State of New Hampshire
Supreme Court

NO. 2019-0009

2019 TERM

OCTOBER SESSION

Appeal of Aaron Geller, M.D.

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

REPLY BRIEF

October 23, 2019

Joshua L. Gordon, Esq.
Law Office of Joshua L. Gordon
(603) 226-4225 www.AppealsLawyer.net
75 South Main St. #7
Concord, NH 03301
NH Bar ID No. 9046

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I. Geller Properly Described the Suprascapular Nerve

The Board based its allegation that Geller "improperly describ[ed] the suprascapular nerve" on a description of treatments Geller provided to Patient-1 in February 2012. In his memorialization of his care, which the Board references in its brief, *Board's Brf.* at 34, Geller wrote:

> [Patient's] right suprascapular nerve region was blocked with 0.5 cc of medication at the suprascapular notch to *decrease afferent pain transmission* originating from the rhomboids minor and major as well as adjacent periscapular posterior shoulder musculature.

PATIENT-NOTE (Feb. 17, 2012), *C.R.* at B270 (emphasis added).

Elsewhere in his notes, and discussed in the Board's brief concerning Patient-7 and Patient-9, *Board's Brf.* at 34-35, Geller had written that: "Suprascapular nerve block may decrease diffuse myofascial muscle spasm pain as the nerve *innervates* the peri-scapular supraspinatus and infraspinatus peri-scapular tissue." PATIENT-NOTE (Oct. 16, 2009) at 10-11 (Patient-7), *C.R.* at D1255 (emphasis added); *see also* PATIENT-NOTE (Sept. 13, 2011) (Patient-9), *C.R.* at E1719. This is an undisputed medical fact.

The Board says "afferent" and "innervate" "mean[] essentially the same thing," *Board's Brf.* at 35, and then accuses Geller of unprofessional conduct for confusing the terms. *Board's Brf.* at 13, 34-35.

"Afferent" is an adjective. It means: "Carrying impulses toward a center, as when a sensory nerve carries a message toward the brain.… Opposite of efferent." TABER'S CYCLOPEDIC MEDICAL DICTIONARY (18th ed. 1997); *see also* MCGRAW-HILL DICTIONARY OF SCIENTIFIC AND TECHNICAL TERMS (6th ed. 2003) ("Conducting or conveying inward or toward the center, specifically in reference to nerves and blood vessels."); STEDMAN'S MEDICAL DICTIONARY (28th ed. 2005) ("Inflowing: conducting

toward a center, denoting certain arteries, veins, lymphatics, and nerves. Opposite of efferent."); WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY (unabridged ed. 2002) ("[B]earing or conducting inward to a part or an organ; conveying nervous impulses from a peripheral part toward a nerve center (as the brain or spinal cord) - opposed to efferent."); NEW OXFORD AMERICAN DICTIONARY (3rd ed. 2010) ("Physiology [-] conducting or conducted inward or toward something (for nerves, the central nervous system….The opposite of efferent.").

"Innervate" is a verb. It means "[t]o stimulate a part, as the nerve supply of an organ." TABER'S CYCLOPEDIC MEDICAL DICTIONARY (18th ed. 1997); *see also* STEDMAN'S MEDICAL DICTIONARY (28th ed. 2005) (innervation means: "The supply of nerve fibers functionally connected with a part."); WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY (unabridged ed. 2002) ("[T]o supply with nerves[.] [T]o arouse or stimulate (a nerve or an organ) to activity."); NEW OXFORD AMERICAN DICTIONARY (3rd ed. 2010) ("[S]upply (an organ or other body part) with nerves.")

In the phrase quoted from Geller's Patient-1 patient-note – "decrease afferent pain transmission" – the word "afferent" indicates the direction of the flow of nerve impulses – to the spinal cord and brain. The description is precise and accurate. Likewise, in the phrase quoted from Geller's Patient-7 and Patient-9 patient-notes, Geller's use of the word "innervate" properly describes the suprascapular nerve as the nerve that arouses the supraspinatus and infraspinatus peri-scapular muscles.

The two words are not synonymous. Geller nowhere conflated them or their concepts, and nowhere used them interchangeably. Geller described using a suprascapular nerve block to treat afferent pain from the rhomboids, but never said he believed the suprascapular nerve innervates the rhomboids. Rather, he accurately documented that the suprascapular nerve innervates "the

peri-scapular supraspinatus and infraspinatus peri-scapular tissue." It is unclear on this record how the Board drew the conclusion that Geller "improperly describ[ed] the suprascapular nerve," but he did not, and this court should reverse Allegation-C.

II. Geller Ensured Follow-Up Drug Testing for Patient-5

Regarding Patient-5, the Board alleges that after her hospitalization in February 2012 and re-start of opioids 10 months later, Geller "did not follow up with any additional tests thereafter." *Board's Brf.* at 25, 45.

However, Geller ensured many tests were performed thereafter. Geller testified that he did seven of them, *Day 3(am)* at 140, *C.R.* at I684, at least one of which is corroborated by record documents showing appropriate results. *See* TABULATED RESULTS FROM MILLENNIUM (test on Jan. 10, 2013), Exh. 65, *C.R.* at C969. Beasley acknowledged that tests were also carried out by other providers at Geller's direction. *Day 2* at 74. While the Board claims that these other tests were done "much later," *Board's Brf.* at 45 (emphasis in original), the Board cites nothing to support that contention.

Accordingly, the Board's understanding of the facts is inaccurate, and Geller adequately screened Patient-5.

Moreover, if in 2012 the standard of care was what the Board now claims it was, there would be no reason for the new rules. Promulgated in 2015, they for the first time "[r]equire[d] 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.

This court should reverse the Board on Allegations -P, -Q, and -R.

III. Geller's Prescriptions for Patient-7 Were Only Occasionally High Dosage

Regarding Patient-7, the Board alleges "Geller continued to prescribe high doses of opioids to Patient 7 for the next five years, at times prescribing in excess of 200 mg morphine equivalency per day." *Board's Brf*. at 27. The allegation is misguided for several reasons.

Date	Morphine Equivalent
January 28, 2008	70
February 25, 2008	150
March 5, 2010	180
January 4, 2012	210
June 20, 2013	210
June 27, 2013	195

First, assuming that 200mg is a "high" dose, the Board's statement is not accurate. The calculators in the record[1] do not show that Patient-7's total dose was high, because there is a gap in the calculators from 2008 to 2010 and from 2010 to 2012. The calculators do not show that from 2008 through 2011 Patient-7's dose went over 200mg, and do not show that Geller was continuously prescribing a "high dose" for a five year period. The record shows that Patient-7's dose fluctuated over time (in response to Geller's assessment of her condition), that there were only occasional periods over 200mg, and then only barely over that threshold.

Second, even with the mandatory rules in place today, testing is not dosage-dependent; high dosage is not cause for heightened testing. The current rules provide for annual testing "for all patients" on long-term opioids.

Finally, dosing is not the point. Allegation-U charges Geller with inadequate *monitoring*. Geller met with Patient-7 for at least a half-hour, every month, for over 6½ years, performing monitoring.

Accordingly, this court should reverse Allegation-U.

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[1]OPIOID DOSE CALCULATOR (Jan. 28, 2008) (70mg), *C.R.* at F2069; OPIOID DOSE CALCULATOR (Feb. 25, 2008) (150mg), *C.R.* at F2070; OPIOID DOSE CALCULATOR (Mar. 5, 2010) (180mg), *C.R.* at F2071; OPIOID DOSE CALCULATOR (Jan. 4, 2012) (210mg), *C.R.* at F2072; OPIOID DOSE CALCULATOR (June 20, 2013) (210mg), *C.R.* at F2073; OPIOID DOSE CALCULATOR (June 27, 2013) (195mg), *C.R.* at F2074.

IV. Geller Acted Within the Standard of Care Prevailing at the Time of Care

Geller argues generally that he is being held, in 2019, after years of well-publicized causes and consequences of a national opioid crisis, to standards and rules that were not in effect in 2002 or 2013. To support that, he testified that at the time, just 7% of opioid patients were being regularly screened.

The Board seeks to undermine that statistic by claiming Geller's only citation is to himself. *Board's Brf.* at 43, n. 7. Not so.

The citation the Board lists is to: "Turner JA, Saunders K, Shortreed SM, *et al.* Chronic opioid therapy risk reduction initiative: impact on urine drug testing rates and results. J.Gen.Intern.Med. 2014 Feb. 29(2): 305-11." *Prescription Drug Monitoring Program Standard of Care to Maximize Safe Opioid Medication Prescribing* (Jan. 14, 2016), Exh. 0078, *C.R.* at F2292 slide 2.

Because Hearing Counsel did not challenge the statistic in the proceedings at the Board, the medical reference cited is not in the record. The statistic is thus undisputed, and remains as support for Geller's argument that he was within the standard of care. Accordingly, this court should reverse Allegation-M.

V. Geller Preserved His Objection to a Truncated Hearing

The Board argues that Geller's lawyer, James Bello, did not adequately preserve his objection to the truncated hearing. *Board's Brf.* at 8.

A four-day trial was anticipated by both parties and the Board. At the prehearing conference, Hearing Counsel Heaton conceded, "when we suggested the two days initially, that was with the hope of settlement and the assessment and maybe narrowing down some of the issues, but we haven't been able to do that." *Prehearing Conf. Trn*. at 16-17. Both Bello and the Board urged her, for example, to discuss drug testing evidence together, instead of patient-by-patient, to save time. But Heaton refused, saying, "there's no way to narrow that down." *Prehearing Conf. Trn*. at 18-20.

Barring settling or narrowing, both parties expected trial to take either four days (Heaton) or a week (Bello). This constitutes preservation of the issue at the earliest possible time. *Prehearing Conf. Trn*. at 23, 25. The parties discussed their witnesses and timetables, and the Board then promised Geller it would not "constrict in any way" Bello's presentation, and yielded that "it's just going to be a full blown hearing." *Prehearing Conf. Trn*. at 20. *See Petition of Sprague*, 132 N.H. 250, 257-58 (1989) (Board of Medicine denied adequate opportunity to cross-examine by setting arbitrary time limitation.)

The order stemming from the prehearing conference "recognize[d] that [Geller] is entitled to a full and vigorous defense." PROCEDURAL ORDER (Dec. 1, 2016), *C.R.* at A144. 14. After the first half-day, the Board issued its scheduling order, specifically listing four additional hearing dates. The first two were "scheduled for January 30-31, 2017," and the second two were "tentatively scheduled for March 13-14, 2017." SCHEDULING ORDER (Dec. 12, 2016) *C.R.* at 146.

Given this, Bello proceeded with an understanding and expectation that Geller's trial would last four additional days, two hard-scheduled on January

30th and 31st, and two sometime in March, probably on the 13th and 14th.

At the end of the day on January 31st, it was clear the Board considered the hearing over. Bello, politely deferential, knowing he had earlier preserved his position on a longer trial, merely waived closing arguments. He did not, however, nullify his earlier argument. Accordingly, this court should reach the procedural issues Geller raised.

VI. Geller Adequately Maintained Electronic Medical Records

The Board alleges Geller was unprofessional in the way in which he handled his electronic medical records. Medical Opinion 5.07 provides, in part:

> The utmost effort and care must be taken to protect the confidentiality of all medical records, including computerized medical records. …
>
> [W]hen … information is stored in computerized data bases:
>
> (1) Confidential medical information should be entered into the computer-based patient record only by authorized personnel. Additions to the record should be time and date stamped, and the person making the additions should be identified in the record;
>
> (2) [Disclosure of existence of electronic data];
> (3) [Notification];
> (4) [Dissemination];
> (5) [Procedures for adding or changing data];
> (6) [Procedures for purging data];
>
> (7) … Access to the computerized data base should be controlled through security measures such as passwords, encryption (encoding) of information, and scannable badges or other user identification;
>
> (8) Back-up systems and other mechanisms should be in place…;
>
> (9)(a) Stringent security procedures should be in place to prevent unauthorized access to computer-based patient records…;
>
> (9)(b) [Destruction of records].

AMA OPINION 5.07 (1998), Exh. 29, *C.R.* at E2020.

Geller complied with these rules. Confidential information was handled only by Geller and his office assistant. His records were time- and date-stamped, and reflect who wrote them. Access was controlled, and Geller ensured backups.

No rule prohibits keeping medical records in a word-processing program, and up to 90 percent of doctors use copy-and-paste in their medical records. *See, e.g.*, Sue Bowman, American Health Information Management Association, *Impact of Electronic Health Record Systems on Information Integrity: Quality and Safety Implications*, PERSPECTIVES IN HEALTH INFORMATION MANAGEMENT (Fall 2013) <http://perspectives.ahima.org/impact-of-electronic-health-record-systems-on-information-integrity-quality-and-safety-implications/#.UlOQPmRgYcs>.

There has been a great deal of public attention on computer security issues in the years since the complaints in 2012. Industry practices have changed, as have Geller's. He is being held, however, to arbitrary standards created by the Board after the fact. This court should reverse Allegation Y.

CONCLUSION

In 2019, Geller is defending conduct that occurred between 2002 and 2013. The Board has allowed him to continue practicing during that time, demonstrating it does not have serious concerns for public safety.[1]

Since the conduct in this case, there has developed and been recognized an opioid crisis, resulting in dramatic changes in public and regulatory attitudes toward opioids and the rules governing opioid prescribing. There have also been substantial changes in public and regulatory attitudes toward maintenance of electronic records.

Beasley, the Board's expert, came from a background in anesthesiology, which uses medications primarily for relieving pain during surgery. Geller's background and practice is the diagnosis and treatment, using medication and non-medication therapies, of peripheral nerve and muscle disorders to facilitate return to work. Though related, the two disciplines have diverging outlooks. Rather than unsafe or unprofessional conduct, this case reflects ordinary disagreement about approaches to medical care, which Beasley repeatedly acknowledged is common. *Day 1* at 138, 139, *C.R.* at I138, I139; *Day 2* at 100, 197, *C.R.* at 245, 342.

Geller is being held, in 2019, to standards that did not exist in 2002 and 2013, and no patient ever came to any harm in Geller's care. Although Geller received the Board's lowest form of discipline, patients and insurance companies do not necessarily make fine distinctions, and the Board's unreasonable sanction has resulted in out-of-proportion professional consequences. This court should reverse.

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[1]The Board misconstrues this point as a statute of limitations claim. *Board's Brf*. at 56.

Respectfully submitted,

Aaron Geller, M.D.
By his Attorney,
Law Office of Joshua L. Gordon

/s/ Joshua L. Gordon

Dated: October 23, 2019

Joshua L. Gordon, Esq.
Law Office of Joshua L. Gordon
(603) 226-4225 www.AppealsLawyer.net
75 South Main St. #7
Concord, NH 03301
NH Bar ID No. 9046

CERTIFICATIONS

I hereby that this brief contains no more than 3,000 words, excluding those portions which are exempted.

I further certify that on October 23, 2019, copies of the foregoing will be forwarded to Laura Lombardi, Esq., Assistant Attorney General.

/s/ Joshua L. Gordon

Dated: October 23, 2019

Joshua L. Gordon, Esq.