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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
STEVEN B. GREENMAN, M.D., RESPONDENT.	:	ORDER 0000714

ORDER OF SUMMARY SUSPENSION

Division of Enforcement Case No. 10MED370, 09MED143, 09MED142, 09MED081

The Petition for Summary Suspension of March 3, 2011 was noticed to be presented at 8:05 a.m., or as soon thereafter as the matter could be heard, on March 16, 2011. At that time, attorney Kim M. Kluck appeared for the Complainant, Department of Regulation and Licensing, Division of Enforcement. Respondent appeared in person and without counsel.

The Wisconsin Medical Examining Board, having considered the sworn March 3, 2011 Petition for Summary Suspension, and the March 14, 2011 Affidavit of Service of Notice of Presentation and Petition for Summary Suspension of Lori Hoechst, and having heard the arguments of counsel, hereby makes the following:

FINDINGS OF FACT

1. Steven B. Greenman, M.D., Respondent, date of birth June 1, 1947, is licensed and registered by the Medical Examining Board as a physician in the State of Wisconsin, pursuant to license number 18938, which was first granted July 11, 1974.

2. Respondent's last address reported to the Department of Regulation and Licensing is 3900 West Brown Deer Road, Milwaukee, WI 53209.

3. At the time of the events set out below, Respondent was self-employed as a physician at his office located at 3900 W. Brown Deer Road, Milwaukee, Wisconsin 53209. He specialized in internal medicine.

PRIOR DISCIPLINE

4. On October 18, 1990, the Board issued a Final Decision and Order in a Disciplinary Proceeding against Respondent, which suspended Respondent's license for 30 days beginning October 18, 1990 for violating Wis. Admin. Code § Med 10.02(2)(p) based on allegations that he inappropriately prescribed Tussionex and Valium to a patient at the same time without monitoring to ensure that the patient would not develop respiratory depression and that he inappropriately prescribed Dilaudid, Percodan, Methadone and Valium to another patient. Following the suspension, Respondent's license was limited to require that he surrender his DEA registration and complete 30 category I credits of continuing medical educations courses on the

subject of prescribing controlled substances. He could petition the Board for removal of the limitation after one year. He could not petition to prescribe Schedule II controlled substances.

5. On January 15, 1992, he petitioned the Board to permit him to prescribe and dispense all but schedule II medications. On January 31, 1992, the Board permitted him to apply for and hold a DEA registration for controlled substances which was limited to Schedules III, IV and V. He could not prescribe Schedule II's and could not petition for further modification until January 31, 1994. He has not yet petitioned for ability to prescribe Schedule II's.

6. On March 20, 1997, the Board issued a Final Decision and Order in a Disciplinary Proceeding against Respondent, in which he was Reprimanded for unprofessional conduct for prescribing benzodiazepines, codeine, hydrocodone, butalbital, amitryptiline and other drugs to a patient under circumstances where he did not document any physical or neurological examination despite the fact that the patient complained of migraine headaches.

ALLEGATIONS RELATING TO 10 MED 370

7. On July 8, 2005, Patient P.K. returned to Respondent's care, after an eight year gap in treatment, at which time her chief complaint was of migraine headaches. Respondent's initial evaluation of Patient P.K. on that date contained no physical or neurological examination, no headache disorder examination, and no documentation of a diagnosis of a headache condition. Furthermore, Respondent's medical charting for Patient P.K. on this date is partially illegible and incomplete; the objective findings documented are insufficient and do not support the diagnoses given; and the diagnosis does not justify the medication prescribed.

8. During the course of his treatment of Patient P.K. in 2005, Respondent saw Patient P.K. approximately one to two times a month. Respondent's medical charting for Patient P.K. is partially illegible and incomplete, in violation of Wis. Admin. Code § Med 21.03(2) and (3).

9. Respondent's conduct in 2005 was below the minimum standards for the profession in the following respects: the physical examinations documented by Respondent are insufficient and do not support the diagnoses given; the diagnoses do not justify the pain medications or amitryptiline prescribed; the pain medications were prescribed in escalating doses without justification; Respondent continued to prescribe pain medications (Fioricet and BUT/APAP/CAF) in the face of contraindications to their use (urine screen positive for presence of methadone, benzodiazepines and PCP); and Respondent inappropriately continued to prescribe Fioricet, which contains acetaminophen, in the presence of an abnormal liver function test on November 22.

10. During the course of his treatment of Patient P.K. in 2006, Respondent saw Patient P.K. approximately one to two times a month. Respondent's medical charting for Patient P.K. is partially illegible and incomplete, in violation of Wis. Admin. Code § Med 21.03(2) and (3).

11. Respondent's conduct in 2006 was below the minimum standards for the profession in the following respects: the physical examinations documented by Respondent are

insufficient and do not support the diagnoses given; the diagnoses do not justify the pain medications or amitryptiline prescribed; the pain medications were prescribed in escalating doses without justification; Respondent continued to prescribe pain medications (Fioricet and BUT/APAP/CAF) in the face of contraindications to their use in that he was aware that Patient P.K. was also getting prescriptions for Fioricet from other physicians; the patient's urine screen was positive for barbiturates, methadone and antidepressants; the patient was diverting methadone from a family member; and the patient was filling prescriptions at numerous pharmacies.

12. During the course of his treatment of Patient P.K. in 2007, Respondent saw Patient P.K. approximately once a month. Respondent's medical charting for Patient P.K. is partially illegible and incomplete, in violation of Wis. Admin. Code § Med 21.03(2) and (3).

13. Respondent's conduct in 2007 was below the minimum standards for the profession in the following respects: the physical examinations documented by Respondent are insufficient and do not support the diagnoses given; and the diagnoses do not justify the pain medications or alprazolam prescribed.

14. During the course of his treatment of Patient P.K. in 2008, Respondent saw Patient P.K. approximately one to two times a month. Respondent's medical charting for Patient P.K. is partially illegible and incomplete, in violation of Wis. Admin. Code § Med 21.03(2) and (3).

15. Respondent's conduct in 2008 was below the minimum standards for the profession in the following respects: the physical examinations documented by Respondent are insufficient and do not support the diagnoses given; the diagnoses do not justify the medications prescribed; the pain medications were prescribed in escalating doses without justification; and Respondent inappropriately continued to prescribe pain medications to the patient in face of contraindications to their use in that he was aware the patient was diverting methadone from a family member and that another family member was an IV heroin user and was taking the patient's hydrocodone pills.

16. During the course of his treatment of Patient P.K. in 2009, Respondent saw Patient P.K. approximately once a month. Respondent's medical charting for Patient P.K. is partially illegible and incomplete, in violation of Wis. Admin. Code § Med 21.03(2) and (3).

17. Respondent's conduct in 2009 was below the minimum standards for the profession in the following respects: the physical examinations documented by Respondent are insufficient and do not support the diagnoses given; the diagnoses do not justify the medications prescribed; he prescribed multiple pain medication agents concurrently with the potential for harmful or fatal consequences without documented reasons for doing so and without telling the patient of the dangers; he prescribed opioid analgesics on top of buprenorphine which had the potential to cause withdrawal; and inappropriately continued to prescribe pain medications to Patient P.K. in face of contraindications to their use in that he was aware the patient was shooting heroin with a family member, that family members had access to her medications and were likely taking them and that the patient was in "detox" for drug addiction.

18. During the course of his treatment of Patient P.K. in 2010, Respondent saw Patient P.K. approximately once every two months. Respondent's medical charting for Patient P.K. is partially illegible and incomplete, in violation of Wis. Admin. Code § Med 21.03(2) and (3).

19. Respondent's conduct in 2010 was below the minimum standards for the profession in the following respects: the physical examinations documented by Respondent are insufficient and do not support the diagnoses given; the diagnoses do not justify the large doses of pain medications prescribed; Respondent prescribed multiple pain medication agents concurrently with the potential for harmful or fatal consequences without documented reasons for doing so and without telling the patient of the dangers and he prescribed opioid analgesics on top of buprenorphine which had the potential to cause withdrawal.

20. At no time during the period of treatment from July of 2005 through 2010 did the Respondent ever refer Patient P.K. to a neurologist or to a specialist in addiction medicine, pain management or headache disorders despite the fact that he consistently prescribed large amounts of pain medications for her initial complaint of migraine headaches and despite the fact that there were a number indications that the patient was demonstrating symptoms of drug addiction and/or abuse.

ALLEGATIONS RELATING TO 09 MED 143 (Patient C.F.)

21. During the course of his treatment of Patient C.F. in 2005, Respondent's medical charting for Patient C.F. is partially illegible and incomplete, in violation of Wis. Admin. Code § Med 21.03(2) and (3).

22. Respondent's conduct in 2005 was below the minimum standards for the profession in the following respects: the physical examinations documented by Respondent are insufficient and do not support the diagnoses given; the diagnoses do not justify the pain medications prescribed; and Respondent continued to prescribe pain medications in the face of contraindications to their use (Patient C.F. reported taking Klonopin tablets from another individual; a drug screen positive for the presence of methadone; and a drug screen positive for the presence of benzodiazepines on October 25, 2005 after Respondent had instructed Patient C.F. to cease taking that medication in March of 2005).

23. During the course of his treatment of Patient C.F. in 2006, Respondent's medical charting for Patient C.F. is partially illegible and incomplete, in violation of Wis. Admin. Code § Med 21.03(2) and (3).

24. Respondent's conduct in 2006 was below the minimum standards for the profession in the following respects: the physical examinations documented by Respondent are insufficient and do not support the diagnoses given; the diagnoses do not justify the pain medications prescribed; Respondent continued to prescribe pain medications in the face of contraindications to their use in that he was aware that Patient C.F. had been discharged from Dr. Hussaini's care for dishonesty regarding his drug use, had a drug screen at St. Francis Hospital which was positive for the presence of benzodiazepines and that Patient C.F. had been receiving

prescription pain medications, benzodiazepines and anti-depressants from other physicians for months during the same time that Respondent had been treating him.

25. During the course of his treatment of Patient C.F. in 2007, Respondent's medical charting for Patient C.F. is partially illegible and incomplete, and he failed to document that he warned Patient C.F. about the dangers of taking multiple pain medications concurrently or of taking buprenorphine in combination with standard opioid analgesics, in violation of Wis. Admin. Code § Med 21.03(2) and (3).

26. Respondent's conduct in 2007 was below the minimum standards for the profession in the following respects: the physical examinations documented by Respondent are insufficient and do not support the diagnoses given; and the diagnoses do not justify the pain medications prescribed; Respondent prescribed multiple pain medication agents concurrently with the potential for harmful or fatal consequences without documented reasons for doing so and without telling the patient of the dangers; he prescribed standard opioid analgesics in combination with buprenorphine which had the potential to cause severe opioid withdrawal; and Respondent continued to prescribe hydrocodone/APAP which contained acetaminophen in the presence of an abnormal liver function test.

27. During the course of his treatment of Patient C.F. in 2008, Respondent's medical charting for Patient C.F. is partially illegible and incomplete, and he failed to document that he warned Patient C.F. about the dangers of taking multiple pain medications concurrently or of taking buprenorphine in combination with standard opioid analgesics, in violation of Wis. Admin. Code § Med 21.03(2) and (3).

28. Respondent's conduct in 2008 was below the minimum standards for the profession in the following respects: the physical examinations documented by Respondent are insufficient and do not support the diagnoses given; the diagnoses do not justify the medications prescribed; the pain medications were prescribed in escalating doses without justification; Respondent prescribed multiple pain medication agents concurrently with the potential for harmful or fatal consequences without documented reasons for doing so and without telling the patient of the dangers; he prescribed standard opioid analgesics in combination with buprenorphine which had the potential to cause severe opioid withdrawal; Respondent continued to prescribe hydrocodone/APAP which contained acetaminophen in the presence of an abnormal liver function test; and Respondent inappropriately continued to prescribe pain medications to the patient in face of contraindications to their use in that he was aware the patient was purchasing Lorazepam off the street.

29. During the course of his treatment of Patient C.F. in 2009, Respondent's medical charting for Patient C.F. is partially illegible and incomplete, and he failed to document that he warned Patient C.F. about the dangers of taking multiple pain medications concurrently or of taking buprenorphine in combination with standard opioid analgesics in violation of Wis. Admin. Code § Med 21.03(2) and (3).

30. Respondent's conduct in 2009 was below the minimum standards for the profession in the following respects: the physical examinations documented by Respondent are

insufficient and do not support the diagnoses given; the diagnoses do not justify the medications prescribed; the pain medications were prescribed in escalating doses without justification; Respondent prescribed multiple pain medication agents concurrently with the potential for harmful or fatal consequences without documented reasons for doing so and without telling the patient of the dangers; and he prescribed standard opioid analgesics in combination with buprenorphine which had the potential to cause severe opioid withdrawal; and Respondent inappropriately continued to prescribe pain medications containing acetaminophen in excess of the accepted maximum daily level in the presence of abnormal liver function tests and a hospitalization for renal failure.

ALLEGATIONS RELATING TO 09 MED 143 (Patient T.S.)

31. During the course of his treatment of Patient T.S. in 2008, Respondent's medical charting for Patient T.S. is partially illegible and incomplete, in violation of Wis. Admin. Code § Med 21.03(2) and (3).

32. Respondent's conduct in 2008 was below the minimum standards for the profession in the following respects: Respondent's initial evaluation of Patient T.S. on July 16, 2008 contained no physical examination findings to support his diagnosis of back pain with fibromyalgia-like quality; the remainder of physical examinations documented by Respondent are insufficient and do not support the diagnosis of fibromyalgia; the diagnosis of fibromyalgia does not justify the pain medications; and Respondent continued to prescribe pain medications in the face of contraindications to their use (early refills, stolen medication prescriptions with no supporting police reports, concerns about overuse).

33. During the course of his treatment of Patient T.S. in 2009, Respondent's medical charting for Patient T.S. is partially illegible and incomplete, and he failed to document that he warned Patient T.S. about the dangers of taking multiple pain medications concurrently or of taking buprenorphine in combination with standard opioid analgesics, in violation of Wis. Admin. Code § Med 21.03(2) and (3).

34. Respondent's conduct in 2009 was below the minimum standards for the profession in the following respects: the physical examinations documented by Respondent are insufficient and do not support the diagnosis of fibromyalgia; the diagnosis of fibromyalgia does not justify the pain medications; he prescribed standard opioid analgesics in combination with buprenorphine which had the potential to cause severe opioid withdrawal; he continued to prescribe pain medications containing acetaminophen in excess of the accepted maximum daily level of 4 g; he failed to address the patient's mildly hyperglycemic test results; and Respondent continued to prescribe pain medications in the face of contraindications to their use (drug screen positive for presence of marijuana and cocaine and concerns from pharmacists and state agencies regarding toxic levels of acetaminophen being prescribed).

35. During the course of his treatment of Patient T.S. in 2010, Respondent's medical charting for Patient T.S. is partially illegible and incomplete, and he failed to document that he warned Patient T.S. about the dangers of taking multiple pain medications concurrently or of

taking buprenorphine in combination with standard opioid analgesics, in violation of Wis. Admin. Code § Med 21.03(2) and (3).

36. Respondent's conduct in 2010 was below the minimum standards for the profession in the following respects: the physical examinations documented by Respondent are insufficient and do not support the diagnosis of chronic back pain; he prescribed standard opioid analgesics in combination with buprenorphine which had the potential to cause severe opioid withdrawal; and he continued to prescribe pain medications containing acetaminophen in excess of the accepted maximum daily level of 4 g in the presence of an abnormal liver function test.

ALLEGATIONS RELATING TO 09 MED 142 (Patient P.S.)

37. During the course of his treatment of Patient P.S. in 2007, Respondent's medical charting for Patient P.S. is partially illegible and incomplete, in violation of Wis. Admin. Code § Med 21.03(2) and (3).

38. Respondent's conduct in 2007 was below the minimum standards for the profession in the following respects: the physical examinations documented by Respondent are insufficient and do not support the diagnosis of a gastric prosthesis (the gastroenterologist only noted a history of gastric bypass); he prescribed pain medications containing acetaminophen in the presence of an abnormal liver function test on November 9, 2007; and Respondent prescribed opioid pain medications in the face of contraindications to their use (criminal background with history of substance abuse).

39. During the course of his treatment of Patient P.S. in 2008, Respondent's medical charting for Patient P.S. is partially illegible and incomplete, and he failed to document that he warned Patient P.S. about the dangers of taking multiple pain medications concurrently or of taking buprenorphine in combination with standard opioid analgesics, in violation of Wis. Admin. Code § Med 21.03(2) and (3).

40. Respondent's conduct in 2008 was below the minimum standards for the profession in that the following ways: he prescribed multiple analgesics concurrently including hydrocodone/APAP, Tramadol, buprenorphine, Carisoprodol and Zolpidem and continued to prescribe opioid pain medications in the face of contraindications to their use (sharing medications with others).

41. During the course of his treatment of Patient P.S. in 2009, Respondent's medical charting for Patient P.S. is partially illegible and incomplete, and he failed to document that he warned Patient P.S. about the dangers of taking multiple pain medications concurrently or of taking buprenorphine in combination with standard opioid analgesics, in violation of Wis. Admin. Code § Med 21.03(2) and (3).

42. Respondent's conduct in 2009 was below the minimum standards for the profession in that the following ways: he prescribed multiple analgesics concurrently including hydrocodone/APAP, Tramadol, buprenorphine, Carisoprodol and Zolpidem; continued to prescribe pain medications containing acetaminophen in excess of the accepted maximum daily

level of 4 g; and continued to prescribe opioid pain medications in the face of contraindications to their use (sharing medications with others; requests for early refills; and concerns by state agencies and pharmacists regarding his prescribing practices).

ALLEGATIONS RELATING TO 09 MED 142 (Patient L.U.)

43. During the course of his treatment of Patient L.U. in 2007 - 2009, Respondent's medical charting for Patient L.U. is partially illegible and incomplete, and he failed to document that he warned Patient L.U. about the dangers of taking multiple pain medications concurrently or of taking buprenorphine in combination with standard opioid analgesics, in violation of Wis. Admin. Code § Med 21.03(2) and (3).

44. Respondent's conduct in 2007 - 2009 was below the minimum standards for the profession in that the following ways: he prescribed pain medications to the patient without conducting an adequate physical examination; the physical examinations documented by Respondent are insufficient and do not support the diagnosis of chronic back pain; he prescribed hydrocodone/APAP in the presence of an abnormal liver function test on April 4, 2007; he prescribed additional hydrocodone/APAP only three days after giving the patient a prescription for 180 tablets of hydrocodone/APAP; he prescribed standard opioid analgesics in combination with buprenorphine which had the potential to cause severe opioid withdrawal; and he prescribed opioid pain medications in the face of contraindications to their use (multiple reports of stolen and lost medications; large gaps in treatment; reports by Patient U.L. of marijuana use; requests for early refills).

ALLEGATIONS RELATING TO 09 MED 081 (Patient N.C.)

45. During the course of his treatment of Patient N.C. in 2008, Respondent's medical charting for Patient N.C. is partially illegible and incomplete, in violation of Wis. Admin. Code § Med 21.03(2) and (3).

46. Respondent's conduct in 2008 was below the minimum standards for the profession in that the following ways: he failed to perform or document any physical examinations before prescribing hydrocodone/APAP 10/325 and he prescribed opioid pain medications in the face of contraindications to their use (using an apparent alias on the sign-in sheet on his first visit).

47. During the course of his treatment of Patient N.C. in 2009, Respondent's medical charting for Patient N.C. is partially illegible and incomplete, in violation of Wis. Admin. Code § Med 21.03(2) and (3).

48. Respondent's conduct in 2009 was below the minimum standards for the profession in that the following ways: the physical examinations documented by Respondent are insufficient and do not support the diagnosis of chronic back pain and he prescribed opioid pain medications in the face of contraindications to their use (seeing multiple physicians for pain medications; using aliases in obtaining prescriptions).

49. Respondent, by engaging in conduct which tends to constitute a risk of harm to patients, as set out above in paragraphs 9-50 above, has committed unprofessional conduct, as defined by Wis. Admin. Code § MED 10.02 (2)(h) and is subject to discipline pursuant to Wis. Stat. § 448.02(3).

50. Respondent, by failing to maintain healthcare records which are consistent with the requirements of Wis. Admin. Code § MED 10.21, as set out above in paragraphs 9-50 above, has committed unprofessional conduct, as defined by Wis. Admin. Code § MED 10.02 (2)(za) and is subject to discipline pursuant to Wis. Stat. § 448.02(3).

51. A formal complaint alleging that Respondent has committed unprofessional conduct has been filed, and is attached.

52. There is probable cause to believe that it is necessary to suspend Respondent's license immediately to protect the public health, safety or welfare, based upon the following conduct by the Respondent:

a) Prescribing increasingly large and toxic doses of acetaminophen which exceeded the maximum daily level allowed in the presence of repeated documentation of abnormal liver function tests to Patients P.K., C.F., P.S. and L.U.;

b) Prescribing multiple pain medication agents concurrently with the potential for harmful or fatal consequences without documented reasons for doing so and without telling the patient of dangers to Patients P.K., C.F., T.S., and P.S.;

c) Prescribing pain medications in increasing doses under circumstances which were not appropriate in that Patient P.K. admitted she was a drug addict, that Patient P.K. was self-escalating her doses of pain medications, that Patient P.K. admitted shooting IV heroin, that Respondent gave her injection syringes with a son in the house who was a known heroin user, that Patient P.K. was getting prescription pain medications from other physicians at the same time that Respondent was prescribing them to her, that Patient P.K. was taking a family member's methadone, that there was diversion of the patient's prescribed medications to family members, and that Patient P.K.'s urine drug screens were positive for the presence of benzodiazepines, methadone, phencyclidine (PCP) and marijuana (THC);

d) Respondent prescribed pain medications in increasing doses under circumstances which were not appropriate: Patient C.F. reported taking Klonopin tablets from another individual; Patient C.F. had a drug screen positive for the presence of methadone which was not prescribed by the Respondent; Patient C.F. had a drug screen positive for the presence of benzodiazepines in October of 2005 after Respondent had instructed Patient C.F. to cease taking that medication in March of 2005; Respondent was aware that Patient C.F. had been discharged from Dr. Hussaini's care for dishonesty regarding his drug use; Patient C.F. had a drug screen at St. Francis Hospital which was positive for the presence of benzodiazepines; Patient C.F. reported that he had purchased Lorazepam off the street; and Respondent was aware that Patient C.F. had been receiving prescription pain

medications, benzodiazepines and anti-depressants from other physicians during the same time that Respondent had been treating him.

e) Respondent prescribed pain medications under circumstances which were not appropriate: Patient T.S. was requesting early refills of her pain medications; Patient T.S. reported that her medication prescriptions had been stolen and failed to provide a supporting police report; and Patient T.S. had a drug screen positive for the presence of marijuana and cocaine.

f) Respondent prescribed pain medications in increasing doses under circumstances which were not appropriate: Patient P.S. reported a criminal background and a history of substance abuse; Patient P.S. reported sharing medications with other individuals; and Patient P.S. was requesting early refills on pain medications.

g) Respondent prescribed opioid pain medications to Patient L.U. in the face of contraindications to their use (multiple reports of stolen and lost medications; large gaps in treatment; reports by Patient L.U. of marijuana use; requests for early refills).

h) Respondent prescribed pain medications under circumstances which were not appropriate: Patient N.C. used an apparent alias on the sign-in sheet on his first visit to Respondent's office; Respondent was aware that Patient N.C. was obtaining prescriptions for pain medications from multiple physicians; and Respondent was advised by a pharmacist that Patient N.C. was using aliases to obtain prescriptions for pain medication.

i) Prescribing standard opioid analgesics (agonists) in combination with buprenorphine which had the potential to cause severe opioid withdrawal without documenting that he warned Patients P.K., C.F., T.S., P.S. or L.U. of the dangers.

53. Respondent, by engaging in conduct which tends to constitute a risk of harm to patients, as set out above in paragraphs 7-53 above, has committed unprofessional conduct, as defined by Wis. Admin. Code § MED 10.02 (2)(h) and is subject to discipline pursuant to Wis. Stat. § 448.02(3).

54. Respondent, by failing to maintain healthcare records which are consistent with the requirements of Wis. Admin. Code § MED 10.21, as set out above in paragraphs 7-53 above, has committed unprofessional conduct, as defined by Wis. Admin. Code § MED 10.02 (2)(za) and is subject to discipline pursuant to Wis. Stat. § 448.02(3).

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board has jurisdiction over this matter pursuant to Wis. Stat.§ 448.02(3) and has authority to summarily suspend Respondent's license to practice medicine and surgery in the State of Wisconsin, pursuant to Wis. Stats. §§ 227.53(3) and 448.02(4) and Wis. Admin. Code § RL 6.

2. There is probable cause to believe that it is necessary to suspend Respondent's license immediately to protect the public health, safety or welfare, based upon the following conduct by the Respondent:

a) Prescribing increasingly large and toxic doses of acetaminophen which exceeded the maximum daily level allowed in the presence of repeated documentation of abnormal liver function tests to Patients P.K., C.F., P.S. and L.U.;

b) Prescribing multiple pain medication agents concurrently with the potential for harmful or fatal consequences without documented reasons for doing so and without telling the patient of dangers to Patients P.K., C.F., T.S., and P.S.;

c) Prescribing pain medications in increasing doses under circumstances which were not appropriate in that Patient P.K. admitted she was a drug addict, that Patient P.K. was self-escalating her doses of pain medications, that Patient P.K. admitted shooting IV heroin, that Respondent gave her injection syringes with a son in the house who was a known heroin user, that Patient P.K. was getting prescription pain medications from other physicians at the same time that Respondent was prescribing them to her, that Patient P.K. was taking a family member's methadone, that there was diversion of the patient's prescribed medications to family members, and that Patient P.K.'s urine drug screens were positive for the presence of benzodiazepines, methadone, phencyclidine (PCP) and marijuana (THC);

d) Respondent prescribed pain medications in increasing doses under circumstances which were not appropriate: Patient C.F. reported taking Klonopin tablets from another individual; Patient C.F. had a drug screen positive for the presence of methadone which was not prescribed by the Respondent; Patient C.F. had a drug screen positive for the presence of benzodiazepines in October of 2005 after Respondent had instructed Patient C.F. to cease taking that medication in March of 2005; Respondent was aware that Patient C.F. had been discharged from Dr. Hussaini's care for dishonesty regarding his drug use; Patient C.F. had a drug screen at St. Francis Hospital which was positive for the presence of benzodiazepines; Patient C.F. reported that he had purchased Lorazepam off the street; and Respondent was aware that Patient C.F. had been receiving prescription pain medications, benzodiazepines and anti-depressants from other physicians during the same time that Respondent had been treating him.

e) Respondent prescribed pain medications under circumstances which were not appropriate: Patient T.S. was requesting early refills of her pain medications; Patient T.S. reported that her medication prescriptions had been stolen and failed to provide a supporting police report; and Patient T.S. had a drug screen positive for the presence of marijuana and cocaine.

f) Respondent prescribed pain medications in increasing doses under circumstances which were not appropriate: Patient P.S. reported a criminal background and a

history of substance abuse; Patient P.S. reported sharing medications with other individuals; and Patient P.S. was requesting early refills on pain medications.

g) Respondent prescribed opioid pain medications to Patient L.U. in the face of contraindications to their use (multiple reports of stolen and lost medications; large gaps in treatment; reports by Patient L.U. of marijuana use; requests for early refills).

h) Respondent prescribed pain medications under circumstances which were not appropriate: Patient N.C. used an apparent alias on the sign-in sheet on his first visit to Respondent's office; Respondent was aware that Patient N.C. was obtaining prescriptions for pain medications from multiple physicians; and Respondent was advised by a pharmacist that Patient N.C. was using aliases to obtain prescriptions for pain medication.

i) Prescribing standard opioid analgesics (agonists) in combination with buprenorphine which had the potential to cause severe opioid withdrawal without documenting that he warned Patients P.K., C.F., T.S., P.S. or L.U. of the dangers.

3. It is imperatively required and necessary to suspend Respondent's license to practice medicine and surgery immediately to protect the public health, safety and welfare.

ORDER

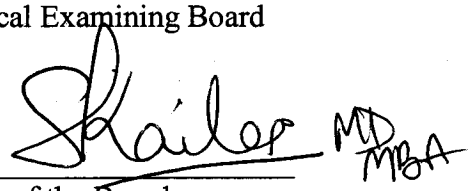
NOW THEREFORE IT IS HEREBY ORDERED that the license of Steven B. Greenman, M.D., to practice medicine and surgery in the state of Wisconsin be and is summarily suspended until the effective date of a final decision and order issued in the disciplinary proceeding against Respondent, unless otherwise ordered by the Board.

IT IS FURTHER ORDERED that a Notice of Hearing commencing a disciplinary proceeding shall be issued no more than 10 days following the issuance of this Order of Summary Suspension.

IT IS FURTHER ORDERED that Respondent is hereby notified of his right, pursuant to Wis. Admin. Code § RL 6.09, to request a hearing to show cause why this summary suspension order should not be continued and is further notified that any request for a hearing to show cause should be filed with the Wisconsin Medical Examining Board, 1400 East Washington Avenue, P.O. Box 8935, Madison, WI 53708.

IT IS FURTHER ORDERED that in the event that Respondent requests a hearing to show cause why the summary suspension should not be continued, that hearing shall be scheduled to be heard on a date within 20 days of receipt by the Board of Respondent's request for hearing, unless Respondent requests or agrees to a later time for the hearing.

Wisconsin Medical Examining Board

By:  3/16/11

A Member of the Board Date

GREENMAN/KLUCK/LH/3-15-11