

FILED

June 11, 2014

NEW JERSEY STATE BOARD  
OF MEDICAL EXAMINERS

STATE OF NEW JERSEY  
DEPARTMENT OF LAW & PUBLIC SAFETY  
DIVISION OF CONSUMER AFFAIRS  
STATE BOARD OF MEDICAL EXAMINERS

---

In the matter of:

ADAM C. GILLISS, D.O.

HEARING COMMITTEE REPORT  
AND ORDER OF  
TEMPORARY SUSPENSION

---

*Overview*

On June 11, 2014, a hearing on the Attorney General's application for the temporary suspension of the medical license of respondent Adam C. Gilliss, D.O. was held before a duly appointed Hearing Committee of the Board, comprised of Board members Stewart Berkowitz, M.D. (Committee chair), Scott Metzger, M.D. and Richard Angrist, M.D. Deputy Attorney General Bindi Merchant then appeared for the Attorney General, and respondent appeared represented by Michael J. Keating, Esq., from the law firm Dughi, Hewit & Domalewski.

The application for temporary suspension was predicated upon allegations in a filed administrative complaint that Dr. Gilliss indiscriminately prescribed controlled dangerous substances and other drugs, and provided grossly negligent care, to seven patients (identified by their initials only, in order to protect confidentiality). The Attorney General supported his case with

**CERTIFIED TRUE COPY**

documents entered into evidence, to include Dr. Gilliss' medical charts (for each of the seven patients), prescription profiles for six of the seven patients and a written expert report prepared by Christine Healy, D.O. Dr. Gilliss testified in opposition to the application, both generally about his practice of osteopathic medicine and specifically about the care he provided and the prescriptions he wrote for each of the seven patients.

For the reasons set forth in greater detail below, the Committee concludes that the Attorney General has palpably demonstrated that Dr. Gilliss' continued practice of medicine would present clear and imminent danger to the public health, safety and welfare. In each of the seven cases, Dr. Gilliss embarked on a reckless course of conduct by prescribing, month after month and year after year, addictive opiates, to include Oxycontin, Oxycodone and Percocet, for patients whose exclusive diagnosis was somatic dysfunction. In each case, Dr. Gilliss prescribed:

- without conducting any meaningful work-up, to include screening for risk factors or diagnostic evaluation of the patient prior to initially prescribing opiates;

- without ordering laboratory or diagnostic testing, or making any referrals to other specialists, at the time of initial prescribing and thereafter throughout the course of treatment;

- without making periodic efforts to evaluate the need for continued opiate prescribing, to attempt to wean patients from opiates or to conduct trials of non-narcotic therapies;

- without making any meaningful efforts to monitor or assess the efficacy of treatment, and/or to assess whether any given patient might have become addicted to prescribed opiates; and

-- without conducting any testing (or ever accessing the New Jersey Prescription Monitoring Program website, hereinafter the "PMP") to assess whether any patient(s) was taking drugs as Dr. Gilliss prescribed, obtaining CDS from other prescribers, filling prescriptions at multiple pharmacies, or to assess the possibility that any patient was diverting prescribed drugs.

In each case, Dr. Gilliss maintained only the most cursory of medical records - indeed, charting for the vast majority of patient visits between February 2009 and November 2013, for all seven patients, consisted of nothing more than the notation "as above." In many cases, patient progress notes for multiple visits, often spanning periods exceeding one year, were set out on one page of the medical chart and, in one case (patient S.S.), every single progress note (twenty-two visits over a period exceeding three years) was recorded on a single page of the medical record.

Dr. Gilliss' lax practices necessarily exposed each of the seven patients to substantial risk(s) of suffering adverse effects from opioid use and of developing tolerance or addiction to prescribed opiates. In the alternative, Dr. Gilliss' failure to monitor patients facilitated the diversion of prescribed drugs. In two specific cases (patients S.S. and B.J.), Dr. Gilliss wrote opiate prescriptions for patients who he should have recognized were at high risk for suffering potentially serious or even fatal complications from opioid therapy, and in both cases he seemingly did so without doing anything to follow or monitor either patient's condition after the introduction of opiates. Additionally, in

S.S.' case, respondent failed to diagnose or order testing to evaluate radiculopathy, even though it is apparent that S.S.' presenting symptoms were consistent with possible lumbar radiculopathy. That failure, in turn, prevented S.S. from obtaining disease specific treatment.

Even Dr. Gilliss' prescribing of non-opiate drugs was done in an entirely cavalier fashion, as he routinely and repeatedly failed to chart any efforts to evaluate the efficacy of prescribed non-opiates. Remarkably, Dr. Gilliss didn't even take blood pressure readings for patients he prescribed antihypertensive medications.

Dr. Gilliss, by his own admission, had no training or education in pain management and knew that he was perceived to be an "easy mark" for drug-seeking patients, but took no measures to alter his lax practices (or obtain additional education) until late 2013, after he became aware that he was the subject of a Board investigation. We conclude that Dr. Gilliss placed both his patients, and the public generally, in harm's way, and based thereon conclude that cause exists to warrant and fully support the entry of an Order temporarily suspending his license to practice medicine and surgery pending the completion of plenary proceedings in this matter.

We set forth below a brief summary of the procedural history of this matter and of the testimony and evidence entered at

the temporary suspension hearing, as well as more detailed explanation of the reasons why he have concluded that Dr. Gilliss' medical license should be temporarily suspended pending the completion of plenary proceedings in this matter.

*Procedural History*

This matter was opened before the State Board of Medical Examiners on May 12, 2014, upon the filing of a seven count verified administrative complaint. An Order to Show Cause was entered simultaneously requiring respondent to appear before a Committee of the Board on May 28, 2014, for a hearing on the Attorney General's application for the temporary suspension of his license.

The complaint alleges that Dr. Gilliss violated multiple provisions of the statutes and regulations governing medical practice in New Jersey when providing care to seven patients, to include without limitation allegations that he engaged in gross and/or repeated acts of negligence and that he indiscriminately prescribed to each patient. The Complaint was supported by Dr. Gilliss' medical records for each patient, prescription profiles obtained by subpoena for six of the seven patients and by an expert report dated May 7, 2014, prepared by Christine Healy, D.O., which reviewed and commented upon respondent's care of each of the seven patients. Deputy Attorney General Bindi Merchant also submitted a

letter brief, dated May 9, 2014, in support of the application for temporary suspension.

On May 27, 2014, the Board entered an Order granting respondent's request for an adjournment of the May 28, 2014 hearing, to afford respondent's counsel additional time to prepare for the hearing. Dr. Gilliss was then prohibited from prescribing any Controlled Dangerous Substances to any patient for any reason. The Order further provided that a hearing on the application for temporary suspension was to be scheduled, on a peremptory basis, on June 11, 2014.

Respondent filed an Answer to the Complaint, generally denying all substantive allegations, on June 4, 2014. Respondent's counsel then submitted, by e-mail dated June 9, 2014, a summary identifying and discussing issues raised in the Complaint.<sup>1</sup>

At the June 11, 2014 meeting, the Board expressly delegated authorization to hear the application for temporary suspension to a Board Committee. The Hearing Committee was specifically authorized and empowered to take any and all actions that could otherwise be taken by the full Board, to include without limitation ordering the immediate temporary suspension of respondent's license in the event such action was deemed

---

<sup>1</sup> A copy of Mr. Keating's e-mail, and two attachments thereto (a sample of a recent progress note entered by Dr. Gilliss for one of his current patients, and a copy of an unsigned form dated March 8, 2012, generally stating that physicians at Gilliss Family Care provide osteopathic manipulative treatment only) was distributed to Committee members in advance of the hearing.

appropriate. The Board further directed that any action of the Committee was to have full force and effect upon its pronouncement, but that any Committee action would be subject to review by the full Board at the next scheduled Board meeting on July 9, 2014. That review will be based on the record of this matter, to include all pleadings, documents in evidence and the transcript of the Committee hearing. The Board will then vote whether to adopt, modify or reject any findings made or actions ordered by the Committee.

*Hearing before Committee*

A hearing on the application for the temporary suspension of respondent's license commenced at 10:15 a.m. on June 11, 2014. As noted above, Deputy Attorney General Bindi Merchant appeared for complainant John Hoffman, Acting Attorney General of New Jersey. Respondent Adam Gilliss, D.O. appeared, represented by Michael J. Keating, Esq.

The Attorney General's application for temporary suspension was supported solely by documents that had been appended to the certifications of DASG Merchant and Puteska (submitted initially as verification for the Complaint), which documents were all entered into evidence without objection.<sup>2</sup> In addition to the

---

<sup>2</sup> The following documents were entered into evidence (all without objection by either party) at the hearing:

Attorney General's Exhibits:

- 
- A: Curriculum Vitae of Dr. Gilliss, dated April 8, 2014
  - B: Dr. Gilliss' medical record for patient A.B.
  - C: Dr. Gilliss' medical record for patient B.J.
  - D: Dr. Gilliss' medical record for patient E.A.
  - E: Dr. Gilliss' medical record for patient H.C.
  - F: Dr. Gilliss' medical record for patient K.W.
  - G: Dr. Gilliss' medical record for patient M.G.
  - H: Dr. Gilliss' medical record for patient S.S.
  - I: Certified Patient Prescription profiles for patients A.B., B.J., E.A., H.C., K.W. and S.S.
  - J: Certification of David M. Puteska, DAG, dated May 8, 2012 (to include copy of letter from DAG Puteska to Dr. Gilliss dated November 12, 2013 enclosing subpoena duces tecum for patient records and attaching certification completed by Dr. Gilliss dated November 21, 2013 certifying that each of the seven patient records were true, accurate and complete copies of the records on file in Dr. Gilliss' office).

Respondent's Exhibits

- R-1 Letter dated June 7, 2014 from Ann Karty, M.D. to Dr. Gilliss (re: receipt of 2 hours continuing education credit for completion of CME Bulletin: Extended-Release and Long-Acting Opioid Analgesics: Risk Evaluation and Mitigation Strategy).
- R-2 Certification of Completion of Continuing Education for attending "Clinical Challenges in Opioid Prescribing: Balancing Safety and Efficacy" (note: no recipient name was identified on the Certificate, and the Certificate is undated)
- R-3 Print out of Continuing Education transcript (documentation of 7.25 hours of continuing education credits online).
- R-4 Exemplar of Patient Progress Note (for unidentified patient) dated May 16, 2014.
- R-5 Form dated March 8, 2012 (stating that physicians at Gilliss Family Care "do not practice family medicine" and that agreement to accept you as a patient "is for osteopathic

seven individual patient records and the prescriptive records, the Attorney General's case was supported by the written expert report of Christine Healy, D.O. dated May 7, 2014 (Exhibit J). Dr. Healy reviewed the treatment records and prescription profiles for each of the seven patients. She observed generally that:

Dr. Gilliss' records provide minimal, frequently illegible, handwritten and typed notes for medical visits. Many of these entries provide no more than one line dated entries which note "As above" sometimes followed by the name of prescribed drugs. The majority of these drugs are controlled substances as defined in the NJ Opioid prescribing guidelines. The majority of visits for all 7 patients from 2009 to present fail to note the following: chief complaint, subjective findings, vitals, physical exam, current medications, allergies, diagnoses (for both allopathic and osteopathic diagnoses), treatment plans and planned follow-up. None of the records include past medical and surgical histories or complete musculoskeletal exams despite the fact that all patients presumably complain of pain and receive treatment with prescribed medications and Osteopathic Manipulative Medicine (OMM) for dysfunction.

Dr. Healy then proceeded to individually analyze Dr. Gilliss' treatment of each of the seven patients. She concluded that in each chart, "Dr. Gilliss fail[ed] to document pertinent physical exams, diagnoses based on exams, and a treatment plan consistent with good medication. The only significant documentation throughout these seven patient charts is the consistent prescribing of controlled substances. Review of Dr.

---

manipulative treatment only and you must have a family physician that is available for all of your medical care 24 hours a day.")

Gilliss' controlled dangerous substance prescribing reveals more specifically a lack of diagnosis, treatment plan and surveillance for all seven patients." Dr. Healy ultimately concluded that "a comprehensive review of Dr. Gilliss' charts demonstrates a gross deviation from the standards of care for Family Practice physicians in each of the seven cases discussed above."

DAG Merchant argued, in both her letter brief and in her oral arguments before the Committee, that Dr. Healy's findings should be fully adopted by the Committee. She further argued that Dr. Healy's findings should fully support a determination that Dr. Gilliss' practice presents clear and imminent danger to the public health, safety and welfare.

Dr. Gilliss' defense was based exclusively on his own testimony and limited documents entered into evidence (see footnote 2 above). No expert report was submitted on Dr. Gilliss' behalf, nor were any witnesses other than Dr. Gilliss himself called to testify at the temporary suspension hearing. Mr. Keating argued that this case should be recognized to be one that is primarily about Dr. Gilliss' failure to have maintained adequate records, as distinguished from his failure to have properly treated any of the seven patients. In his closing arguments, he also urged the Committee to consider options short of a temporary suspension, such as continuing restrictions on the prescribing of CDS and/or imposing practice monitoring requirements.

Dr. Gilliss initially provided the Committee with background information about his medical education and training. Dr. Gilliss testified that he was trained in osteopathic manipulative medicine ("OMM"), and provided the Committee with a general overview of both OMM and osteopathic manipulative treatment ("OMT"). Dr. Gilliss testified that he engages in "sequencing" to attempt to identify an area of a patient's body that is restricted and causing pain, and then applies OMT to that area (Transcript of Committee Hearing, hereinafter "T", 23:14 - 27:16).<sup>3</sup> Dr. Gilliss further testified that analgesic medicines can be important adjuncts to OMT, as the goal of OMT is restoration of function and pain medication can aid in helping a patient get back to a more meaningful level of function. (T: 27:22 - 29:17).

Dr. Gilliss testified that, although he initially sought to split his practice between general family practice and OMM, by

---

<sup>3</sup> Definitions of Osteopathic Manipulative Medicine and of Osteopathic Manipulative Treatment found in the "Glossary of Osteopathic Technology," prepared by the Educational Council on Osteopathic Principles of the American Association of Colleges of Osteopathic Medicine, revised November 2011, are as follows:

Osteopathic Manipulative Medicine (OMM) is "the application of osteopathic philosophy, structural diagnosis and use of OMT in the diagnosis and management of the patient."

Osteopathic Manipulative Treatment (OMT) is "the therapeutic application of manually guided forces by an osteopathic physician to improve physiologic function and/or support homeostasis that has been altered by somatic dysfunction."

See:

<http://www.aacom.org/resources/bookstore/Documents/GOT2011ed.pdf>

2009 he had limited ("more than 99%") his practice to patients with a diagnosis of somatic dysfunction who were under his care for OMM and OMT exclusively. Dr. Gilliss further testified that he stopped participating with insurance companies in 2009. (T: 31:15 - 32:16; 33:12 - 35:9).

Dr. Gilliss explained to the Committee that somatic dysfunction has 4 primary features generally referred to by the acronym "TART": tenderness on palpation, asymmetry of static positioning, restriction of motion and tissue texture changes. (T: 36:7 - 36:14). Dr. Gilliss then explained the initial evaluation process which he conducts to determine whether to take on a new patient, and stated that all of his patients have a diagnosis of somatic dysfunction and all are receiving OMM and OMT (T:41:8 - 47:3). Dr. Gilliss' initial examination and history consists of a "strictly visual inspection of the body and how things move, and then palpation of the body in relation to the parts." (T: 56:16 - 56:19). He does not check blood pressure or listen to a patient's heart and lungs, although he conceded that he has continued to renew blood pressure medications for some of his patients who are being followed by other primary care physicians. (T:56:20 - 58:20).<sup>4</sup>

---

<sup>4</sup> Dr. Gilliss later testified, on direct examination, that on the initial office visit he takes blood pressure, listens to heart and lungs, checks pulses, does a basic medical exam and a musculoskeletal exam and then "documents with words." (T:62:22 - 63:15). While this testimonial inconsistency was not further explored at the hearing, it is objectively

Dr. Gilliss testified that approximately 60 - 65% of his patients are prescribed narcotic analgesics (T: 47:4 - 47:25). Dr. Gilliss conceded that he had no specific training and background in pain management (beyond his osteopathic training in managing patients with somatic dysfunction), and his only CME in the use of opioid analgesics was completed on-line within two months of the date of the temporary suspension hearing. (T: 53: 20 - 54:18).

Dr. Gilliss further admitted that he knew that he was considered to be an "easy mark," as he had been told that by a neighbor who was also a patient. Dr. Gilliss testified that the perception had been "eliminated" within the past year, in part based on his use of the PMP database to identify patients who were having prescriptions filled at multiple pharmacies (T: 91:4 - 92:1). Dr. Gilliss started using the PMP as a tool for his practice at the end of 2013 (T:98:22 - 99:3).

Dr. Gilliss repeatedly testified that he has made recent changes to his practices, to include keeping more detailed progress notes (T: 63:21 - 67:10; and see R-4 in evidence), checking the PMP, attending CME and reading a book "Responsible Opioid Prescribing." (T:110:21 - 112:18; and see R-1, R-2 and R-3 in evidence). Significantly, all of the changes occurred after Dr. Gilliss became aware that his practice was being investigated (that

---

the case that not a single one of the seven patient charts include documentation of blood pressure or vital signs in any typed entry for any patient visit from 2009 forward.

is, after he received a subpoena to produce the records for the seven patients who are the subject of his complaint)<sup>5</sup>, and none of the changes would therefore be evident upon review of any of the medical records in evidence.

On cross examination, Dr. Gilliss was asked to review his care of many of the individual patients identified in the complaint. While Dr. Gilliss sought to explain the basis for particular prescriptions he wrote and/or for decisions he made to change opiates and/or the doses of prescribed doses, he was unable to point to a single progress note in any patient record that supported or explained those decisions. Dr. Gilliss conceded that his entire patient record for A.B., which encompassed approximately 50 office visits over a period of forty-four months (between January 26, 2010 and October 17, 2013) was set forth on three pages of typed notes, the overwhelming majority of which were on a single line and consisted of nothing more than the note "as above" followed by listing of opiates prescribed. Dr. Gilliss further acknowledged that he never recorded any vital signs, pain scales or noted any allergies (other than to the extent the patient was asked, on an initial intake form, to quantify his pain and list his

---

<sup>5</sup> Dr. Gilliss testified that he first realized that the medical records he was maintaining were "inadequate" after he received the subpoena for medical records. (T:102:1 - 103:17). Dr. Gilliss sought to explain that after he stopped participating with insurance companies, he "thought of the records as being for [his] memory," (T:102:20 - 22), but conceded that any subsequent treating physician would not be able to look at his records and understand what he was doing or thinking. (T:103:7 - 17).

allergies) in A.B.'s patient record, and that he never ordered any imaging studies, laboratory work or toxicology screens for A.B. at any time. Additionally, although A.B. completed a pain management contract (a copy of which was maintained in the patient record), Dr. Gilliss admitted that he took no steps to confirm whether or not A.B. was compliant with the contract until November or December of 2013, when he checked the PMP and thereafter discharged A.B. as a patient. Dr. Gilliss claimed that he did not perform any urine screens on A.B. because he never suspected that A.B. was not compliant with the pain management contract. (generally, T: 117:12 - 124:20).

In a similar ilk, Dr. Gilliss testified that he took no measures to check whether patients B.J. (T:135:5 - 135:19) and S.S. (T: 157:16 - 158:18) were actually taking medications as prescribed, based on his general observations of each patient's appearance and his lack of any suspicion of diversion. At the conclusion of cross examination, Dr. Gilliss acknowledged that CVS pharmacy will no longer fill any prescriptions he writes for Controlled Substances. (T:162:16 - 163:21).

#### *Findings*

Upon consideration of the record before us, we find that the Attorney General has palpably demonstrated that Dr. Gilliss' continued practice would present clear and imminent danger to public health, safety and welfare. In her expert report (which is

unrebutted at this time), Dr. Healy comprehensively reviewed Dr. Gilliss' medical and prescription records and analyzed the care he provided to each of the seven patients. Dr. Healy opined that Dr. Gilliss engaged in grossly negligent medical practices in each of the seven cases.

While Dr. Healy did not have the opportunity to consider Dr. Gilliss' testimony when she prepared her report, we find nothing in that testimony which would cause us to reject or even discount any of Dr. Healy's opinions. Dr. Gilliss conceded that the reason that his medical records did not include laboratory or toxicology screens was because no such testing was done. It is clear and not disputed that, between February 2009 and November 2013, Dr. Gilliss continuously prescribed opiates to each patient, never attempted trials of non-narcotic prescriptions, never considered alternative therapies, and never took any other steps to evaluate the efficacy and appropriateness of continued opiate therapy. Dr. Gilliss thus failed, over periods spanning years, to ever comply with the requirements of N.J.A.C. 13:35-7.6(g) (a licensee who continuously prescribes CDS to a patient for a period of three months or more is required to review the course of treatment at a minimum once every three months).<sup>6</sup> Dr. Gilliss

---

<sup>6</sup> Dr. Gilliss testified that his office in fact performs in-house urine screens on certain patients, to include patients who might present with appearance changes and/or patients whose subjective reporting of pain is inconsistent with objective findings. See, generally, T: 77:25 - 84:6. The record presently is not sufficiently developed to allow this

likewise conceded that he did nothing (at least until the time that he received the subpoena) to monitor whether his patients were filling prescriptions at multiple pharmacies or receiving prescriptions from multiple practitioners<sup>7</sup>, that he had no background or education in pain management and that he continued to write opiate prescriptions even knowing that he was perceived to be an "easy mark" by drug-seeking patients. In short, Dr. Gilliss has presented nothing by way of defense which would dissuade us from finding that his prescribing of opiates (and non-opiates as well) to each of the seven patients was done in a cavalier and

---

Committee to make any findings regarding the number (actual or percentage) of patients who have been sent for urine screens, the period of time that Dr. Gilliss' office has conducted such screening, the adequacy of testing done or the manner in which testing results may be recorded in a patient chart. Nor is the record adequately developed to allow this Committee to make any determinations whether Dr. Gilliss acts in an appropriate fashion if urine screens detect additional drug use or disclose that a patient is not taking prescribed medicines. What is clear and beyond dispute, however, on the record before this Committee is that Dr. Gilliss did not conduct any urine screens on any of the seven patients identified in the Administrative Complaint, even though each patient was prescribed opiates continuously for periods spanning multiple years.

<sup>7</sup> While Dr. Gilliss secured signed drug monitoring agreements from two of the seven patients, S.S. and A.B., and while those monitoring agreements required the patients to obtain prescriptions only from Dr. Gilliss and to fill the prescriptions at a single pharmacy, Dr. Gilliss' failure to take any steps to enforce the agreements rendered them pointless. The record is clear that Dr. Gilliss never sought to monitor where A.B. or S.S. had their prescriptions filled, never checked the PMP to seek to determine if either patient was receiving prescriptions from multiple providers and never conducted a single urine screen on either patient (through November 2013). Had he done so, he would have been able to determine that A.B. in fact violated the terms of the contract by obtaining prescriptions for Oxycodone and Oxycontin from other providers (see Exhibit I, p. 012) and by filling prescriptions at multiple pharmacies.

indiscriminate manner, in turn placing his patients at risk of developing addictions or tolerance to prescribed medicines and/or facilitating the diversion of CDS.<sup>8</sup> That finding, in turn, fully supports a determination that Dr. Gilliss' continued practice would present clear and imminent danger to the public health, safety and welfare.

In addition to the concerns outlined in Dr. Healy's report that we have herein adopted, we independently and additionally find that cause to support a determination that Dr. Gilliss' practice would present clear and imminent danger can be found upon review of the medical records of patients S.S. and B.J.

*Patient S.S.*

Dr. Gilliss' medical record for patient S.S. includes a patient intake form which S.S. completed on her first visit to Dr. Gilliss on September 20, 2010. On that form, S.S. was asked to indicate on drawings where she was having pain and asked to list all medications that she was then taking. S.S.' drawing suggests that she was having pain in the buttocks and down the back of her legs. S.S. noted that "bending over" made the pain "worse," and she rated the pain as 10 on a scale of 1-10. (Exhibit H; SS004).

---

<sup>8</sup> We further note that Dr. Gilliss' suggestion that he only conducts urine screens on patients he regards as "suspicious" for not taking medication appropriately (see T: 124:4 - 124:19; 83:21 - 84:6) is not exculpatory, but instead evidences a basic lack of knowledge regarding addiction, diversion, and the benefits of conducting periodic urinalysis on all patients prescribed opiates.

On a "new patient prescreen form," S.S. described her problems as "low back problems - sometimes can't even walk." S.S. answered "none" to the question "what current medications are you taking (pain management)?" (Exhibit H; SS007).

From that information alone, we suggest that Dr. Gilliss should have immediately considered and recognized that S.S.' presenting symptoms were consistent with a diagnosis of lumbar radiculopathy, and that the radiculopathy could well have been a source of the pain S.S. was experiencing. At a minimum, Dr. Gilliss should have included radiculopathy within a differential diagnosis and taken steps to have S.S. further evaluated with imaging studies. Dr. Gilliss cannot eschew responsibility, as a medical licensee, to possess the basic knowledge and skill set necessary to recognize "classic" presentations (such as S.S.' presenting symptoms for lumbar radiculopathy), regardless whether or not his practice is limited to OMM and OMT. His failure to have identified radiculopathy as a possible source of S.S.' presenting symptoms clearly could have placed S.S. (or any other patient presenting with similar symptoms) at grave risk of suffering permanent nerve damage or other harm from complications of unrecognized and untreated radiculopathy.

Apart from the failure to consider radiculopathy, the danger Dr. Gilliss' practice presents is illustrated both by his decision to start an opiate naïve patient on a substantial initial

dosage of narcotics (without any monitoring) and by his curious choice of the manner in which he wrote prescriptions for S.S. On her very first visit, Dr. Gilliss wrote S.S. a prescription for Percocet (5mg oxycodone/325mg APAP) #240 ii QID, notwithstanding that he then knew (or should have known from review of her intake forms) that S.S. had not previously been prescribed opiates and would thus be taking opiates for the very first time.<sup>9</sup> We suggest that Dr. Gilliss' introduction of Percocet at that level necessarily presented immediate life-threatening risks to S.S., and that Dr. Gilliss thus needed to closely monitor S.S. for possible adverse side effects of opiate use in the initial days and weeks following the introduction of Percocet. Dr. Gilliss, did not, however, conduct any monitoring of S.S.' responses to his initial opioid prescription, and indeed didn't even see S.S. again in his office for twenty-eight days.

Alternatively, it is entirely possible that S.S. may not have in fact been at any risk of suffering any ill effects from the sudden introduction of opiates at the levels Dr. Gilliss prescribed, if she obtained the prescriptions not for her own use but instead for resale or other diversion of the prescribed drugs. On that point, we note that it is particularly alarming that every

---

<sup>9</sup> Although Dr. Gilliss testified that he did not "believe" that S.S. was an opioid-naïve patient at the time he started her on Percocet (T: 159:13-16), there is nothing in her patient record which supports that belief, and it is seemingly contradicted by the information S.S. provided on the intake forms she completed at the time of her initial visit to Dr. Gilliss.

prescription Dr. Gilliss wrote S.S. throughout the three year period he treated her was for 5mg branded tablets, initially of Percocet and thereafter of Oxycodone.<sup>10</sup> Given that Dr. Gilliss' use instructions were that S.S. take 2 pills at a time 4 times daily, he could just have easily written for 10mg pills (i.e., Dr. Gilliss could have prescribed Percocet and then Oxycodone in 10mg pills to be taken 4 times daily, thereby allowing him to prescribe 120 pills rather than 240 pills per prescription while producing the same analgesic effect). There is nothing within Dr. Gilliss' records that offers a reader any explanation or rationale for prescribing 5mg pills to be taken two at a time, and Dr. Gilliss was unable to offer any explanation why he wrote the prescription for 5mg tablets when asked at the hearing. (see T:159:13 - 161:3). While we are aware that the Attorney General has not offered any direct evidence to support a finding that S.S. (or any of the six other patients) diverted prescribed medications, Dr. Gilliss' election to write for 5mg tablets raises "red flags," particularly given our general awareness that 5mg "branded" pills are particularly sought after and command a high value when resold illegally.<sup>11</sup> It is thus the

---

<sup>10</sup> Dr. Gilliss' records suggest that he wrote S.S. prescriptions for a total of 4,660 5/325 Percocet between September 20, 2010 and January 17, 2012. On March 13, 2012, Dr. Gilliss substituted Oxycodone 5mg for Percocet, and thereafter proceeded to write prescriptions that would have allowed S.S. to obtain a total of 5,760 5mg Oxycodone tablets for visits through October 22, 2013 (assuming that S.S. received two prescriptions for 240 tablets on each visit, which would be generally consistent with the recorded length of time between visits).

case that if S.S.' purpose in visiting Dr. Gilliss was to obtain drugs for purposes of diversion (perhaps having sought out Dr. Gilliss knowing of his reputation), Dr. Gilliss facilitated that conduct and maximized the value of each prescription he issued by writing each and every prescription for 5mg tablets.

While we cannot know, on the record before us, whether S.S. took all, some or none of the opiates Dr. Gilliss prescribed, our inability to know anything about her drug use is a product of Dr. Gilliss' failure to monitor her use of opiates by any testing over the entire three year course of treatment. It is thus the case that Dr. Gilliss' laxity either placed S.S. at great risk of harm from possible adverse effects of opiate use, or simply made it easy for S.S. to obtain a supply of drugs for illegal resale, which in turn would have caused substantial harm to the public at large. In either case, the above analysis of S.S.' medical record buttresses our determination that Dr. Gilliss' continued practice presents clear and imminent danger to the public health, safety and welfare.

*Patient B.J.*

Dr. Gilliss prescribing of opioids to patient B.J. was also of great concern to the Committee, given the information about

---

<sup>11</sup> An additional "red flag" suggestive of possible diversion is the fact that S.S. paid for all of her visits to Dr. Gilliss in cash (Exhibit H, SS008-09), as that foreclosed any possible review of the prescribing by a third party payor.

B.J.'s height, weight and diagnosed sleep apnea that can be gleaned. While it appears that Dr. Gilliss never recorded the patient's height or weight in any of his chart notes (despite treating B.J. for over a decade beginning in February 2002), B.J. was in fact a morbidly obese patient<sup>12</sup> and was diagnosed with severe obstructive sleep apnea in January 2003.<sup>13</sup> Despite those significant risk factors, it appears that Dr. Gilliss started B.J. on Oxycontin ER 40 mg bid #60 monthly in 2005, added Percocet 10/325 QID #120 in 2006, and thereafter continuously wrote B.J. prescriptions for opiates through November 2013.

Given the severity of B.J.'s sleep apnea and his morbid obesity, B.J. was at a significantly higher risk of suffering adverse effects or consequences, to include respiratory depression, from opiate therapy. Dr. Gilliss' failure to conduct any monitoring or testing only exacerbated those risks. There is nothing in B.J.'s patient record that suggests that Dr. Gilliss understood or appreciated the potential risks of opioid therapy for B.J., which yet again provides additional support for our

---

<sup>12</sup> See Exhibit C; BJ 019, an undated "medical examiner's report" completed by another physician (name illegible) listing B.J.'s height and weight as 6'0" and 372 pounds respectively; and Exhibit C; BJ 026, Report completed by Shiva Gopal, M.D. on 8/18/05, listing patient height as 70" and weight as 365 pounds.

<sup>13</sup> See Exhibit C; BJ 063-064, letter report of Jonathan Kass, M.D., dated 2/3/03 and nocturnal polysomnography report recorded 1/16/03, finding "severe obstructive sleep apnea".

conclusion that his continued practice would present clear and imminent danger.

*Analysis of Respondent's Arguments*

In his oral arguments to the Committee, Mr. Keating suggested that this case should be considered to be a "record-keeping" case alone. Both Dr. Gilliss and counsel concede that Dr. Gilliss' record-keeping was "inadequate," but both suggest that the OMM and OMT treatments that Dr. Gilliss provided should be recognized to be medically indicated and beneficial. We decline to draw that inference, as to do so would allow Dr. Gilliss to benefit from his repeated failure to have recorded any meaningful information in his medical records. Simply put, the naked charting of the notation "as above" precludes anyone reading or reviewing Dr. Gilliss' charts from being able to reasonably know or understand what treatment Dr. Gilliss provided to any patient on any given visit, and from making any judgment whether any of Dr. Gilliss' opiate prescribing benefitted and/or allowed for improvement in functional status of any patient.<sup>14</sup>

Medical record keeping is a critical component of a physician's medical practice, as the record is ultimately the only

---

<sup>14</sup> Notwithstanding that observation, we did note that it would appear that patient M.G.'s functionality progressively and substantially worsened under Dr. Gilliss' care. At the time M.G. was first seen in 2004, he was noted to be a Temple student who enjoyed golf, martial arts and tennis. He now appears to be a chronic, opiate dependent pain patient who is no longer able to engage in the activities that he previously enjoyed.

window that can be opened to shed light on a physician's practice. Dr. Gilliss' failure to complete medical records effectively shuttered that window. From 2009 forward, his typed office notes include only minimal documentation at best. While we find Dr. Gilliss' suggestion that the records were sufficient to "refresh" his own memory to be implausible, at a minimum Dr. Gilliss' failure to chart any meaningful information in any patient record placed his patients at risk and compromised their care because no subsequent treating provider could possibly have gleaned any useful information from review of Dr. Gilliss' records.<sup>15</sup>

Mr. Keating also urged that we consider, in lieu of ordering the temporary suspension of Dr. Gilliss' license, imposing other limitations on Dr. Gilliss' practice at this time, such as continuing a prohibition on the prescribing of Controlled Dangerous Substances and/or imposition of practice monitoring or periodic medical record reviews. While we considered whether actions short

---

<sup>15</sup> We note that it is entirely unclear, on the record before us, what use is made of the "form" letter dated March 8, 2012, which Dr. Gilliss presented in defense (Exhibit R-5). That generic letter includes language expressly advising patients that care provided by Dr. Gilliss is limited to osteopathic treatment and that all other care is to be obtained from another family physician. Significantly, no copy of that form was maintained in any of the seven charts in evidence, despite the fact that all seven patients continued to receive care from Dr. Gilliss after March 8, 2012. As we noted above, however (in our discussion of Dr. Gilliss' failure to have considered a diagnosis of radiculopathy based on S.S.' initial presenting symptoms), Dr. Gilliss cannot completely disclaim responsibility for all non-osteopathic elements of all of his patients' care, assume that all other care will be the responsibility of another physician and/or prescribe drugs such as anti-hypertensives assuming that the obligation to monitor the patient's blood pressure rests with another physician.

of a full temporary suspension might be sufficient to adequately protect the public, we ultimately concluded that nothing short of a temporary suspension would be sufficient to ameliorate Dr. Gilliss' reckless behaviors, and/or to compensate for the fundamental deficiencies in basic medical knowledge and judgment that permeate this record.<sup>16</sup>

#### *Summary and Order*

We conclude that the Attorney General has made a palpable and compelling showing that Dr. Gilliss' continued practice presents clear and imminent danger to the public health, safety and welfare. Dr. Gilliss' untethered opiate prescribing to each of the seven patients, along with his myopic focus on the diagnosis of "somatic dysfunction", placed each patient at significant risk of harm. The evidence before this Committee demonstrates a fundamental absence of judgment by Dr. Gillis, along with a consistent pattern of compromised and dangerous practices, which

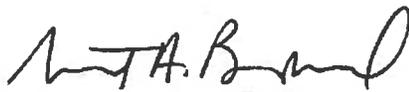
---

<sup>16</sup> We are cognizant that Dr. Gilliss appears to have, very recently, made some efforts to improve his medical record-keeping and his knowledge base of opiate prescribing and pain management, and that he recently started to access the PMP as a monitoring tool in his practice. While these actions may all eventually be appropriate to address and remediate concerns identified in this case, the efforts are in their infancy and all were started only after Dr. Gilliss learned that his practice was being investigated by the Board. In the aggregate, we are not convinced that any remedial efforts made by Dr. Gilliss thus far have progressed to a point that would allow for us to have confidence that the interests of patients and the public at large could be adequately protected were Dr. Gilliss to be allowed to continue to practice, even were he to do so with a preclusion from prescribing CDS.

necessarily placed Dr. Gilliss' patients and/or the public at large (that is, if Dr. Gilliss has been exploited as a target of individuals seeking to obtain and divert pain killers) at profound risk of harm. Based thereon, we unanimously ORDER, effective on pronouncement on June 11, 2014:

The license of respondent Adam C. Gilliss, D.O., to practice medicine and surgery in the State of New Jersey is hereby temporarily suspended, pending the completion of plenary proceedings in this matter.

This Order shall remain in full force and effect pending review by the full Board of the hearing record in this case (specifically, all pleadings, documents entered into evidence and the transcript of the Committee hearing). Following review of the record, the Board will vote whether to adopt, reject or modify the findings and actions taken by the Hearing Committee.



Stewart A. Berkowitz, M.D.  
Board Vice-President

---

Scott E. Metzger, M.D.

---

Richard C. Angrist, M.D.

necessarily placed Dr. Gilliss' patients and/or the public at large (that is, if Dr. Gilliss has been exploited as a target of individuals seeking to obtain and divert pain killers) at profound risk of harm. Based thereon, we unanimously ORDER, effective on pronouncement on June 11, 2014:

The license of respondent Adam C. Gilliss, D.O., to practice medicine and surgery in the State of New Jersey is hereby temporarily suspended, pending the completion of plenary proceedings in this matter.

This Order shall remain in full force and effect pending review by the full Board of the hearing record in this case (specifically, all pleadings, documents entered into evidence and the transcript of the Committee hearing). Following review of the record, the Board will vote whether to adopt, reject or modify the findings and actions taken by the Hearing Committee.

---

Stewart A. Berkowitz, M.D.  
Board Vice-President



---

Scott E. Metzger, M.D.

---

Richard C. Angrist, M.D.

necessarily placed Dr. Gilliss' patients and/or the public at large (that is, if Dr. Gilliss has been exploited as a target of individuals seeking to obtain and divert pain killers) at profound risk of harm. Based thereon, we unanimously ORDER, effective on pronouncement on June 11, 2014:

The license of respondent Adam C. Gilliss, D.O., to practice medicine and surgery in the State of New Jersey is hereby temporarily suspended, pending the completion of plenary proceedings in this matter.

This Order shall remain in full force and effect pending review by the full Board of the hearing record in this case (specifically, all pleadings, documents entered into evidence and the transcript of the Committee hearing). Following review of the record, the Board will vote whether to adopt, reject or modify the findings and actions taken by the Hearing Committee.

Stewart A. Berkowitz, M.D.  
Board Vice-President

Scott E. Metzger, M.D.

Richard C. Angrist, M.D. 7/1/14  
Richard C. Angrist, M.D.