Before the
New Hampshire Board of Medicine
Concord, New Hampshire 03301

In The Matter Of: **Docket No.: 15-08**
Aaron Geller, M.D.
License No.: 10423
(Adjudicatory/Disciplinary Proceeding)

FINAL DECISION AND ORDER

Before the New Hampshire Board of Medicine ("Board") is an adjudicatory/disciplinary proceeding in In the Matter of Aaron Geller, M.D. ("Respondent" or "Dr. Geller") in Docket Number 15-08.

Introduction

Dr. Geller was first granted a license to practice medicine in the State of New Hampshire on October 7, 1998. He completed his M.D. at the University Of Pennsylvania School Of Medicine in 1991 and completed his internship at Mercy Hospital Pittsburgh, Pennsylvania. He completed a physical medicine and rehabilitation residency between 1992 and 1995 at Tufts University in Massachusetts. Respondent maintains his own pain management practice, Nashua Pain Management Corporation, which he founded in 2001.

Between December 2012 and May 2013, the Board received complaints from former patients of the Respondent. At least three patients complained about Respondent's treatment of them during that time frame. As a result, the Board ordered an investigation, which included an unannounced inspection of Respondent's Nashua practice. The Board also ordered that a sampling of Respondent's records be obtained. In August 2015, the Medical Review Subcommittee ("MRSC") completed a Report of Investigation ("ROI") using an outside expert in pain management, Dr. Ralph Beasley, to review the complaints, patient records and Respondent responses. The ROI (at Exhibit CCCC, which contains confidential patient information) discussed issues relative to 9 patients, including concerns over the fabrication of information, inaccurate records, unprofessional and unethical conduct, and poor office maintenance. *See* Exhibit CCCC.

After reviewing the ROI, the Board voted to pursue discipline against Dr. Geller and issued a Notice of Hearing on November 19, 2015. The Notice of Hearing contained allegations against Respondent relative to each of the 9 patients whose records were reviewed. *See* Notice of Hearing paragraph 5, subparagraphs A – CCC. The Notice of Hearing also indicated specific issues to be determined at the hearing including 25 issues found at paragraph 6,

subparagraphs A –Y, claiming violations of RSA 329:17, VI (c), (d) and (g); N.H. Admin. Rule Med 501.02(h), (i)(4); and the AMA Code of Ethics 5.07,7.01,7.02.

The Board subsequently requested an assessment of Respondent's clinical skills. Affiliated Monitors performed the assessment and issued a report in August, 2016. *See* Ex. 74. The report cited several concerns relative to Respondent's management of patients and noted deficiencies in his charting of diagnostic considerations supporting clinical rationale and intervention.

Procedural Background Information:

The Notice of Hearing scheduled the case for January 6, 2016. On December 4, 2015, Respondent's attorney filed an assented to motion to continue. That continuance was granted rescheduling the case for May 4, 2016. *See* Order of Continuance dated December 10, 2015. Additionally, after the Hearing Notice issued, Patient 3 moved to intervene in the matter. The Board granted limited conditional intervention. Hearing counsel moved to clarify the grant of the intervention and requested a prehearing conference. A prehearing conference was held on March 18, 2016. The Board issued a prehearing order clarifying any outstanding issues.

In June, 2016 the Parties filed a Joint Motion for Extension of the Procedural Order Deadlines. The Board issued a Scheduling Order on October 13, 2016, setting a further prehearing conference for November 18, 2016 and scheduling the hearing for December 7, 2016. Hearing counsel moved to continue, noting that a full two days of hearing would be necessary to complete the case and requested two consecutive days for the hearing. The Board denied the Motion by Order dated November 4, 2016. The hearing was commenced on December 7, 2016 and continued on January 30, 2017 and January 31, 2017. *See* Procedural Order dated January 1, 2017. Board members participating in all three days of the hearing were:

Edmund J. Waters, Jr., Presiding Officer
Mike Barr, M.D.
Frank Dibble, Jr., M.D.
Daniel Potenza, M.D.
Mark Sullivan, P.A.
Emily Baker, M.D.

Dr. Geller appeared and was represented by his attorney, James A. Bello of Morrison Mahoney, LLP. Dr. Geller submitted the following exhibits:

A. Myofacial Pain in Patients With Posthoracotomy Pain Syndrom, article, Vol. 25, No. 3, May-June 2000 (pp. 302-205)
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K. Local Block, diagram

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O. Safety and Acceptability of Suprascapular Nerve Block In Rheumatology Patients, article, E. Michael Shanahan, Kieran R. Shannahan, Catherine L. Hill, Michael J. Ahern, Malcolm D. Smith, Clinical Rheumatology 2011, July 20, 2011 doi: 10.1007/s10067-011-1813-3

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Q. The Contribution of Patient Satisfaction of the Opiate Abuse Epidemic, article, Mayo Clinic, August 2014

R. Intervention and Reflection, Basic Issues in Medical Ethics, Fourth Edition, Ronald Munson, University of Missouri-St. Louis

S. Opioid Prescribing for Chronic Pain – Achieving the Right Balance Through Education, article, Daniel P. Alford, M.D., MPH, January 28, 2016, The New England Journal of Medicine

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U. Patient Requests for Nonbeneficial Care, American Medical Association, May 2, 2012, Vol. 307, No. 17, pages 1797-1798

V. Addressing Requests by Patients for Nonbeneficial Interventions, Allan S. Brett, MD, Laurence B. McCullough, PhD, American Medical Association, Vol. 2, pages 149-150

W. 10-Year Follow-Up of Chronic Non-Malignant Pain Patients: Opioid Use, Health Related Quality of Life and Health Care Utilization, , Marianne K. Jensen, Annemarie B. Thomsen, Jette Hojsted, European Federation of Chapters of the International Association for the Study of Pain, Elsevier Ltd., July 28, 2005, doi: 10.1016/j.ejpain.2005.06.001

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QQQ. Consultant, cover sheet, October 2016, Vol. 56, No. 10

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SSS. American Family Physician, cover sheet, September 15, 2016

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WWW. Opioid Overdose-Related Deaths, article, Aaron S. Geller, MD., JAMA, July 27, 2011, Vol. 306, No. 4, Page 379
WWW. Anatomical diagrams A-N
XXX. Affiliated Monitors, Inc. report dated August 10, 2016
YYY. Dr. Andrew Forrest report
ZZZ. Dr. Andrew Forrest Curriculum Vitae
AAAA. Scope of Pain, Safe and Competent Opioid Prescribing Education, Boston University
CCCC. Report of Investigation (ROI) dated 8-6-15, ROI dated 2-23-13 with addendum 10-17-13, ROI dated 6-25-13 with addendum 10-17-13, and ROI dated 3-21-13 with addendum 4-18-13 and 10-17-13
DDDD. Med 501.02 Administrative Rules effective 5-8-13
EEEE. Updated curriculum vitae of Aaron Geller, M.D.
FFFF. Complete copy of medical records for Patient 2
GGGG. Article entitled "Clinical Realities and Economic Considerations: Special Therapeutic Issues in Intrathecal Therapy – Tolerance and Addiction" from the Journal of Pain and Management, Vol. 14 No. 3 (Suppl.) September 1997
HHHH. Celestone Soluspan (Betamethasone Injectable Suspension) Drug Information: Indications
IIII. E-mail to Dr. Geller from Ray Borazanian, CCJM dated 1/30/17

Hearing Counsel submitted the following exhibits:

1. Complaint filed by Patient 1, received December 11, 2012
2. Dr. Geller's Response to Patient 1's complaint, received January 17, 2013
3. Complaint filed by Patient 2, received January 28, 2013
4. Dr. Geller's Response to Patient 2's complaint, received February 19, 2013
5. Complaint filed by Patient 3, received May 2, 2013
6. Dr. Geller's Response to Patient 3's complaint, received May 24, 2013
7. Medical Records for Patient 1
8. Medical Records for Patient 2
9. Medical Records for Patient 3
10. Medical Records for Patient 4
11. Medical Records for Patient 5
12. Medical Records for Patient 6
13. Medical Records for Patient 7
14. Medical Records for Patient 8
15. Medical Records for Patient 9
16. Supplemental Response from Dr. Geller, dated August 30, 2013
17. Supplemental Response from Dr. Geller, dated December 7, 2013
18. Supplemental Response from Dr. Geller, dated July 21, 2014
19. Supplemental Response from Dr. Geller, dated November 24, 2014
20. Letter from Dr. Geller to Governor Charlie Baker, dated January 18, 2015

21. Supplemental Response from Dr. Geller, dated April 4, 2015
22. Curriculum Vitae for Dr. Aaron S. Geller, dated September 9, 2012
23. List of American Board of Pain Medicine members in the state of New Hampshire, printed on October 27, 2015
24. List of American Board of Pain Medicine members with the last name of "Geller," printed on October 27, 2015
25. List of American Board of Electrodiagnostic Medicine members in the state of New Hampshire, printed on June 15, 2015
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    b. February 25, 2008
    c. March 5, 2010
    d. January 4, 2012
    e. June 20, 2013
    f. June 27, 2013
49. Opioid Dose Calculator for Patient 9
    a. November 30, 2010
    b. March 14, 2012
    c. May 31, 2013
    d. June 26, 2013
50. Oxycodone Drug Enforcement Administration ("DEA") Drug Data Sheet, dated Mar 2014
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    a. 6b. The Anterior Divisions
    b. 6c. The Thoracic Nerves
    c. 7. The Fascia and Muscles of the Upper Extremity. a. The Muscles Connecting the Upper Extremity to the Vertebral Column
    d. 7c. The Muscles and Fasciae of the Shoulder
70. Gray's Anatomy, Figure 808: right brachial plexus with its short branches
71. Gray's Anatomy, Figure 409: Muscles connecting the upper extremity to the vertebral column
72. Gray's Anatomy, Figure 1210: Side of neck, showing chief surface markings
73. Curriculum Vitae for Dr. Ralph Beasley, dated January 6, 2016
74. Affiliated Monitors Assessment for Aaron Geller, M.D. dated August 10, 2016
75. "About Dr. Geller" from Nashua Pain Management Corporation Website, printed August 15, 2016
76. Buprenorphine DEA Drug Data Sheet, date July 2013
77. Morphine DEA Drug Fact Sheet
78. Power Point Presentation made by Dr. Geller at Southern NH Medical Center on January 14, 2016
79. Definitions Related to the Use of Opioids for the Treatment of Pain: Consensus Statement of the American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine, 2001
80. Letter from Andrew I. Forrest, M.D., dated October 5, 2016
81. Do Animal Models Tell Us about Human Pain? Pain: Clinical Updates. 2010, Vol. XVIII, Issue 5

Dr. Beasley, a Dartmouth-Hitchcock Medical Center and Geisel School of Medicine affiliated physician specializing in anesthesiology and pain medicine, testified on behalf of hearing counsel. Hearing counsel presented evidence in an attempt to demonstrate that the Respondent has displayed medical practice which is incompatible with the basic knowledge and competence expected of a pain management specialist. Likewise, hearing counsel provided evidence in an effort to show that Respondent also engaged in multiple unethical acts with respect to patient confidentiality, patients' rights, and misrepresenting his own credentials.

Dr. Geller testified on his own behalf, attempting to rebut the evidence with a breadth of knowledge regarding treatment modalities for patients with chronic pain conditions, an awareness of risk stratification while evaluating patients and testimony as to his technical competence, and desire to move pain medicine into a new era.

Discussion

Testimony and evidence on the 9 patients were presented. Evidence was presented that attempted to show the Respondent improperly disclosed Patient 1's medical records to multiple parties without the patient's consent, but did not provide the information to those in which the patient provided a release. Likewise, evidence was presented that Respondent did not treat Patient 3 despite making an appointment with the patient, but when the patient arrived the patient found a closed office. Respondent then performed an unsolicited chart review and

provided information to an insurance company. Patient 3 did not request such a chart review, nor was there an authorization allowing review or disclosure of the individual's private health information.

With regard to Patient 2, the individual wanted to cancel appointments with Respondent; as the individual believed the injections being provided did not provide any lasting relief. The Respondent noted in Patient 2's record that the patient must be falsifying pain relief or he would have solicited higher doses of opioids or requested more injections. Respondent then ascribed some "agenda" to the patient. Ex. 8, p. 52. Respondent ascribed an ulterior motivation to Patient 3, as well. Ex. 9

Throughout the records Respondent's philosophical belief is represented. He holds the position that those individuals who work are at lower risk for addiction than those who do not. This underlying view appears to predispose Respondent to types of treatment. For example, as to Patient 1 Respondent noted,

> The multiple irrational/not medically supportable findings indicate that of the diametrically opposed options of endorsing disability or redirecting the patient to a more fulfilled life of full time work, the patient cannot be permitted to make another irrational selection of disability. It is imperative that she be directed to resume her full time work capacity to optimize her quality of life and duration of life.

Ex. 7, at 158.

Evidence suggested Patient 1 was fully employed at the time of the report. As to Patient 2, Respondent noted,

> Truly optimal patients for opioid narcotics are patients that fear/respect the opioid such that they solicit lower doses given valid concerns regarding addiction. Patients who work full time are at lower risk. Patients who are interested in oral, injected, topical and insufflated non-narcotics are also more favorable patients relative to those who want only narcotics.

Ex. 8, at 38.

Respondent noted the plan for Patient 2 was to continue to work full time "as the distraction afforded by work decreases pain..." *Id.*

In his testimony, Dr. Geller offered that he only has the best interests of his patients in mind when he treats them. He believes that "gainful employment" reduces the risk of addiction. Testimony suggested, however, that Respondent was not trained in addiction management.

Hearing counsel also offered evidence to suggest that Respondent misrepresents not only his credentials but the articles he relies on to support his approach to treatment. For example, Respondent provided an article supportive of "superficial nerve blocks" the literature, however, supported a technique for pathology separate from Dr. Geller's use. Likewise, hearing counsel presented evidence to demonstrate that Respondent will mischaracterize peer reviewed articles to bolster his own opinions. Evidence suggested that Respondent will recommend nerve

blocks and opioids together advising of "supra-additive properties." No clinical research was provided to support the belief. *Compare* Ex. 8, at 33; Ex. 11, at 4; Ex. 12, at 3; Ex. 14, at 4; Ex. 15, at 62 with Exs. 58-60.

As to the alleged misrepresentation of certification, evidence revealed that Respondent claims he is triple Board certified by the American Board of Pain Medicine, American Board of EMG/Peripheral Neurology/ Electrodiagnostic Medicine, and American Board of Physical Medicine and Rehabilitation. *See* Ex. 9, at 16; Ex. 10, at 243, and 251; Ex. 20; Ex. 35, Ex. 75.

Evidence also attempted to show that Respondent has inserted his own writings into medical records attempting to portray findings as peer reviewed literature. *Compare e.g.* Ex. 36 with Ex. 14 at 7.

Throughout the hearing, Hearing Counsel also pointed out the deficiencies in the medical records and how Respondent simply cuts and pastes information into the record. It was also discussed that patient information was not being kept in a protected format, such that patient confidentiality could be maintained.

Testimony and evidence also suggested that Respondent was displaying medical practice incompatible with the competence expected of a pain management specialist. The testimony of Dr. Beasley suggested that the medical records reviewed were deficient in that it appeared Respondent was inaccurately describing anatomy of a specific area or the needle placement for "block" procedures. Testimony focused on suprascapular nerve blocks which Respondent suggests were to treat pain in the rhomboid. Dr. Beasley provided testimony that the Rhomboidei are innervated by the dorsal scapular nerve but the suprascapular nerve innervates the supraspinatus and the infraspinatus. Ex 7, 8, 10-15; Ex 69-a – d. The scientific literature does not suggest that suprascapular nerve blocks are used to treat chronic rhomboid pain.

Other evidence suggested that Respondent uses intercostal nerve blocks to treat diffuse lower back pain. Respondent's position was that while his approach is debated, nonetheless cadaveric/anatomic texts support innervation with branching innervation from the intercostal nerves piercing the latissimus dorsi and the paraspinal musculature.
However, the testimony suggested there is no doubt that the use of intercostal nerve blocks is not endorsed for myofascial pain. Ex 74, at 10.

Hearing counsel also presented evidence in order to prove that certain representations made by Respondent are at odds with current medically accepted principles of pain management using opioid therapy. Respondent contends that certain drugs are "abuse resistant" including Vicodin, Percocet, Kadian and OxyContin. Ex 13 at 255, 287, 29; Ex. 18, at 23-32. He also suggests that opioid tolerance is a myth and any need for an increase is an

addiction. Seven of the nine patients evaluated through the investigation were treated with opioids. Evidence suggested that only two of those seven patients were given urine drug screens.

Respondent ordered one urine drug screen for Patient 4 on February 3, 2003, even though he continued to prescribe opioids to her for over eleven years. Ex. 10. Respondent also ordered only one drug screen for Patient 5 during the two year period reviewed, even though Patient 5 had been reported to be using heroin during this time and had previously been discharged from another pain clinic for failing to present for a pill count. It is Respondent's opinion that drug testing all patients is a waste of resources and that it will harm patients by creating unreliable results that will lead to falsely incriminating patients. Ex. 18, at 5-14. Respondent also suggests that drug screens should only be ordered when the patient's history or physical exam indicates some aberrant finding.

Respondent states that circumstances suggesting the need for drug testing include patients refusing certain opioids, patients who claim efficacy with only highly abused opioids, patients who take opioids at night, patients who consume benzodiazepines, patients who indicate they have lost prescriptions, and "young patients who are unemployed and have no source of income." Ex. 18, at 5-14.

The medical charts reveal that no vital signs are noted, and no real objective findings are made relative to monitoring opioid use. Dr. Beasley, contrary to Respondent's opinions, testified that simply discussing behavioral issues or observing gait, eyes and skin are insufficient to identify problems in chronic opioid patients. Testimony and evidence were presented that drug screens are crucial in monitoring a patient's compliance. Evidence revealed that Patient 9 was never drug tested despite a daily morphine equivalency in excess of 400 mg. Respondent suggests that Patient 9 was at a low risk for abuse because Patient 9 did not fabricate tolerance or solicit higher dosing. Ex. 18. Likewise, Patient 5 was never drug tested because Respondent found the patient to be at a low risk for abuse, however, it was later learned that Patient 5 had also been using intravenous heroin. Ex 11 at 30. Respondent was shocked to learn of the heroin abuse because she was such a "responsible" person.

Dr. Beasley testified that the standard of care of a pain specialist is to order urine drug screens. Additionally, it was noted that Respondent's overall pain management care fell below the standard of care where Respondent did not address mental health or substance abuse issues as part of the treatment. Two patients noted depression, but no referrals were made relating to mental health concerns. Ex 74, at 5-6.

Finally, it was noted and presented that the Affiliated Monitors report suggested that Respondent engage in a monitoring program that would include clinical discussions and record

reviews, and implement a recordkeeping system for his patients.

Findings of Fact and Rulings of Law

There is no doubt that Dr. Geller believes in what he is doing, and believes his practice is beyond what the pedestrian pain specialist does in today's treatment. His treatment borders on the unorthodox. Dr. Geller's technical practice appears to within the standard of care, but treating patients with an intercostal nerve block to treat diffuse low back pain does differentiate from what is peer reviewed and scientifically accepted.

Dr. Geller rarely reports results in his records and his record keeping borders on the abysmal.

In going through paragraph 6 of the Notice of Hearing the Board finds the following:

There was insufficient evidence to make a finding to support paragraphs A, B, D, F, G, H, I, J, L, N, O, S, T and X.

There was sufficient evidence to support the following subparagraphs:

C- Respondent's improper describing of the suprascapular nerve amounts to a display of medical practice which is incompatible with the basic knowledge of competence.

E- Respondent displayed unprofessional conduct when he failed to obtain Patient 1's authorization before disclosing confidential medical information.

K- Respondent failed to use sound medical judgment and hold the best interests of the patent paramount in writing the report on patient 3. Dr. Geller never spoke with the patient and put his mission of blended social theories ahead of the patient.

M- Respondent's failure to order adequate drug screens for patients treating with opioids for chronic pain displays medical practice which is incompatible with basic competence in treating such patients. The rules in effect during the time of this treatment required such drug testing.

P – By failing to review Patient 5's medical records or performing a drug screen prior to prescribing opioids, Respondent engaged in professional misconduct.

Q – Likewise, Respondent's failure to order a drug screen and restarting Patient 5 on opioid therapy within 10 months of her intravenous heroin use is incompatible with good medicine and amounts to professional misconduct given the high risk of the patient.

R- Respondent's failure to properly monitor patient 5 and having no diagnostics to support the decision to restart therapy violate the practice act where circumstances of this particular patient warranted such monitoring.

U. - Respondent's explanation was unconvincing as to his reasons for failing to monitor patient 7. He performed no urine test on the patient and could not explain the morphine equivalency. See Ex. 14.

V. - Respondent's prescribing of high doses of opioids without monitoring patient 9 rises to the level of repeated negligence. See Ex 15, Ex 67.

W.- Respondent's explanation relating to his board certifications was not credible. The American Board of Medical Specialties does not recognize the Board of Pain Medicine. It is clear that Respondent is certified in Physical Medicine and Rehabilitation, but adding Pain Medicine as a certification is a misrepresentation.

Y- Respondent failed to properly maintain his electronic medical records as he would take the records to his house for "storage." Such lapses in security violate the AMA Code of Ethics.

The Board also believes as to subparagraph X that while not rising to the level of misconduct, Respondent's referencing his publications as published notes is not behavior the Board would endorse. The Board believes Respondent's credibility is diminished in this regard.

The Board may take disciplinary action against a licensee upon finding that the licensee has engaged in unprofessional conduct, or has displayed practice which is incompatible with the basic knowledge and competence expected of persons licensed to practice a specialty. RSA 329:17, VI (c) and (d). The Board's administrative rules further provide that a violation of the ethical standards adopted by the Board constitutes unprofessional conduct within the meaning of RSA 329:17, VI (d). N.H. Admin. Rule Med 501.01 (a). The Board has also adopted the American Medical Association's ("AMA") Code of Medical Ethics as part of its administrative rules. Med 502.01(h).

AMA Code of Ethics makes clear throughout its opinions that "[t]he interest of the patient is paramount in the practice of medicine, and everything that can reasonably and lawfully be done to serve that interest must be done by all physicians who have served or are serving the patient." AMA Code of Ethics Opinion 7.01. Opinion 10.015 further explains, "The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place the patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare." AMA Code of Ethics Opinion 10.015. Included as fundamental elements of the patient-physician relationship is the patient's "right to make decisions regarding the health care that is recommended by his or her physician," including the right to accept or refuse recommendations for medical treatment." AMA Code of Ethics Opinion 10.01.

The totality of the evidence as testified to and as supported in the exhibits sufficiently demonstrate that Dr. Geller has displayed medical practice incompatible with the competence of someone practicing pain management. Likewise the repeated failure to perform basic testing, or the beliefs that are not supported by current medical literature, as well as the failure to properly keep and maintain medical records, rises to a violation of the Medical Practice Act.

Disciplinary Action:

Based upon the Findings of Facts and Rulings of Law above, the Board voted at the conclusion of the January 31, 2017 hearing to reprimand Respondent and issue a fine of $2,000. The Board also orders that Respondent take remedial education on any knowledge deficit determined by Affiliated Monitors in its August 2016 report. Respondent shall work with a monitor, who shall be a Board Certified Pain Specialist. The Monitor's name and curriculum vitae shall be submitted to the Board by November 1, 2018, to be reviewed by the Board at its November 7, 2018 meeting. The Monitor shall review the August 2016 Affiliate Monitors' report and shall assess, on a quarterly basis, improvement in those deficit areas, with the monitor submitting quarterly reports. The first quarterly report shall be submitted to the Board within ninety (90) days of the Board's approval of the Monitor, and then subsequent reports submitted quarterly until March of 2021.

THEREFORE, IT IS ORDERED that the Respondent is REPRIMANDED; and

IT IS FURTHER ORDERED that Respondent shall pay an administrative fine in the amount of $2,000. The Respondent shall pay this fine in full within sixty (60) days from the effective date of this Final Decision and Order by delivering a money order or bank check, made payable to "Treasurer, State of New Hampshire," to the Board's office at 121 South Fruit Street, Concord, New Hampshire 03301; and

IT IS FURTHER ORDERED that Respondent take remedial education on any knowledge deficit determined by Affiliated Monitors in its August 2016 report. Respondent shall work with a monitor, who shall be a Board Certified Pain Specialist. The Monitor's name and curriculum vitae shall be submitted to the Board by November 1, 2018, to be reviewed by the Board at its November 7, 2018 meeting. The Monitor shall review the August 2016 Affiliate Monitors' report and shall assess, on a quarterly basis, improvement in those deficit areas, with the monitor submitting quarterly reports. The first quarterly report shall be submitted to the Board within ninety (90) days of the Board's approval of the Monitor, and then subsequent reports submitted quarterly until March of 2021; and

IT IS FURTHER ORDERED that this Final Decision and Order shall become a permanent part of the Respondent's file, which is maintained by the Board as a public document; and

IT IS FURTHER ORDERED that this Final Decision and Order shall take effect as an Order of the Board on the date an authorized representative of the Board signs it.

BY ORDER OF THE BOARD

Date: 10/5/2018

Penny Taylor

Penny Taylor, Administrator
Authorized Representative of the
New Hampshire Board of Medicine