had already been receiving opioids from another physician, and Geller prescribed a substantially lower dose. While she had risk factors, Geller's ORT analysis determined they were not disqualifying,[398] and Patient-5 showed no aberrant behaviors.[399] Geller therefore saw no compelling reason to test her,[400] with which Beasley concurred.[401]

When Geller learned Patient-5 had overdosed, he immediately terminated opioids, began working with her to address personal problems that led to it, met with her family, and referred her to professionals for help.

Geller admits being misled.[402] Doctors, however, tend to have a "truth bias."[403] Both Geller and Beasley conceded they have been surprised learning they were fooled by some patients.[404] Physicians, however, are not judged by a standard of perfection. *See, e.g., Nestorowich v. Ricotta*, 767 N.E.2d 125, 131 (N.Y. 2002).

Geller refused to abandon Patient-5 in her most vulnerable state. Instead, he helped manage her pain, first without opioids, allowing her to maintain physicality and employment, which Geller believed was her healthiest path.

Nearly a year after Patient-5's heroin use, Geller had extensive clinical information verifying sobriety.[405] He restarted her on opioids at an extremely low dose, for ongoing pain. He deliberately did not test her before restarting, because it would be easy to fake,[406] but conducted unannounced testing at her very next appointment, and thereafter, all with appropriate results.[407] Geller also noted changes in her personal life which downgraded her risk and made relapse unlikely.

The record shows that, while Geller did not predict Patient-5's

problems, he acted within the standard of care, and screened when it was necessary and meaningful. This court should thus reverse Allegations -P, -Q, and -R.

F. Drug Screening Patients, Allegation-M

Geller's monitoring of his remaining opioid patients (Patients -2, -4, -6, and -8) was not directly criticized by the Board, though Allegation-M presumably encompasses them. With all four, Geller took conservative approaches to prescribing, trialling non-opioid treatments and increasing dosages slowly, if at all, to make it possible for the patients to work, exercise, engage with family, and avoid surgery. Both Patient-4 and Patient-6 disclosed unconsumed tablets, indicating lack of abuse.

Because the record includes many years of treatment for Patient-4, a review of her record illuminates Geller's approach. Although she was on a low opioid dose, Geller observed Patient-4 each month, evaluating her mental and physical state. He noted educational aspirations and professional successes and challenges. He discussed her family, including her daughter's death and her son's military deployment, and counseled her through the carrier's attempt to deny workers' compensation coverage. Patient-4 was drug-tested by Geller once, at the outset of treatment, but Geller's dedication included monitoring all aspects of her well-being to ensure opioid safety.

The record shows that Geller drug screened when it was necessary, thus acting within the standard of care. Beasley conceded "every doctor has different philosophies,"[408] and that they sometimes disagree[409]; even if another might have acted differently, it does not mean Geller's care was substandard. This court should reverse Allegation-M.

G. Mere Disagreement Among Doctors

The only witnesses who testified about the standard of care for the clinical allegations were Geller and Beasley. By the time of hearing, Beasley was part of the medical-regulatory apparatus. The Board's truncation disallowed Forrest's testimony, and therefore it never heard any disinterested expert on the standards of care for opioid monitoring and drug screening. Geller expected to rely on Forrest's expert opinion, and had he testified, the Board would have been more enlightened regarding the quality of Geller's care.

At most, the proceeding showed that Geller and Beasley disagreed. It is not professional misconduct or a deviation from the standard of care for a doctor to recommend approaches differing from other physicians. *See, e.g.*, *Rolon-Alvarado v. Municipality of San Juan*, 1 F.3d 74, 78 (1st Cir. 1993) ("It is … insufficient for a plaintiff … merely to show that another doctor would have chosen to treat the patient in a manner different from … the attending physician."). There was no allegation that Geller harmed any patient ever.

Accordingly, the Board was in error in finding misconduct, and this court should reverse the reprimand.

Non-Clinical Allegations

IV. Disclosure of Patient-1 Information to Insurance Company, Allegation-E

Allegation-E alleges that Geller was not authorized to disclose Patient-1's medical information to her doctor, and to Chubb, her workers' compensation carrier. The allegation cites violation of two medical ethics opinions, adopted by reference. N.H. ADMIN. R. MED 501.02(h). They provide:

> History, diagnosis, prognosis, and the like acquired during the physician-patient relationship may be disclosed to an insurance company representative only if the patient … has consented to the disclosure.[410]
>
> Notes made in treating a patient are primarily for the physician's own use and constitute his or her personal property.… The record is a confidential document involving the patient-physician relationship and should not be communicated to a third party without the patient's prior written consent, unless required by law or to protect the welfare of the individual or the community.[411]

Thus, disclosures are allowed in four circumstances: requirement of law, patient authorization, protecting patient welfare, protecting community welfare. Geller had all four.

First, New Hampshire's workers' compensation statute provides:

> The act of the worker in applying for workers' compensation benefits constitutes authorization to any physician … to supply all relevant information regarding the worker's occupational injury or illness to the insurer.… Medical information relevant to a claim includes a past history of complaints of, or treatment of, a condition similar to that presented in the claim.

RSA 281-A:23, V(a)(1). While he admits possibly being mistaken,[412] Geller understood Patient-1 was a workers' compensation claimant, and Chubb was the

insurer.[413] She told him she was off work receiving benefits, the records she gave him were related to workers' compensation eligibility, those and others he received contemporaneously listed Chubb, the records directed Geller to explore "treatment options," Geller was to complete a "work comp form," and the form asked about capacity-to-work. It therefore looked like a workers' compensation case mandating disclosure.[414]

Second, Geller had authorization. Patient-1 signed a broad privacy waiver allowing disclosure for purposes of treatment, continuity of care, workers' compensation, and best interest of the patient. Geller recalled conversations where Patient-1 requested he send information to various insurers, and she gave him carriers' contact information.[415] *See Hellman v. Bd. of Registration in Medicine*, 537 N.E.2d 150 (Mass. 1989) (rejecting discipline where patient's attorney gave doctor authorization for disclosure).

Third, Geller had a duty to the patient. Medical literature says functionality is the criterion for chronic opioid treatment, and employment is central to functionality. From his observation and review of medical records, Geller considered Patient-1 employment-capable. He therefore believed his oath of beneficence required disclosure in Patient-1's best heath interest.[416] *See Stempler v. Speidell*, 495 A.2d 857, 861 (N.J. 1985) ("[P]atient's right of confidentiality [is] not absolute.… [D]isclosure may … be made to a person with a legitimate interest in the patient's health.").

Fourth, because Geller felt Patient-1 was exploiting him to avoid working, he had a duty to deter misuse of benefits. *Horne v. Patton*, 287 So. 2d 824, 829-30 (Ala. 1973) (duty of non-disclosure "subject to exceptions prompted by the supervening interests of society, as well as the private interests of the patient himself.").

Patient-1 leaned on Geller to act "ASAP or I won't have any income at all." To the extent Geller mistakenly disclosed to the wrong entity, in haste to

execute his patient's wishes, he contemporaneously apologized. Geller disclosed out of respect for Patient-1's interests, and therefore the Board appropriately rejected Allegation-F; similarly for Allegation-G concerning Patient-2.

Regarding disclosure to Patient-1's primary doctor, in addition to the other grounds, Geller had a duty to ensure continuity of care, authorization for which was in Patient-1's privacy waiver.[417]

Finally, even Beasley thought Geller did not breach any duties by disclosing to Chubb,[418] and there is no allegation that Geller's error had any adverse legal or medical sequelae. This court should reverse Allegation-E.

V. "Blended Social Theories," Patient-3, Allegation-K

Citing a medical ethics opinion, Allegation-K claimed Geller did not use sound medical judgment or hold the best interests of the patient paramount when he wrote a report regarding Patient-3. The Board said Geller "put his mission of blended social theories ahead of the patient."[419] The referenced ethics opinion provides:

> The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering.
>
> A patient-physician relationship exists when a physician serves a patient's medical needs, generally by mutual consent between physician and patient …. In some instances the agreement is implied, such as in emergency care or when physicians provide services at the request of the treating physician. In rare instances, treatment without consent may be provided under court order.… Nevertheless, the physician's obligations to the patient remain intact.
>
> The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare.
>
> Within the patient-physician relationship, a physician is ethically required to use sound medical judgment, holding the best interests of the patient as paramount.[420]

Due to scheduling snafus, Geller and Patient-3 never met face-to-face, never had "interactive communication" establishing the patient relationship. While a physician-patient relationship may exist absent a meeting, that

generally occurs when doctors act upon request of another doctor, *see, e.g., Smith v. Pavlovich*, 914 N.E.2d 1258, 1266 (Ill.App. 2009), an exception built into the rule, and there is a well-established exception for warnings about infectious diseases. *See, e.g., Powell v. Catholic Medical Center*, 145 N.H. 7 (2000). But "a physician who gives an informal opinion at the request of the treating physician, but who provides no services, conducts no laboratory tests, reviews no test results, and charges no fee, does not owe a duty of care to the patient whose case was discussed." *Reynolds v. Decatur Memorial Hospital*, 660 N.E.2d 235 (Ill.App. 1996). Thus, Geller had no obligations to Patient-3, and cannot be disciplined for conduct outside doctor-patient parameters.

Beyond that, Patient-3 was a workers' compensation case, where it is common for doctors to perform independent medical reviews, *see e.g.,* 281-A:38, II; *Appeal of Malo*, 169 N.H. 661, 664 (2017), or a "work capacity evaluation," *Petition of Blake*, 137 N.H. 43, 45 (1993), with which Geller was familiar.[421]

Thus, Geller wrote a record-review report. Iber, the first colleague analyzing Geller's conduct, "s[aw] no deviation from the standard of care" because "[t]his is much like an … IME, in that the patients are not in a traditional doctor patient relationship."[422] The Board sanctioned Geller for doing his job.

Because it was a workers' compensation case, where records are mandatorily disclosed, the Board appropriately rejected Allegations -H, -I and -J, which concern Geller sharing the report with other doctors and the carrier.

Geller's conclusion, which he emphasized was based on records review and not in-person observation, was that Patient-3 was capable of employment. Geller expressed his medically-based understanding that employment is key, with which Beasley agreed:

> Dr. Geller sets high goals for his patients in that he requires patients to work full time.…While

> these goals have the best interest of the patient in mind, they are a higher standard than what most pain practitioners would require.[423]

Therefore, it is no "mission of blended social theory" to say work improves outcomes. Even if it were a mere "social theory," Geller has a right to say it, especially in the best interest of his patient and society. *See Krebiozen Research Foundation v. Beacon Press*, 134 N.E.2d 1 (Mass. 1956) (doctors' right to publish book unfavorable to cancer medication). And even if Geller wrote zealously, his evaluation did not affect Patient-3's benefits.

Finally, the records showed that Patient-3 was ingesting potentially lethal combinations, and had work capacity but was seeking benefits. Geller had duties[424] to "protect the welfare of the individual [and] the community."[425]

Accordingly, this court should reverse Allegation-K.

VI. Off-Site Storage of Records, Allegation-Y

Allegation-Y claims Geller improperly maintained his electronic medical records because he took them "to his house for 'storage.'"[426] According to the Attorney General's investigator, these were "paper records stored off site at his home in Hollis."[427] Geller testified:

> The electronic records were stored in the office. The paper records I brought home and stored in a locked basement at home with a padlock on the door in a closet that nobody had access to. And the house is, of course, always locked as well.[428]

The ethics opinion, which the allegation cites, specifically targets, and is entitled, "Confidentiality: Computers."[429] Because the allegation is limited to paper records, the only arguably relevant portion is the first sentence, which provides:

> The utmost effort and care must be taken to protect the confidentiality of *all medical records*, including computerized medical records.[430]

Beyond this, it is undisputed there exists no rule addressing doctors storing voluminous, dated, or excess paper records off-site.[431] The only rule, with which Geller complied, requires records be complete and legible, and include diagnoses and prescriptions. N.H. ADMIN. R. MED 501.02(d) & (e), *Appx*. at 62.

Off-site storage of medical records is common. *See, e.g., Brice v. Sec'y of Health & Human Servs.*, 240 F.3d 1367, 1377 (Fed. Cir. 2001); *Thornburg v. El Centro Regional Medical Center*, 48 Cal. Rptr. 3d 840, 843 (2006); *Migliori v. Boeing, Inc.*, 114 F. Supp. 2d 976, 981 (C.D. Cal. 2000).

Nothing contradicts Geller's testimony about his security arrangements, and nothing suggests security was lax.

It is apparent that Geller took "utmost effort and care … to protect the confidentiality" of off-site records, and this court should reverse.

VII. Board Certifications, Allegation-W

On his website,[432] and in blurbs ending each patient-note, Geller lists:[433]

- Board Certified, American Board of EMG/Peripheral Neurology/Electrodiagnostic Medicine
- Board Certified, *American Board of Pain Medicine* [ABPM]
- Board Certified, American Board of Physical Medicine & Rehabilitation.[434]

Rules define "board certified" to mean "a physician who is currently certified by a medical specialty board recognized by the American Board of Medical Specialties (ABMS)." N.H. ADMIN. R. MED 301.01(c).

Allegation-W claims that Geller "misrepresent[ed] his current board certifications." The Board found:

> The American Board of Medical Specialties [ABMS] does not recognize the Board of Pain Medicine [ABPM]. It is clear that Respondent is certified in Physical Medicine and Rehabilitation, but adding Pain Medicine as a certification is a misrepresentation.[435]

In its allegations, the Board cited two statutory provisions, although it is unclear on which it relied. The first says a licencee is subject to discipline for:

> includ[ing] in advertising any statement of a character tending to deceive or mislead the public or any statement claiming professional superiority.

RSA 329:17, VI(g). The second says a licencee is subject to discipline for having "engaged in dishonest or unprofessional conduct." RSA 329:17, VI(d).

Beasley testified that ABPM is not recognized by ABMS.[436] There was no attempt to corroborate Beasley's assertion, however, or to substantiate whether Beasley had any knowledge or expertise in medical certifications, and no documentary support on whether ABPM is actually recognized by ABMS.

Even if Beasley were correct, there was no evidence that Geller was aware of non-recognition; that non-recognition was so well-known in the field

that Geller should have known; or whether, if he knew, Geller was dishonest or merely mistaken. The record contains no aspersions of ABPM, or suggestions it is a substandard certification. Rather, Beasley testified he also is ABPM certified and that "[i]t's a good board certification."[437] There was no evidence that Geller's listing of ABPM certification would tend to deceive or mislead the public, especially given that Geller was board certified by other respected institutions that are, apparently, recognized by ABMS, and Geller's otherwise accomplished resumé. There was no evidence that anyone was deceived.

Geller intended no harm, and the Board had insufficient basis for its finding. If there was a technical violation, it was trivial. This court should reverse.

Procedural Issues

VIII. Truncated Hearing and Beasley's Conflict of Interest

The hearing was arbitrarily shortened from four days to two-and-a-half, preempting Geller's expert's testimony. While Geller offered the standard of care on clinical issues, he was the respondent, and is not expected to be heard as a dispassionate witness. No expert was allowed to disinterestedly present Geller's side.

Beasley testified on whether standards of care existed. However, Beasley participated in writing the Heaton/Beasley report in 2015, and was appointed to the MRSC in 2016. When he testified, he was a member of the medical-regulatory system, and therefore had an interest in the prosecution against Geller. *See Fenlon v. Thayer*, 127 N.H. 702, 708 (1986) (witness's bias based on employer).

> When a single individual commingles investigative, accusative, and adjudicative functions, the mere appearance of prejudice may be sufficient to violate due process.

Appeal of Trotzer, 143 N.H. 64, 68 (1998); N.H. CONST. pt. 1, art. 15; U.S. CONST. amds. 5 & 14.

"[W]here issues of fact are presented for resolution by an administrative agency, due process requires a meaningful opportunity to be heard." *In re Town of Nottingham*, 153 N.H. 539, 551 (2006). While Forrest submitted an expert report, because the standard of care is a factual issue for licencing boards, *Matter of Bloomfield*, 166 N.H. 475, 485 (2014), the Board is required to hear live testimony. *Petition of Grimm*, 138 N.H. 42, 46-47 (1993).

Geller expected Forrest, in live testimony, to counter Beasley's views of the standard of care regarding clinical issues. But when truncation hijacked Forrest's rebuttal, the Board stole Geller's opportunity to present competing views, and left it with a biased view.[438] Had Forrest testified, the Board may

have drawn different conclusions regarding the standard of care, altering the outcome. Similarly, the Board disallowed Geller from questioning the basis for AMI's recommendations, which became part of the Board's order regarding remedy.[439]

This court should find that truncation and bias violated Geller's constitutional rights to fully present his case, N.H. CONST. pt. 1, arts. 14 & 15; U.S. CONST. amds. 5 & 14, rule they were prejudicial, and reverse the discipline.

IX. Expert Report Withheld

Beasley's "expert review" is referred to in a report of investigation authored by Assistant Attorney General Michelle Heaton.[440] But Beasley's actual report, issued four months prior, is not in the record, was not disclosed, and Geller has never seen it. Nonetheless, Beasley was the Board's expert, and the prime witness against Geller.

Disclosure of expert reports is required in civil litigation. RSA 516:29-b; SUPER. CT.R. 27. Withholding an expert report is prejudicial, and requires striking the expert's testimony. *Wong v. Ekberg*, 148 N.H. 369 (2002).

Geller did not have the expert report of the primary witness against him. He had hearing counsel's *version* of Beasley's opinions – organized and prepared by the prosecutor – but not the report by Beasley himself. Without it, Geller could not be fully equipped for effective cross-examination of his accuser. Unlike *In re SAU #44*, 162 N.H. 79, 85 (2011), where there was an "elaborate process provided to [the employee] prior to termination," here Beasley's own report was the only unvarnished view of his opinion, and therefore "the risk of an erroneous deprivation," *id.,* was substantial.

Beasley's testimony should have been disallowed, and this court should reverse.

X. Lengthy Process Belies Discipline

Patient-1's complaint initiating this matter was filed in 2012. The Board conducted its investigation in 2013 and 2014. Commencement of disciplinary action was in November 2015. The hearings were held in December 2016 and January 2017. The Final Order imposing discipline was issued over a year-and-a-half later, in October 2018. Geller was responsible for none of these lags.

The pace of the disciplinary action against Geller has been so glacial, the original complaints so aged, and changes in operative rules and Geller's practice now so altered, that any purported concern for Geller's competence or conduct is nonsensical. This court should reverse.

CONCLUSION

For the Board to impose discipline, it had to show Geller:

> engaged in dishonest or *unprofessional conduct* or has been grossly or repeatedly negligent in practicing medicine or in performing activities ancillary to the practice of medicine or any particular aspect or specialty thereof, or has intentionally injured a patient while practicing medicine or performing such ancillary activities.

RSA 329:17, VI(d) (emphasis added).

"'Unprofessional conduct' must relate to conduct that indicates an unfitness to practice the profession. The actions that constituted unfitness to practice are commonly established by the generally accepted practices and procedures within the professional community." *Matter of Bloomfield*, 166 N.H. 475, 481 (2014).

Pressured to address the opioid epidemic, the Board held Geller to testing rules that came into effect years after treatment. It also truncated the hearing, preventing Geller's expert from testifying on the standards of care. The only remaining expert had an interest in the proceeding.

The Board disciplined Geller, not because it found him incompetent or unethical, but because he counsels what patients, and perhaps the broader medical establishment, do not necessarily want to hear about the health benefits of work.

Accordingly (and to the extent Allegation-Z was retained), the Board's process and outcome was unjust and unreasonable, and this court should withdraw discipline.

Respectfully submitted,

Aaron Geller, M.D.
By his Attorney,
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/s/ Joshua L. Gordon

Dated: July 31, 2019

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REQUEST FOR ORAL ARGUMENT AND CERTIFICATIONS

Because the issues in this appeal concern all medical professionals and consumers in New Hampshire, are based on complex facts, and affect Dr. Geller's livelihood, this court should entertain oral argument.

I hereby certify that the decision being appealed is addended to this brief. I further certify that this brief contains no more than 12,831 words, excluding citations to the certified record contained in the appendix, and also excluding those portions which are exempted.

I further certify that on July 31, 2019, copies of the foregoing will be forwarded to Laura Lombardi, Assistant Attorney General, Esq.

/s/ Joshua L. Gordon

Dated: July 31, 2019

Joshua L. Gordon, Esq.

ADDENDUM