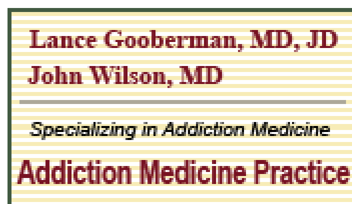
Lance Gooberman, M.D., F.A.B.A.M.
Attorney at Law

Board Certified in Addiction Medicine
Member of the Bar of the Commonwealth of Pennsylvania and the State of New Jersey

Medical Practice

Dr. Gooberman helps patients recover from drug and alcohol addiction in his private medical practice. He is a Fellow of the American Society of Addiction Medicine, and has given lectures worldwide on the subject.



See Dr. Gooberman's CV >
Addiction Medicine Practice >
AddictionMedicinePractice.com

Naltrexone Pellets

Drug addicts wanting to quit often relapse after becoming clean because they can't stop themselves from using the drug again. Dr. Gooberman invented a method of administering Naltrexone maintenance therapy that allows these people to become productive members of society.

Patented Process >
PelletTechnologies.com

DWI and Other Expert Legal Services

Dr. Gooberman combines his degrees in the fields of medicine and law to give him a valuable perspective with his work as an expert in DWI and alcohol cases.

See our Fee Schedule >
DWI Services >

Download site as PDF (73pg)

Website developed by CyberGnarus

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EXPERT SERVICES

Medical Practice

- Addiction Medicine

DWI

- Alcohol Facts (.doc - Draeger)
- Client Interview (.pdf)

Consulting

- Fee Schedule (.pdf)
- Pellet Technologies LLC

DWI Report
DWI Expert Testimony
Other Expert Testimony
Consulting: Interlock Devices
Detoxification
Naltrexone Pellets
Naltrexone Pellet Maintenance Therapy
Drug and Alcohol Evaluation
ATRA Evaluation
Suboxone/Subutex Therapy

search this site:

i want to:

- be detoxified
- contact dr. gooberman
- learn more about pellets
- get a license to make pellets
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PATENTED PROCESS

US Patent No. 5,789,411 - Improvements to rapid opioid detoxification

US Patent No. 6,004,962 - Rapid opioid detoxification

US Patent No. 6,203,813 - Pharmaceutical delivery device and method of preparation therefor

- American Society of Addiction Medicine (ASAM) Policy

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Contact Dr. Gooberman

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Alternate:	1.856.663.4447
Fax:	1.856.488.6380

One South Centre Street
Second Floor
Merchantville, New Jersey 08109

CURRICULUM VITAE

LANCE L. GOOBERMAN, M.D., J.D., F.A.B.A.M.

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Email: lgooberman@aol.com
http://www.lancegooberman.com/
http://www.naltrexzone.com/
http://www.pellettechnologies.com/

PERSONAL

Date of Birth:	August 1, 1951
Married:	Three children
Bilingual:	English & Spanish

EDUCATION

Pennsauken High School Pennsauken, New Jersey	1966-1970
Findlay College Findlay, Ohio	1970-1971
Rutgers University Camden, New Jersey	1971
Camden County College Blackwood, New Jersey	1972-1973
Autonomous University of Guadalajara Guadalajara, Mexico	1973-1974
Autonomous University of Ciudad Juarez Ciudad Juarez, Mexico	1974-1978

University of Texas at El Paso El Paso, Texas	1977
Widener University School of Law Wilmington, Delaware	2001 – 2004

INTERNSHIP AND RESIDENCY TRAINING

Wilmington Medical Center Wilmington, Delaware Rotating Internship	1978-1979
Cooper Hospital/University Medical Center Camden, New Jersey Residency, Internal Medicine	March 1980-April 1982 April 1983-July 1983

LICENSURE *

New Jersey MA38191	Issued 1980
Pennsylvania MD-038545-L	Issued 1980
Admitted to the Bar of the Commonwealth of Pennsylvania	2005
Admitted to the Bar of State of New Jersey	May 15, 2007

* 5 year suspension, 2 years active, 3 years stayed, 5-1-03 to 5-1-08, Medical

EMPLOYMENT HISTORY

Emergency Physician Associates Emergency Room West Jersey Health Systems Voorhees, New Jersey	April 1982 to April 1983
Cooper Hospital Pain Center Cooper Hospital, University Medical Center Camden, New Jersey Medical Consultant	May 1982 to April 1983
Private Practice Internal Medicine Addiction Medicine Forensic Addiction Medicine Merchantville, New Jersey	 1982 to 1996 1987 to June 2003 1993 to June 2003
Lance L. Gooberman, M.D., P.C. Addiction Medicine Forensic Addiction Medicine Merchantville, New Jersey	 1996 to June 2003 1996 to June 2003
President Breath Alcohol Testing, Inc. Merchantville, New Jersey	1993 to 1995

Founder, President, Chief Medical Officer U.S. Detox, Inc.	1995 to May 2003
Merchantville, New Jersey	1995 to June 2003
NaltrexZone, L.L.C.	May 2003 to present
Pellet Technologies L.L.C.	January 1, 2009 - Present
Interlock Device of New Jersey L. L. C.	January 1, 2009 - Present

HOSPITAL APPOINTMENTS & PRIVILEGES (1982-2003)

Cooper Hospital, University Medical Center
Camden, New Jersey
Staff Physician

Our Lady of Lourdes Medical Center
Camden, New Jersey
Staff Physician

West Jersey Health Systems
Camden, Voorhees, Berlin & Marlton Division
Staff Physician
Admitting Privileges-Detoxification Unit

Underwood Memorial Hospital
Woodbury, New Jersey
Staff Physician

Kennedy Health System
Cherry Hill, New Jersey
Staff Physician

FELLOWSHIPS

The American Society of Addiction Medicine	1999
American College of Legal Medicine (ACLM) Fellowship	2006

CERTIFICATIONS

Educational Commission for Foreign Medical Graduates	1979
American Society of Addiction Medicine	1990
National Draeger, Inc. Breathalyzer Operator Course 900/900A	1993
National Draeger, Inc. Breathalyzer Level I Trainer Instructor	1994
National Draeger, Inc. Alcotest 7110 Training	1998
American Society of Addiction Medicine-Recertification	1998
National Draeger, Inc.	2008

Operator Certificate Alcotest 7110 MKJII-C

Alcotest® 7110 MKIII-C Draeger Factory Training Course and Certification	2008
Diplomat of the American Board of Addiction Medicine	2009

SOCIETIES

American Society of Addiction Medicine

American College of Legal Medicine

CONTINUING EDUCATION

Upon Request

PRESENTATIONS

Round table discussion with Governor-elect James Florio "The Perils of Drug and Alcohol Addiction," Trenton, New Jersey, January 15, 1990

Panel on "Safe Homes" Program: Representing The Field of Addiction Medicine Bishop Eustace Preparatory School, Pennsauken, New Jersey, October 21, 1991

Chief Residents Conference "Managed Care Protocol for Addictions" Cooper Hospital, University Medical Center Camden, New Jersey, November 20, 1991

The Robyn Stevens Show, "Interview on Alcoholism," Channel 13 TV, Turnersville, New Jersey, January 26, 1993

Chief Rounds; Panel Discussion Participant: "Alcoholism and Alcoholic Cardiomyopathy" Cooper Hospital, University Medical Center, Camden, New Jersey, February 4, 1993

1993-1994 Internship Survival Lectures, "Alcohol/Narcotic Withdrawal," Cooper Hospital, University Medical Center, Camden, New Jersey, August 13, 1993

Critical Care Education Day for Nurses, "The Addicted Critically Ill Patient," West Jersey Health Systems, Camden, New Jersey, September 22, 1993

Lecture, "Rapid Opiate Detoxification," sponsored by Ohmeda Pharmaceutical, New York City New York, January 23, 1996

Paper Session, "Rapid Opiate Detoxification," American Society of Addiction Medicine, Atlanta, Georgia, April 19, 1996

Component Session, "Rapid Opiate Detoxification," American Society of Addiction Medicine, Atlanta, Georgia, April 20, 1996

Course Director, "Evaluating Outcome of Opiate Detoxification Under General Anesthesia: The Last 100 Years of Opiate Detoxification;"

American Society of Addiction Medicine, 28th Annual Medical-Scientific Conference, San Diego, California, April 20, 1997

Lecturer: "Development in Rapid Opiate Detoxification Under General Anesthesia: Experience with over 1,000 Patients in Four Countries;" 41st International Council on Alcohol & Addiction; International Institute, Cairo, Egypt, May 19, 1997

Lecturer: "Octrcotide Prevents Diarrhea During Rapid Opiate Detoxification," 41st International Council on Alcohol & Addictions; International Institute, Cairo, Egypt, May 19, 1997.

Lecturer: "Depo-Naltrexone Implants for Opiate Dependence: Clinical Experience, Plasma Levels, and Opiate Challenge, Results in over 200 Patients," 41st International Council on Alcohol & Addictions; International Institute, Cairo, Egypt, May 19, 1997

Lecturer: "Depo-Naltrexone After Opiate Reversal Under General Anesthesia," presented at the University of Pennsylvania, Department of Psychiatry, Treatment Research Center Seminar Series, Philadelphia, Pennsylvania, July 28, 1997.

Lecturer: "Heroin Addiction Treatment" presented at American Osteopathic Academy of Addiction Medicine, 102nd Annual AOA Conference and Scientific Seminar, San Antonio, Texas, October 20, 1997.

Lecturer: "Naltrexone Implants" presented at the 4th International Stapleford Conference on Addiction Medicine at the Royal Society of Medicine, London, England, January 9, 1998.

Lecturer: "DWI and Addiction Medicine Issues" presented at the American Society of Addiction Medicine, Medical Review Officer Forensic Issues in Addiction Medicine Conference, Atlanta, Georgia, February 19, 1998.

Poster Presentation: "Depo-Naltrexone versus Oral Naltrexone Post-Detoxification" presented at the American Society of Addiction Medicine, 29th Annual Medical Scientific Conference, New Orleans, Louisiana, April 17 - 19, 1998.

Lecturer: "Addiction Medicine: A Tool for Early Intervention, Component Session of Forensic Addiction Medicine" presented at the American Society of Addiction Medicine, 29th Annual Medical Scientific Conference, New Orleans, Louisiana, April 17 - 19, 1998.

Lecturer: "Antagonist Assisted Abstinence" presented to the Department of Medicine, West Jersey Health Systems, Voorhees, New Jersey, May 12, 1998.

Lecturer: "Opiate Reversal Under General Anesthesia with Induction of Naltrexone Maintenance Therapy Utilizing Depo-Naltrexone Preparation" presented at the 10.European Congress of Anesthesiology, Frankford, Germany, July 3, 1998.

Lecturer: "Drug Addiction-A Treatable Disease. New Treatments for Heroin Addiction" presented at the 1998 American Psychiatric Association Annual Conference, Toronto, Ontario, Canada, June 4, 1998.

Lecturer: "The Outpatient ICU: An Ideal Setting for Rapid Opiate Detoxification" presented at the 23rd Australian and New Zealand Annual Scientific Meeting on Intensive Care, Adelaide, Australia, October 9, 1998.

Lecturer: "Rapid Opiate Detoxification" presented to Camden County Probation Department, Blackwood, New Jersey, November 5, 1998.

Poster Presentation: "Depo-Naltrexone for Protection Against Opiate Defect in the Post Detoxification." Presented at the 9th Annual Meeting and symposium of the American Academy of Addiction Psychiatry, Amelia, Island, Florida, December 3 - 6, 1998.

Lecturer: "Effects of Alcohol on the Human Body" presented to Widener University Law School, Chester, Pennsylvania, January 25, 2000.

Lecturer: "Antagonist Assisted Abstinence" presented to the Poison Control Center, Philadelphia, Pennsylvania, February 29, 2000.

Lecturer: "Rapid Detoxification Techniques" presented to the 11th Annual Clinical Meeting of the American Academy of Pain Management. Las Vegas, Nevada, September 23, 2000.

Lecturer: "Naltrexone Pellets for Implantation" presented to Vilnius University, Vilnius, Lithuania, August 17, 2001.

Lecturer: "An Alternative to Incarceration for Heroin Addicts" presented to Hunterdon County Probation Department, Flemington, New Jersey, October 2, 2001.

Lecturer: "Naltrexone Pellets for Implantation" presented to Physicians and Pharmacists at the Detoxification Centre in Lisbon, Portugal, January 8, 2002.

Lecturer: "Effects of Alcohol in the Human Body" for the course "Alcohol Vehicles and the Law", presented at Widener University Law School, Wilmington, Delaware, Spring Semesters, 2000, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009.

Lecturer: "Development of Naltrexone Pellets" presented at the Wuhan International Naltrexone Depot Symposium 2007, Wuhan, China.

PUBLICATIONS

Rapid Opiate Detoxification, Journal of Addictive Diseases, Volume 15, No. 2 (1996), Abstract 7, p. 117, Lance Gooberman, M.D., Thaddeus Bartter, M.D.

Rapid Opiate Detoxification, American Journal of Drug and Alcohol Abuse, Volume 22, No. 4, pp. 489-495(1996), Lance Gooberman, M.D.,

Thaddeus Bartter, M.D.

Rapid Opiate Detoxification and Naltrexone Induction Under General Anesthesia and Assisted Ventilation: Experience with 510 Patients in Four Countries, In Press 1996, Acta Psychiatrica Belgica, Colin Brewer, M.R.C., Psycho, Mary Laban, M.R.C.A., Charles Schmulian, F.F.A., Lance Gooberman, M.D., Yiannis Kasvikis, M.R.C. Psych. Nabil Abdel Maksoud, M.D.

Rapid Opioid Detoxification, Journal of the American Medical Association, Letter to the Editor, Volume 279, No. 23, Page 1871, June 17, 1998, Lance L. Gooberman, M.D.

AWARDS

Benjamin Franklin Emerging Business Award, U.S. Detox Center, Merchantville, New Jersey

Most Innovative Service, Philadelphia, Pennsylvania, November 1996

UNITED STATES PATENTS

1) **Improvement to Rapid Opioid Detoxification**
Patent Number 5,789,411
Issued August 4, 1998

2) **Rapid Opiate Detoxification**
Patent Number 6,004,962
Issued December 21, 1999

3) **Pharmaceutical Delivery Device and Method of Preparation Therefor**
Patent Number 6,203,813
Issued March 20, 2001

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&

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Medical Practice - Addiction Medicine

After finishing medical school in 1978 Dr. Lance Gooberman completed a rotating internship at the Wilmington Medical Center and a residency in **internal medicine** at Cooper Hospital/ University Medical Center. He then practiced **emergency medicine** while developing a primary care practice. He continued in **primary care** for 12 years. In 1987 Dr. Gooberman developed an interest in **addiction medicine** and began to focus his practice in that area. In 1999 he was certified by examination from The American Society of Addiction Medicine.

Dr. Gooberman then began to focus his practice almost entirely on addiction medicine and in 1996 he sold his primary care practice in order to concentrate on addiction medicine full time. He became a **fellow of the American Society of Addiction Medicine** in 1999 based upon his community service, writing and teaching in addiction medicine. His area of concentration was **opiate addiction** and he received three United States Patents or innovations in this area.

As a result of these activities Dr. Gooberman was frequently asked to provide **expert opinion** in his area of expertise. He has been qualified numerous times and in many jurisdictions for his expertise in medicine generally and addiction medicine more specifically.

- Tutorial - Opiate Addiction Treatment
- The NaltrexZone (TM)

LANCE GOOBERMAN, M.D., J.D., F.A.S.A.M.

FEE SCHEDULE FOR CONSULTATION AND EXPERT TESTIMONY

Document review with report preparation in DWI case	$500 flat fee
Document review, consultation with attorney, and report preparation	$225/hour
Depositions	$1,500/half day $3,000/full day
Court appearances (portal to portal)	
DWI cases in Burlington, Camden, Gloucester and Mercer Counties	$800 flat fee
DWI cases in all other New Jersey counties	$1,500 flat fee
All other court appearances	$1,500/half day $3,000/full day

DWI QUESTIONNAIRE

INTERVIEW____________________
PAYMENT RECEIVED___________

ATTORNEY______________________________

Phone #_____________________________

Fax #: ______________________________

____
Location of alleged violation

COURT:__________________________

Court date:_______________________

NAME:____ AGE:______________ DOB:______________

ADDRESS:____

PHONE #: HOME_______________________________ WORK:_________________________________

Age:_________

Weight:_____________. lbs. Ht:____________ Build: ڤSm ڤMed ڤLg

Ideal Body Weight _________________

QTY.	CONTAINER (bottle/can/glass/shot)	SIZE (Oz) (8,12,16)	BEVERAGE		TOTAL OUNCES		%ALCOHOL (5,12,20,40)	OZ./PURE ALCOHOL
_______	______________	________	______________	=	___________	X	__________	____________
_______	______________	________	______________	=	___________	X	__________	____________

WIDMARK Formula-from calculator

MAX.BAL:_____________________________________

Time of First drink _____________________________________

Time of breath test:_____________________________________

Difference: ____________________________________

Theoretical BAL: _________________________________ g%

Breath test result ____________ minus Theoretical BAL_______ = variance of _________ g%

MEDICATIONS:

ALLERGIES:

PAST MEDICAL HISTORY:

Hospitalizations (Date and Dx):

Surgeries (Date and procedure):

Do you see a doctor regularly? ﭬ Yes ﭬ No
If yes, for what?

INJURIES:

Ankles:	ﭬ Yes ﭬ No	Feet	ﭬ Yes ﭬ No
Legs	ﭬ Yes ﭬ No	Back	ﭬ Yes ﭬ No
Knee	ﭬ Yes ﭬ No	Hips	ﭬ Yes ﭬ No

SOCIAL HISTORY:

Marital Status: Living with:

Employment:

REVIEW OF SYSTEMS

				Explain
Neurology:	Vertigo (dizziness)	ف Yes	ف No	
	Seizure Disorder	ف Yes	ف No	
	Head Injury	ف Yes	ف No	
	Nerve Damage	ف Yes	ف No	
	Learning Disability	ف Yes	ف No	

ENT:

Post Nasal Drip	ف Yes	ف No
Chronic congestion	ف Yes	ف No
Halitosis	ف Yes	ف No
Sore Throat	ف Yes	ف No
Excess Salivation	ف Yes	ف No
Throat clearing	ف Yes	ف No
Hoarseness	ف Yes	ف No
Something caught in throat	ف Yes	ف No
Rhinitis (runny nose)	ف Yes	ف No
Choking spells	ف Yes	ف No
Voice changes	ف Yes	ف No
Persistent coughing	ف Yes	ف No
Have you ever had sinus x-rays?	ف Yes	ف No

RESPIRATORY:

Asthma; ف Yes ف No

Allergies: ف Yes ف No

Did you have cold or flu symptoms at the time of the arrest? ف Yes ف No

GI:

Ulcers	ف Yes	ف No
Gastritis	ف Yes	ف No
Hiatal Hernia	ف Yes	ف No
Indigestion or heart burn or chest pain	ف Yes	ف No
Burping or Belching	ف Yes	ف No
Difficulty Swallowing	ف Yes	ف No

Do you use Antacids? ف Yes ف No

What types?

Have you ever have an upper GI x-ray (where you drink a liquid while they take x-ray pictures)?

ف Yes ف No

ENDOCRINE:

Do you have diabetes? ق Yes ق No

If so, what medications do you take?

DENTAL HISTORY

Do you wear dental plates?	ق Yes	ق No
Do you use adhesive?	ق Yes	ق No
What kind? ______________________________		
Do you have bridges?	ق Yes	ق No
Gum Disease or gingivitis	ق Yes	ق No
Did you use mouthwash before you were arrested?	☐ Yes	☐ No
Did you use mouthwash just before the time of the arrest?	☐ Yes	☐ No
Did you eat or drink anything just before the time of the arrest?	ق Yes	ق No
Anything peppermint just prior to arrest?	☐ Yes	☐ No

NOTES:

DISCOVERY

Date________________ and Time_________________ of alleged violation.

Narrative Report:

Odor of ETOH beverage on breath? ☐ Yes ☐ No

Standard psychophysical tests (roadside sobriety testing)? ☐ Yes ☐ No

One leg stand ☐ Yes ☐ No

Finger to nose ☐ Yes ☐ No

Walk and turn ☐ Yes ☐ No

Other tests ☐ Yes ☐ No

Alphabet ☐ Yes ☐ No

Horizontal gaze nystagmus (HNG) ☐ Yes ☐ No

Other: ____

Date________________ and Time_________________ of arrest.

Were Miranda warnings administered at the time of arrest?

☐ Yes (Time_________________) ☐ No

Was anything signed? ☐ Yes (Time_________________) ☐ No

Observations:

Appearance

Pale: ☐ Yes ☐ No **OR** Flushed: ☐ Yes ☐ No

Vomiting at time of arrest ☐ Yes ☐ No

Any unusual observation at time of arrest noted? ☐ Yes ☐ No

If so, explain:

Was "Paragraph 36" read? ☐ Yes (Time________________) ☐ No

Was it signed? ☐ Yes (Time________________) ☐ No

<u>Breath Testing:</u>

Model ☐ 900 ☐ 900A ☐ 7110 (Go down to Saferstein checklist below)

Time between the VIOLATION and the taking of the first breath sample was _______________ **OR**

Time between the ARREST and the taking of the first breath sample was _______________.

Was the breath test done by the same officer that did the arrest? ☐ Yes ☐ No

Was the officer that did breath test present at all times: ☐ Yes ☐ No

First breath test: Time______________ Result________________

Second breath test: Time______________ Result________________

Third breath test: Time______________ Result________________

If Model 900 or 900A:

Was check list complete for the first test? ☐ Yes ☐ No

Was check list complete for the second test? ☐ Yes ☐ No

Was check list complete for the third test? ☐ Yes ☐ No

Was there a Breathalyzer test ticket? ☐ Yes ☐ No

Breathalyzer Instrument Inspection certificates:

Period BEFORE the arrest and breath test of this individual? ☐ Yes ☐ No

Period AFTER the arrest and breath test of this individual? ☐ Yes ☐ No

WITHIN 30 days of the arrest and breath test of this individual? ☐ Yes ☐ No

☐ Before certificate ☐ After certificate

Does the ampoule control number ampoule used for the breath tests match an ampoule control number on one of the certificates? ☐ Yes ☐ No

Was there a valid operator's certificate?

For the operator ☐ Yes ☐ No

For the calibrator (if Model 7110) ☐ Yes ☐ No

If not, give: Date of certification or last refresher date ________________ and the

Date of the breath test _________________________.

Saferstein checklist for Model 7110

Please note that any “□” without a check mark indicates the document is missing from the discovery packet.

A review by my office of the above captioned case has revealed the following:

☐ Alcohol Influence Report` Reported Result ________________ % BAC

Date of arrest ____________ Instrument serial #__________________________

☐ Certificate of Analysis – 0.10% Simulator Solution Control Lot #______________________

☐ Calibrating Unit New Standard Solution Report (0.10%) for Bottle #______________

☐ Current Certificate of Accuracy for Simulator Unit Serial #___________________________

☐ Certificate of Accuracy for the Alcotest 7110 MK111

☐ Alcotest 7110 Calibration Record conducted within 1 year prior to arrest

Date of Calibration _________________________

☐ Alcotest 7110 Calibration Certificate, Part 1 Control Tests (0.10%)

☐ Certificate of Analysis – 0.10% Simulator Solution Control Lot #______________________

☐ Current Certificate of Accuracy for Simulator Unit Serial #___________________________

☐ Alcotest 7110 Calibration Certificate, Part II, Linearity Tests (0.04%, 0.08%, 0.16%)

- ☐ Certificate of Analysis – 0.04% Simulator Solution Control Lot #________________________
- ☐ Current Certificate of Accuracy for Simulator Unit Serial #_____________________________
- ☐ Certificate of Analysis – 0.08% Simulator Solution Control Lot #________________________
- ☐ Current Certificate of Accuracy for Simulator Unit Serial #_____________________________
- ☐ Certificate of Analysis – 0.16% Simulator Solution Control Lot #________________________
- ☐ Current Certificate of Accuracy for Simulator Unit Serial #_____________________________
- ☐ Current Ertco-Hart Digital Temperature Measuring System – Record of Calibrator

Certificate of Accuracy for Alcotest 7110 Temperature Probe

Summary of Temperature Probe Certificates Received:

Serial #	Exp Date
______________________________________	______________________________________
______________________________________	______________________________________

We are in receipt of ________ Certificate(s) of Accuracy for Alcotest 7110 Temperature Probe, listed above. One temperature probe was used during your client's breath test. A separate temperature probe was used by the New Jersey State Police Coordinator during the calibration of this instrument.

☐ If this box is checked, an outdated temperature probe has been provided.

Please be advised that we are currently unable to correlate simulator units with their corresponding temperature probes. At this time we have no way to determine if this expired temperature probe was used during the calibration of the instrument or during the administration of your client's breath test.

☐ If this box is checked, more than two temperature probe certificates have been provided.
We have learned that a maximum of two temperature probes are relevant to this case, as noted above. Please be advised that we are currently unable to correlate simulator units with their corresponding temperature probes. At this time we have no way to determine which temperature probes were used during the calibration of the instrument and during the administration of your client's breath test.

Were Miranda warnings administered a second time (after breath test)? ☐ Yes (Time_______) ☐ No

Was anything signed? ☐ Yes (Time________________) ☐ No

Was there additional questioning? ☐ Yes (Time________________) ☐ No

Lance l. Gooberman, M.D., J.D. 9-15-05

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DWI EXPERT TESTIMONY

Issues that can affect Standardized Field Sobriety Testing (SFST) and Evidentiary Breath Alcohol Testing

- Abscesses
- Allergies
- Asthma
- Antihistamine decongestant medications
- Bariatric (weight loss) surgery
- Blood loss from bleeding, broken bones, bruising etc.
- Breath sprays and asthma sprays
- Bronchitis
- Bronco spasm with chronic coughing
- Chronic back pain
- Cold (uri)
- Concussion
- Dental apparatus (bridges, braces, etc.), infections and other issues
- Depression
- Deprivation period
- Diabetes
- Dizziness (vertigo, Meniere's disease)
- Dry mouth and salivary gland issues
- Emphysema (chronic obstructive pulmonary disease(COPD))
- Ear infections
- Elevated temperature
- Fever
- Flu (uri)
- Gastroesophageal reflux disease (GERD)
- Gingivitis
- Head injury
- Infections
- Injuries
- Insufficient documents for breath testing machine
- Medications
- Operator's certificate missing or outdated
- Orthopedic conditions
- Otorhinolarynogologic (ear, nose, and throat (ENT)) issues
- Over the age of 60
- Overweight
- Peppermints

i want to:

- be detoxified
- contact dr. gooberman
- learn more about pellets
- get a license to make pellets
- hire dr. gooberman as an expert

- Sinusitis (acute and chronic)
- Thyroid disease
- Upper respiratory tract infections (uri)
- Vasodilator (pale or flushed facial appearance)
- Vertigo (Meniere's disease)

Contact Dr. Gooberman to find out how he can help with your case.

Rapid Opiate Detoxification

American Journal of Drug and Alcohol Abuse

VOLUME 22, NO. 4, PP. 489-495(1996)

LANCE GOOBERMAN, M.D., THADDEUS BARTTER, M.D.

Opiate addiction is a growing health-care problem in the United States. The U.S. Department of Health and Human Services' Substance Abuse branch issued a report in December 1994[1] stating that the number of emergency department visits directly related to heroin use rose from 48,000 in 1992 to 63,000 in 1993, a 31% increase. The rate of heroin-related episodes per 100,000 people rose 81%, from 15 to 28 per 100,000 during the interval 1990 to 1993[1]. Breakdown of the heroin-using population into ethnic groups and age groups demonstrated that all subsets have increased rates for the interval studied[1]. Heroin use is also moving to the suburbs. The lay press states that both heroin usage and heroin-related deaths in middle-class and wealthy suburbs have increased dramatically from 1990 to 1994[2].

Opiate addiction engenders intense physical dependence. Apart from psychosocial issues, the chemical dependence makes the transition to abstinence extremely difficult. Not only do individuals lose the euphoric effects of opiates, they also have to run the gauntlet of an extremely uncomfortable withdrawal. Traditional methods of detoxification, still commonly used[3] have been slow, uncomfortable, expensive, and have had high dropout rates.

The availability of new drugs and several findings have led to a potential solution to many of the problems cited above. First, it was found that administration of opiate antagonists accelerates opiate withdrawal, allowing one to telescope a 1-3-week process into a few hours[4]. Second, it was shown that clonidine[5] and sedative-hypnotic drugs[6-8] are capable of attenuating the abstinence syndrome. Third, studies have demonstrated that naloxone reverses the respiratory depression associated with sedative-hypnotics, and thus might allow one to administer doses of sedative-hypnotics that might produce respiratory depression without the naloxone[9, 10]. The respiratory effects of naltrexone may be the same but have not

been documented. In recent years, a few physicians have given opiate antagonists to accelerate withdrawal under the cover of drugs that attenuate the abstinence syndrome[6-8, 11-13]. Some studies have involved intubation[6-8, 11], while some have used sedation without intubation[4, 5, 12, 13].

The increases in opiate addiction will lead to an increased need for effective detoxification. Humane opiate detoxification is now possible. Although the principles and efficacy of rapid opiate detoxification (ROD) have been established, details about exactly how and where ROD should be performed still need to be worked out. We describe the experience with a series of patients who underwent opiate detoxification at our institution.

METHODS

Over a 4-month period, 25 patients underwent 29 separate detoxifications. There were 14 women and 12 men. Mean age was 32.6 years, with a range of 24 to 48 years. Changes in approach with experience allow subdivision of the detoxifications into four distinct subgroups as discussed below.

The first 9 detoxifications (group 1) were accomplished with PO (by mouth) naltrexone. Standard premedication included carbamazepine and clonidine PO and phenobarbital IM (intramuscularly). After initial sedation, the patients were given a dose of PO naltrexone. Sedation was then continued on a PRN (as needed) basis in an attempt to control withdrawal symptoms. Detoxification was successful in all cases, with a mean of 1.8 days in the hospital. The method was effective, but despite the premedication, medications were being used to "catch up" with withdrawal symptoms throughout withdrawal, which was inexorable once naltrexone had been administered. It was also difficult to use PO medications for breakthrough symptoms in partially sedated patients. Thus, the medical regimen was changed.

Group 2 patients were treated initially with subcutaneous naloxone instead of naltrexone. Group 2 consisted of 12 detoxifications. The standard therapy involved PO clonidine and carbamazepine, IM phenobarbital, and then subcutaneous naloxone, 0.4 mg in an initial dose followed by intermittent doses. Phenobarbital dosing was tailored to the individual, with a goal of somnolence with arousability. After detoxification was deemed to be complete, the patients were allowed to wake up and were given a dose of PO naltrexone. The regimen was generally well tolerated; 11 of the 12 patients were detoxified in a mean of 2.0 days. One patient could not be sedated adequately, and had to be converted from rapid detoxification to a more gradual detoxification.

Despite its efficacy, the technique noted above was problematic. It required close monitoring in order to maintain the proper balance of sedation. Undersedated patients were agitated and combative, while oversedated patients needed close monitoring. In addition,

appropriate sedation was difficult with only PO and subcutaneous routes of administration available. Because of these difficulties, Group 3 consisted of three detoxifications using more traditional means. Initial withdrawal occurred under the cover of carbamazepine, clonidine, and phenobarbital without using opiate antagonists. The three patients were allowed to complete a mean of 2.7 days of withdrawal and were then discharged. Withdrawal was initiated with this approach, but was not complete by the time of discharge; the patients were not given opiate antagonists during hospital stay or at the time of discharge. Thus, naltrexone maintenance could not be established.

After discussion with hospital administration, it was agreed that patients for ROD would be admitted into the intermediate intensive care unit, where the five patients in Group 4 were detoxified. The move to the intermediate intensive-care unit increased the nurse-patient ratio, such that patients were observed more closely. Use of this unit allowed the intravenous administration of sedating drugs, so that sedative effect could be attained more rapidly than is possible with oral or subcutaneous administration. It also allowed mechanical ventilation. After one patient was detoxified using IV (intravenous) phenobarbital and diazepam followed by intravenous naloxone, the decision to take more direct control was made. The last four patients in Group 4 were induced with propofol, intubated, and ventilated. They were maintained on a propofol drip. Norcuron was given as needed to control muscle movement for a 4-hour period, after which the propofol was stopped, allowing the patients to wake up rapidly. All four of these patients had been completely detoxified by hour 4, as demonstrated by a lack of abstinence syndrome when they were given 50 mg of naltrexone PO immediately upon awakening. A period of vomiting did occur with discontinuation of sedation and paralysis, but airway control was maintained until the patients were fully awake and vomiting had ceased; patients were fully functional by the time of extubation. They were watched over night, and no adverse events occurred over that interval.

DISCUSSION

What we have described is clinical experience with a series of patients, not a prospective clinical study. Nevertheless, we feel that the experience bears several lessons, all of which are relevant to the issue of opiate detoxification.

First, we have reconfirmed the validity of rapid detoxification using opiate antagonists to block opiate receptors and sedative-hypnotics to subdue symptoms during the conversion. Our experience parallels that of the literature; ROD is possible in as little as 4 hours. The mechanism appears to be active displacement of opiates from opiate receptors when the receptors are flooded with the antagonists, as opposed to the gradual loss of bound opiate with "supported" withdrawal. Not only is the time span for withdrawal reduced by many days; in addition, the opiate receptor blockade achieved by

ROD means that a dose of narcotics given to a patient having completed ROD would have no physiologic effects. While this cannot be mistaken as a guarantee of abstinence, it does provide a window of time for addicts to be symptom-free and refractory to drugs and to be engaged in programs with the goal of long-term abstinence. The ability to continue taking naltrexone orally (either alone or in a program involving observed administration) also provides the opportunity to extend that window.

We wish to stress that ROD is a technique for detoxification, not a cure for addiction. ROD avoids much of the physical comfort of withdrawal and may avoid attrition caused by the pain of withdrawal, but it cannot be expected to suffice or to offer long-term efficacy unless clients are treated within a psychosocial context. We strongly advocate lifelong participation in a 12-step program as indispensable in maintaining abstinence.

Second, we have described for the first time an aggressive regimen using propofol, mechanical ventilation, and norcuron to control the withdrawal period. Propofol's short half-life, coupled with short-acting paralysis, allowed an unparalleled degree of control. Thus our clinical experience has shown efficacy within a full range of approaches from "catching up" to naltrexone-induced withdrawal with sedatives to controlling the patient completely before beginning antagonists. What remains to be shown is which approach offers the best combination of safety, efficacy, and efficiency. Perhaps the optimal treatment plan would involve some intermediate point in the continuum.

Third, our experience has shown us that ROD is a technique without a home. If patients are to be sedated optimally, they should be monitored more closely than is possible on a routine hospital floor. On the other hand, the intermediate intensive-care unit is a step-down unit for the intensive-care unit and also receives subacute cases from the emergency room; it is not designed and was sometimes unable to accept scheduled admissions that were nonurgent but required monitoring. In addition, our experience demonstrated that patients who were stable when given a large dose of naltrexone after ROD required no subsequent intervention; no significant adverse effects occurred during overnight observation. Thus, the overnight stay is not needed. ROD does not have to be a hospital procedure. We would argue that opiate detoxification should ideally be accomplished in a unit designed specifically for detoxification. Medical models include outpatient surgicenters and dialysis units.

In conclusion, ROD is humane, fast, and efficient. It is also cost-effective, and would allow more of the health-care dollars spent on opiate addiction to go to programs that alter the social milieu and encourage sustained abstinence. The techniques involved in ROD require expertise and monitoring, but the patients are not critically ill and are detoxified electively; this detoxification would be best effected in centers for ROD and not in beds borrowed from the

critical-care system.

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RAPID OPIATE DETOXIFICATION AND NALTREXONE INDUCTION UNDER GENERAL ANESTHESIA AND ASSISTED VENTILATION:
EXPERIENCE WITH 510 PATIENTS IN FOUR COUNTRIES

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ABSTRACT

This paper describes some modifications of the original Vienna method of rapid opiate

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detoxification under general anesthesia (RODA) and naltrexone induction. We use muscle relaxants and assisted ventilation, with propofol, isoflurane and thiopentone. Octreotide greatly reduced gastrointestinal secretions. There were no significant anesthetic complications. Most patients were fit for discharge within 24 hours. Heroin dose did not correlate with speed of recovery. Abstinence rates as high as 76% at four months were achieved. Patients were successfully withdrawn from as much as 200 mg of methadone daily. Post-detox management is discussed.

INTRODUCTION

Loimer et al (1988a; 1988b) first described the technique of opiate withdrawal precipitated and accelerated by opiate antagonists while the patient is anesthetized for a few hours. They used methohexitone or thiopentone for anaesthesia. Patients were intubated but not paralyzed. Initially, they used a naloxone infusion. Later, patients receiving methadone at doses up to 120 mg daily were detoxified and transferred to full doses of naltrexone in 4-6 hours (Loimer et al, 1991a).

The Vienna group originally speculated that barbiturates, such as thiopentone, had a particular ability to suppress precipitated withdrawal symptoms but it appears that virtually any standard anesthetic agent can be used for this technique. Brewer (1989a) first described the use of propofol, which gives a very rapid recovery. Clonidine was given as a premedication because of its effectiveness in other techniques of precipitated withdrawal using sedation rather than anesthesia (Charney et al, 1986; Brewer et al, 1988; Senft, 1991). Naltrexone was administered during anesthesia via the nasogastric tube.

RODA has become more widely used in the last three years. This is due partly to its commercialization and promotion by the Spanish-Israeli CITA group, who are attempting to patent the procedure (Brewer, 1996b). However, there is a growing realization although it is neither appropriate nor necessary for all patients and may attract many patients who find conventional withdrawal difficult and/or unpleasant. Some will not even contemplate withdrawal, so great is their fear (Milby et al, 1986). Furthermore, although rapid opiate detoxification under oral sedation (RODOS) is often a satisfactory alternative technique, some patients are difficult to sedate and may present nursing problems (Brewer et al, 1988; Brewer, 1989b; Senft, 1991). It is difficult to identify these patients in advance. We present some data on 510 patients having RODA at clinics in London (80 cases), Merchantville, New Jersey (355 cases), Athens (25 cases) and Cairo (50 cases), using similar techniques.

PATIENT SELECTION AND CHARACTERISTICS

The clinics in London and Athens offered several withdrawal techniques, and the final choice was largely left to the patient. In London, where methadone maintenance was also an option, several patients were advised to try a period of stabilization on methadone before reconsidering detoxification. Cairo patients were discouraged from detoxifying if they were thought to be motivated largely by external pressures. The New Jersey clinic offered only RODA. In Athens, of 60 consecutive patients seeking withdrawal, 35 (60%) chose other methods. All patients were told repeatedly that detoxification was usually only a stage in the treatment of addiction and that after-care, including supervised naltrexone was important.

Few patients suffered from conditions which contraindicated general anesthesia. Two known HIV positive patients were treated in London, one with a CD4 count of 120. Of the Athens patients, 18 (72%) had hepatitis C.

All Athens patients were heroin users (mean daily use 0.7 grams) as were most of the New Jersey and Cairo patients. In contrast, 30% of London patients were detoxified from methadone. Thirty-six percent of Athens patients and a similar proportion in London were also dependent on benzodiazepines.

ANESTHETIC TECHNIQUES

The main difference from previously described methods was that all patients had assisted ventilation, usually with atracurium as the relaxant. Propofol was the usual induction and maintenance agent, but isoflurane in a closed circuit was used in 18% of London cases and thiopentone was used in several cases in Cairo. Propofol is expensive and the use of muscle relaxants reduces the total amount needed for the procedure. Duration of anesthesia was four hours in New Jersey and four to six hours elsewhere. Pre-medication includes antiemetics, usually droperidol or ondansetron and a benzodiazepine. H_2 blockers or proton pump inhibitors are given to reduce acid secretion in case of aspiration. Clonidine was used in all the centres.

Diarrhea is poorly controlled by anti-withdrawal drugs and is not suppressed by anesthesia. Opiates are ineffective in the presence of opiate antagonists. Profuse liquid diarrhea is common in precipitated withdrawal. All centres initially used pre-treatment laxatives and/or enemas, but the growth-hormone analog octreotide, given IV or subq as a pre-medication greatly reduced diarrhea and bowel preparation is now unnecessary. A full report on octreotide's effectiveness is in preparation. Monitoring includes constant ECG, respiration, pulse, BP, SaO_2, and end tidal CO_2. A urinary catheter is inserted but removed before awakening.

ADMINISTRATION OF OPIATE ANTAGONISTS

In all centres, IV naloxone 1.6-2 mg was given initially. About 20 minutes later, naltrexone in doses from 12.5 mg to 25 mg is given as a suspension via the nasogastric tube. After the naloxone, New Jersey patients also receive 2 mg of IV nalmefene, an opiate antagonists with a half life of ten hours. Further doses of naltrexone are given two to three hours later to a total of 50 to 200 mg. Higher doses may cause more side effects, but by ensuring opiate blockade for up to four days may reduce the likelihood of early relapse.

Following naltrexone administration, there are usually few signs of withdrawal. Piloerection may be seen and, more rarely, sweating. The dose of muscle relaxant is titrated for less than total paralysis and slight movements of the limbs may be seen initially.

EMERGENCE FROM ANESTHESIA

Patients vary in their behavior at this stage. Most are drowsy but all New Jersey patients get out of bed within 30 minutes and walk to the toilet with assistance before returning to bed, if necessary, for a period of observation. A minority of patients are restless and need further sedation. Further doses of antiemetics and octreotide can be given for nausea and diarrhea.

These problems generally settle within a few hours. Octreotide greatly reduces gastric as well intestinal secretions. If necessary, clonidine should be given in adequate doses provided blood pressure is at least 80/50 and the pulse at least 50 per minute (Charney et al, 1986). Comparative studies are needed to show whether it is more effective if given as part of the premedication or whether it is equally effective if given before extubation.

POST-ANESTHETIC MANAGEMENT

The speed of recovery is very variable and seems to bear little or no relationship to the normal daily dose of opiate. Some patients are fit to walk out of the clinic unaided an hour after extubation. All New Jersey cases are treated as out-patients and leave the clinic after a few hours to go home or to stay at nearby hotels where they can receive regular medical or nursing visits. In Athens, Cairo and London, the patients stay in the hospital over night. Occasionally a second night seems advisable, especially if home circumstances are less than ideal (the original Vienna patients stayed in the hospital for five to seven days but all were ambulant by the second day and their treatment was paid for by the state health service).

POST-DETOX MANAGEMENT

Management varied in the four centres, reflecting both cultural differences and expectations and the clinical background of the physicians involved. All patients were advised to take naltrexone for at least six months under family supervision. In addition, New Jersey patients, treated by an internist, were strongly encouraged to join or rejoin 12-step groups in line with the importance attached to this approach in the US. Athens and London patients, treated by psychiatrists were offered individualized programs using cognitive behavior concepts. In Cairo, where treatment was coordinated by a medical toxicologist, regular urine testing and family involvement were emphasized. If patients seemed to have few underlying problems, management largely involves being generally supportive and available.

RESULTS

WITHDRAWAL SYMPTOM RATINGS

The most complete set of data relates to the Athens patients. Using a 20 item 4-point withdrawal rating scale developed by Bradley et al (1987), patients were rated on admission before RODA and again the following day before discharge. The overall rating was slightly, but not significantly worse after RODA (paired T-tests pre- vs. post- = 8.5 vs. 12.5, t=1.5). However, on symptom by symptom comparison (Wilcoxon matched pairs), diarrhea (7=2.8, p less than 0.005), feeling cold (Z=2.4 p less than 0.01) and hot and cold flushes (Z=2.6, p less than 0.0l) were significantly worse. Neither age of patient, duration of opiate use, nor usual opiate dose correlated with symptom severity (Pearson correlation).

COMPLICATIONS

No serious anesthetic complications were encountered using these methods. One New Jersey patient developed bradycardia and first degree heart block, probably related to clonidine which responded to beta-adrenergic agonists.

ABSTINENCE RATES DURING FOLLOW-UP

RODA was first used in Cairo in October of 1995 and the follow-up data are unusually complete. Of the first 30 patients representing all patients detoxified at least four months ago, only five patients have not been regularly followed-up, usually because of living or working abroad. Regular urine tests have been done in the remaining 25 cases. As of July, 1996, only one out of the 25 had relapsed to opiate use, though in four cases, urine has been positive for cannabis. The very high 'success rate' in the Cairo patients - 76% even if all patients lost to follow-up are assumed to have relapsed - probably reflects both the rigorous selection of well-motivated patients and the suitability of close-knit Egyptian family structures for treatment involving family supervised naltrexone, which increases abstinence rates considerably compared with conventional treatment programs (Gerra et al, 1995).

Follow-up data are less complete for the other centres. RODA patients probably don't have better long-term results than comparable patients who complete conventional in-patient withdrawal programs. However, "It seems likely that a significant proportion of patients who would fail (or have failed repeatedly) to complete conventional withdrawal will succeed with the help of anesthesia or sedation. This is one important reason for putting these techniques on the therapeutic menu." (Brewer, in press).

IS WITHDRAWAL MORE DIFFICULT FROM METHADONE?

Many addicts and addiction physicians believe that withdrawal from methadone is worse than from heroin but patients who receive methadone treatment may not be representative of the majority of heroin abusers. They may take methadone precisely because they have withdrawal symptoms, which are worse than average. Animal studies show that the severity of withdrawal symptoms is, at least in part, genetically determined (Suzuki et al, 1987). The same is probably true of humans. Withdrawal severity correlates poorly with daily opiate dose (Kosten et al, 1989). To answer the question objectively, a group of methadone addicts would have to be randomized to remain on methadone or take equivalent doses of morphine for at least a week before RODA. Some pure methadone addicts recover quickly even from doses up to 200 mg daily. Some pure heroin addicts take longer than average. However, even in the worst cases, patients with jobs can usually return to work within a week.

DISCUSSION

These results confirm that RODA is not only rapid and humane, but also an effective and acceptably safe method of opiate withdrawal. It is clear that most patients have relatively mild withdrawal symptoms which soon improve and the findings in the Athens group are similar to those previously reported by the Vienna group (Lormier et al, 1991b). However, claims that patients experience no withdrawal symptoms are manifestly untrue (CITA informs its patients that any discomforts they experience on waking are not withdrawal symptoms, but a "a sign that the body's immune system has begun functioning again). Furthermore, a small minority have persistent, if largely subjective symptoms, in which can be very distressing even if they cannot always be assessed on the standard withdrawal rating scales. Appropriate medication can assist the recovery process. Apart from naltrexone and clonidine or lofexidine, hypnotics were the most widely prescribed class of drugs. Sleep patterns can take several weeks to normalize. Anti-depressants have not been frequently prescribed.

Farrell (1994) claims that because death from uncomplicated opiate withdrawal is virtually unknown, it is not justifiable to introduce the potential hazards of anesthesia. However, the relatively slight hazards of modern anesthesia in generally young patients (without the added

risks of a surgical procedure) must be set against the frequent and sometimes lethal complications of continuing opiate abuse, especially IV abuse. It should equally be said that since nobody dies from bad teeth, an unshapely nose, or the pain of childbirth, it is unjustifiable to offer general anesthesia for the management of these conditions. Provided that the risks are small and adequately explained, patients are surely entitled to take them (Brewer, 1996a). Punitive attitudes to drug addicts apparently make some health professionals feel that they do not 'deserve' good symptom relief (Brewer, 1995).

RODA and early discharge mean that, compared with conventional withdrawal programs, many more patients can be treated during a given period. Unconscious patients do not manipulate nursing and medical staff or smuggle opiates into the ward.

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by Joshua Davis

WIRED MAGAZINE
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Bryan Peterson sat on the toilet in the master bathroom of his Palm Springs, California, home and tried to find a vein between his knuckles. It was virgin territory - he had never injected himself in a spot he couldn't cover up. But now that he'd been fired from his job in the estimating department of a construction company, he didn't care about covering up anymore. Plus, he couldn't find a vein in his arms, which were swollen with pools of pus and heroin. The thin, translucent blue veins snaking across the back of his hand filled him with joy. He slid the needle in beside his knucklebone. It hurt.

Two weeks later, he'd blown out all the tiny veins in his hands and feet. Unable to absorb all that fluid, they burst, adding more blood to the already toxic mix festering under his skin. He started plunging the needle deep into his bicep, shooting heroin directly into the muscle. The drug seemed to sizzle as he injected it.

Peterson was 36 and had been addicted for three years. Before that, he was just a normal working guy who liked to play guitar in a local rock band. Over the past two and a half years, he'd tried to kick his habit cold turkey three times and attended a few Narcotics Anonymous meetings. He'd make it through the first step - acknowledging that he was powerless over his addiction - and that was it. Even with the group therapy sessions and encouragement from fellow addicts, he couldn't stay clean for more than

10 days. The withdrawal pains were so unbearable, he fantasized about cutting off his legs to stop the aching. And when the pain subsided for a moment, he was racked with nausea and diarrhea. His body was holding him hostage: Either take the drug, it said, or you'll feel so much pain you'll want to die.

Then one day Peterson was talking to a friend who mentioned a miracle treatment gaining popularity in the Los Angeles area. Doctors were anesthetizing addicts and using an intravenous drug cocktail to induce an almost instantaneous withdrawal from the heroin. Within 24 hours, an addict would be pronounced clean and sober. Peterson borrowed the $15,000 for the procedure from his family, shot up one last time, and headed for Orange County.

"The 12-step program is an outdated 20th-century concept," says Clifford Bernstein, an assistant clinical professor of anesthesiology at UC Irvine and medical director of the Waismann Institute, the nation's leading rapid detox center. "For 70 years, thanks to Alcoholics Anonymous, addicts have been told they're suffering from a spiritual problem. AA assumes that you can talk someone out of their addiction - which is ridiculous. Addiction is a medical problem. If somebody has cancer, you don't try to talk them out of their disease."

Bernstein's steeply angled eyebrows make him look surprised and angry. When he speaks, he's quiet and measured, but his expression suggests amazement at the foolish things people believe. His eyebrows arch even higher when he examines Peterson's ravaged arms.

The procedure is scheduled to take place in the Garden Grove Hospital and Medical Center's intensive care unit, which Peterson now shares with a burn victim, a barely breathing obese woman, and a screaming elderly lady with multiple bone fractures. If he weren't about to undergo rapid detox, Peterson would be considered too healthy to be here. It's been 30 hours since he last shot up, and though he's well into the early stages of withdrawal, he's only suffering from a cold sweat, a dull ache in his leg, and a mounting panic.

The reaction is normal. Opiate molecules have a chemical structure similar to endorphins - a natural hormone that regulates pain and pleasure. When a heroin user shoots up, the opiates in the drug plug into the nerve receptors normally occupied by

endorphins. If opiates are administered repeatedly, endorphin production drops. The body has essentially been tricked into short-circuiting the natural pain-pleasure regulation system.

The addiction turns ugly when the opiate is withheld. Without the presence of either the opiates or the natural endorphins, an addict's pain receptors cease to regulate brain signals. The unimpeded flow of stimulation causes acute pain while triggering a cascade of reactions throughout the body: sweating, uncontrollable diarrhea, vomiting, and severe depression. It's not fatal - though it may feel like it - and the addict often relapses just to stop the torment. It usually takes two to three weeks of suffering before natural endorphin production resumes and the pleasure-pain equilibrium is restored.

Considering the ordeal, it's not surprising that quitting cold turkey works only about 5 percent of the time. To improve on that success rate, drug treatment experts have traditionally relied on three approaches: methadone, symptomatic treatment, and Narcotics Anonymous. Methadone, and its modern substitute buprenorphine, are opiates that don't produce a high. An addict taking these drugs has essentially moved from a risky, illegal dependency to a safer, legal one. But if they don't take the methadone, withdrawal begins within hours. For users who don't want to be addicted to any substance, treating the symptoms with a combination of anti-nausea, antidiarrheal, and sedation drugs can help ease the pain of withdrawal. Finally, the support of an NA group is usually recommended in conjunction with all other treatments. These methods have a success rate of 30 percent to 40 percent after a year.

Bernstein says he has a better way to kick opiate addiction - one that painlessly strips the drug from the brain's nerve receptors in 20 minutes. The procedure, which relies on a combination of medicines, is carried out while the patient is anesthetized - a conscious patient would be in so much agony there would be risk of a heart attack. According to Bernstein, the roughly 2,500 patients the institute has treated wake up after an hour and are no longer addicted. Even if an addict were to shoot up after the procedure, there would be no effect. The opiate would be blocked from binding with the receptors already occupied by naltrexone, a drug

which must be taken orally for a year. Bernstein says 65 percent of Waismann patients are still clean after a year.

Critics dismiss those numbers and denounce the Waismann method as a scam that takes advantage of desperate addicts. But the American Society of Addiction Medicine has come out in support of the treatment, and the society's former president claims that it's one of the most innovative developments in the field since the advent of the 12-step program in the 1930s.

With a recent surge in the abuse of opiate-based painkillers such as OxyContin, the institute's business is booming. He has put up billboards across the country and has explained the procedure on MTV, CBS, and NBC. So far, he's drowning out his critics. And, like Lasik eye surgery in the 1990s, rapid detox is making the transition from experimental technique to standard procedure offered nationwide. Competitors have emerged: A rival rapid detox center opened last year in Los Angeles, and there are centers in Colorado, Florida, Illinois, Michigan, New Jersey, and New York. Hundreds of addicts are going through rapid detox each year, and proponents like Bernstein are positioning the approach as a modern, humane alternative to Narcotics Anonymous.

Which makes Peterson an early adopter. Now anesthetized, he lies almost motionless in the intensive care unit. Blue fluid is being pumped through his veins. Withdrawal has never been so easy. But it's also never been so deadly.

In 1988, Austrian physician Norbert Loimer was studying opiate withdrawal when he discovered that injecting addicts with naloxone - the intravenous form of the opiate blocker naltrexone - achieved what he referred to as "acute detoxification." It was accompanied by intense suffering, which he tried to alleviate by sedating the patients. It worked. His experimental process condensed the typical weeks-long withdrawal into a matter of days. Though he believed that the procedure was too dangerous to be offered to the public, he published his findings in a medical journal, where they were read with interest by addiction medicine specialists.

One of them was Lance Gooberman, an American MD who concluded that the danger of Loimer's rapid detox method was outweighed by the fact that addicts were dying on the streets every day.

Gooberman knew the risks of drug dependence first hand - he was an alcoholic and had been hooked on methamphetamines before he began treating other addicts. He understood that many junkies wouldn't even consider kicking - conventional detox scared them too much. A faster, less painful withdrawal could mean the difference between going into treatment and death for many. So in 1994 Gooberman took Loimer's experimental work and turned it into a business.

Over the next five years, Gooberman performed more than 2,300 rapid detoxifications in his offices in Philadelphia and southern New Jersey. According to county coroners, seven of those addicts died of complications relating to the procedure. That was enough for David Samson, New Jersey's attorney general, to file civil charges against Gooberman in October 1999, accusing him of "repeated gross malpractice, professional negligence, professional incompetence, and professional misconduct." Samson contended that rapid detox was an unproven treatment that put too much strain on patients' bodies. It just wasn't reasonable, the complaint explained, to assume that a two-week ordeal could be safely condensed into an hour. He argued that Gooberman was promising more than he could deliver and creating "a clear and imminent danger to the public's health, safety, and welfare."

While Gooberman was building his practice on the East Coast, Bernstein was recruited to head up the Waismann Institute in Beverly Hills, California. The institute was founded by Clare Waismann, a Brazilian businesswoman who realized that rapid detox addressed an unmet need. The market was crowded with 12-step programs and methadone clinics, but all of them required addicts to stick with a program. Rapid detox largely removed willpower from the experience - it was a concept Waismann thought would make her institute the dominant detox facility on the West Coast and, eventually, in the nation.

Bernstein was an ideal partner. He had attended a respected medical school (Rutgers), understood opiate addiction, and was a med school faculty member. He was energetic, believed in the treatment, and was ready to devote his credentials and time to winning mainstream acceptance for it.

But the headlines generated by the case against Gooberman weren't making it easy. Gooberman was on trial, but the defendant in the three-year case

was really the procedure itself. Most of the testimony concerned the alleged dangers and benefits of rapid detox. And since the FDA does not regulate medical procedures, the case became a battle over the legitimacy of the treatment.

Samson laid out his argument clearly, beginning with the obvious: Opiate withdrawal is a nonlethal condition, but seven of Gooberman's patients had died. Anesthesia alone carries a small risk of death. When coupled with an infusion of novel drugs, there's no telling how dangerous it can be, particularly since there have been no large-scale scientific studies on the procedure's effectiveness. In essence, he was saying that the cure was worse than the disease.

David Smith, a leading addiction doctor and former president of the American Society of Addiction Medicine, disagreed. Smith testified that rapid detox was the procedure of last resort for addicts who had tried everything else and failed. Many of them just couldn't withstand the pain of withdrawal. Gooberman offered them another option. His patients came from a population whose health was already compromised - just treating them was a risk. But the fact that he tried to help them didn't mean he was responsible for their deaths. "How many would have died if they'd stayed on drugs?" Smith asks. "Treatment is not a threat to public health, and the attorney general did a disservice by trying to criminalize it."

The judge in the case agreed that Samson was overreaching. In a 353-page opinion handed down at the end of 2002, he concluded there was no evidence that rapid detox "caused or contributed" to the seven deaths. He called the treatment "potentially promising" - but rebuked Gooberman for a variety of medical oversights, fined him $11,500, and revoked his license for six months. The attorney general appealed, and Gooberman soon settled the case out of court. He agreed to pay $375,500 to the state and $30,000 to the families of the deceased. He also agreed to have his medical license revoked for two years. His reputation was damaged beyond repair. No hospital would hire him, and he disappeared from public view.

That left one man in the media spotlight - just in time for a surge in demand. Bernstein made it through rapid detox's early years without a fatality, and now OxyContin abuse was skyrocketing. The treatment had been legally vindicated, and

Bernstein's main competitor on the national stage couldn't practice medicine anymore.

Bernstein smiles as the cameraman holds the shot. It's early in 2001, and the Gooberman case rages on. 48 Hours, the CBS newsmagazine show, is documenting the plight of Troy Swett, a 22-year-old OxyContin addict. Swett has just arrived at the hospital in Orange County to be detoxed, and Bernstein is ready for his close-up. "Congratulations for coming," Bernstein says, shaking Swett's hand. "It's the first step."

In a traditional 12-step program, the first step is to admit powerlessness over the addiction. Now, according to Bernstein, the first step is arriving at the Waismann Institute. This kind of national exposure is important for Bernstein. It's an opportunity to continue redefining how the public thinks about addiction.

During the segment, Bernstein notes that 90 to 95 percent of his patients are clean after a month. The on-air reporter asks about long-term effectiveness, to which Bernstein replies, "People walk out of here, their withdrawal is finished, and they're not craving." And the segment moves on.

But the numbers deserve more scrutiny. They are compiled by the Waismann staff without independent confirmation. They are also based solely on follow-up phone calls, and there's no guarantee that everyone is called. (At least one Waismann client, OxyContin addict Tim Lincoln, says he was never contacted after he returned home to Texas. He relapsed after two months.) Bernstein doesn't defend the absolute accuracy of the success rate stats. "Maybe it's a little off," he says, "but it's still much, much higher than methadone or Narcotics Anonymous programs."

Even substantiated statistics wouldn't necessarily prove that rapid detox is better than conventional treatments. The type of patients who come to the Waismann Institute tend to have more family and social support and can afford the $15,000 fee. They are more likely to get clean in any kind of treatment program. And there's another twist: Bernstein says that about 70 percent of his patients are addicted to prescription painkillers. He admits that the success rate for heroin addicts is probably lower, but he doesn't know the exact figure. Still, Waismann advertises a single success rate - 65 percent - and is therefore luring heroin abusers with a potentially

exaggerated promise.

Bernstein cites independent studies to buttress his claims. A study from the University of Miami School of Medicine in 2000 reports a 55 percent abstinence rate six months after rapid detoxification. A German clinical investigation in 2000 found a 68 percent success rate at 12 months. But neither study compared the procedure with a control group, so it's impossible to state whether patients would have been more or less successful with another treatment.

Herbert Kleber, director of the division on substance abuse at Columbia University, takes issue with Bernstein's claims. "I challenge him to take 100 addicts off the street and show a 65 percent success rate," Kleber says. "He won't be able to."

Kleber has just completed the largest scientific study of rapid detox to date, and his numbers don't come close to matching Bernstein's. Using a $1 million grant from the National Institute on Drug Abuse, Kleber followed 105 abusers through rapid detox and two other treatments. He found that after three months, rapid detox fared no better than other methods.

But even if it doesn't work as advertised, it's still a useful treatment that can seem like a miracle cure. Even Tim Lincoln, the relapsed OxyContin addict from Texas, grudgingly admits it served a purpose. Before he went to see Bernstein, he tried to quit twice, only to suffer a week of diarrhea, nausea, and severe depression each time. Though he didn't feel good after rapid detox, he didn't have any diarrhea or nausea. Essentially, Bernstein's treatment allowed him to skip that first and most painful week of the process.

It was an illusory victory - Lincoln relapsed within two months. He eventually found the willpower to suffer through the withdrawal on his own and, with the help of Narcotics Anonymous, is clean now. But for addicts who cannot make it through that first week of withdrawal any other way, the $15,000 procedure may be their only hope. And for white collar addicts - business executives, doctors, celebrities, sports stars - the quick fix promised by rapid detox is a powerful draw.

Amanda, a busy Northern California medical-supply sales rep who asked that her real name not be used, was popping 20 Vicodins a day but didn't want to take a lot of time to deal with her addiction. Before

she found out about Waismann, she was preparing for a 30-day detox in Malibu. Bernstein, she says, cured her in a weekend: "They put me under Friday. I was a little groggy Saturday. By Sunday, I was ready to get back to work. And I had no desire for the pills."

While criticism from within the medical community hasn't influenced Bernstein, competition may. In November, Chicago-based Midwest Rapid Opiate Detoxification Specialists opened a center in LA. Jake Epperly, the clinical director, distinguishes his method from the Waismann practice by emphasizing "the absolute necessity of a continuing care recovery program" based on Narcotics Anonymous. Epperly runs his own halfway house in Chicago and markets his group as the only rapid detox service in the US with a 28-day inpatient aftercare program.

Of course, closely monitoring a former user's sobriety is a pillar of NA. Addicts are expected to attend 90 meetings in 90 days and speak regularly with a sponsor who has been off drugs for an extended period.

Bernstein has never offered a robust aftercare program. He trusts in the science, not the therapy. At the Waismann Institute, the $15,000 fee includes 6 to 12 follow-up phone calls from a psychologist. Bernstein is particularly adamant that the Narcotics Anonymous approach is counterproductive. "The last thing I want is for my patients to sit in a room with a bunch of other addicts and spend all their time talking about drugs," he says. "It's like a cult. Plus, that's where all the drug dealers hang out."

But Bernstein is adapting. He says that he is in the process of creating his own Waismann-branded luxury recovery center near a beach in Orange County, where addicts can stay after detox. According to Bernstein, it'll be nicer and more effective than Epperly's program. Rather than attend group meetings, patients will be encouraged to play golf and take walks on the beach.

Epperly scoffs at the approach. "Golfing won't keep them off drugs," he says. "Just because their bodies don't crave it doesn't mean they psychologically don't want it."

Bryan Peterson is sitting in the backyard of his parents' suburban home in the hills outside Las Vegas. It has been two weeks since he underwent rapid detox. The swelling in his extremities has gone

down, and the scabs on his arms have fallen off. There are dark bags under his eyes, and his skin looks like yellowed parchment. But he manages a meager smile. For the first time in two years, he's been sober for more than a few days. "Everything just looks a little greener," he says, staring out at the mostly gray desert.

Then he taps his fingers on the glass table in front of him. He lights a cigarette. He's got nothing to do. His next scheduled phone conversation with the Waismann psychologist isn't for three days. Peterson admits that he opened the yellow pages a couple of days ago and found the address of a local methadone clinic. "It's the easiest place to score," he says. But he didn't go, and he says that he feels better every day. By mid-November, he was still clean and he moved with his fiancée to Glasgow, Kentucky. It's a dry town - no alcohol is sold within city limits - and it's supposed to be very green.

Contributing editor Joshua Davis (jd@wiredmag.com) wrote about supercoca in issue 12.11.

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ADDICTION SPECIALIST TO EXPAND TREATMENT

Linda Johnson, Associated Press

COURIER-POST
12-30-2002

TRENTON:

An addiction treatment doctor who says his implanted medication pellets help recovering addicts stay clean plans to bring them to patients elsewhere.

Dr. Lance Gooberman, who operates the U.S. Detox Inc. clinic in Merchantville since 1996 has made an implanted half-inch pellets containing medicine that blocks the high from opiates.

The pellets, patented by Gooberman in March 1991, are inserted just under the skin on the back of the arm. They contain the drug naltrexone which blocks the effects of heroin and other opiates for about two months to help recovering addicts overcome temptation.

The U.S. Food and Drug Administration approved naltrexone in the early 1970s for treating drug addiction and more recently alcoholism. It is widely used on addicts, usually in pills, but recovering addicts sometimes stop taking them so they can get high.

At least one company now had a long-acting injection of naltrexone.

Gooberman and a colleague last month were exonerated of malpractice charges in the deaths of patients receiving a different treatment, rapid opiate detoxification under anesthesia. The long investigation and trial Gooberman said overshadowed all the good his pellets have done.

While the pellets are not approved for sale by the FDA, Gooberman can compound them for use in his own patients.

He said he's implanted at least 100 pellets per month since 1996 in patients -including some from England and the West Coast-

recovering from addiction to heroin, methadone and other opiates.

As far as he can tell, the pellets help keep patients clean for two months and many come back for more implants.

"This has been a wonderful idea. It's working, "Gooberman said, "I want to make this more broadly available to more people."

He plans to license use of his pellet-making procedure and an insertion kit to other addiction specialists. Gooberman also hopes to privately raise about $5 million to perform three types of experiments -chemical analyses, tests on guinea pigs and tests in healthy volunteers - so he can seek FDA approval to sell his pellets.

But he has no hard data to prove how long the pellets are effective, other addiction experts say.

"It sounds like a good idea, assuming there is a recognized way to screen people to see who is appropriate for this," said Robert Hunsicker, president of the National Association of Addiction Treatment Providers.

Hunsicker said use of the pellets is being widely discussed in the field, especially for patients who repeatedly relapse.

Dr. Donald R. Jasinski, Chief of the Center for Chemical Dependence at Johns Hopkins Bayview Medical Center, said many researchers have had ideas like Gooberman's but could not find a long-term system that consistently releases opiate-blocking medicine.

"Naltrexone itself works but this preparation is not FDA approved, nor has it been tested with rigorous science,: Jasinski said.

Gooberman's patients are convinced it works - as long as they keep getting pellets.

Stacey, a 25 year old college student from Toms River, said they kept her off heroin for eight months, but she relapsed because I haven't hit bottom." She returned to Gooberman for detoxification treatment in July and has since gotten two pellets implanted, has no cravings and hasn't used drugs since.

"He's a miracle worker. He really is," said Stacy, who has referred more than a dozen other addicts to Gooberman.

Irene Waldron, a Wilmington, Del. Nursing home administrator said the pellets got her son Glenn off heroin for nearly a year before he relapsed. After another painful detoxification, Glenn got a new pellet implanted Friday.

"I was really depressed this morning and once I got it in my arm, I perked right up," said Glenn, 30 a carpenter. "I'm starting over for the fourth time. I'm done" with drugs.

His mother, who lobbies on issues affecting the elderly, now plans to ask the Delaware Legislature to consider use of naltrexone to reduce the amount of time drug offenders must spend in jail.

"It's the only humane way that I can see where addicts can get clean," Waldron said.

Meanwhile, Gooberman awaits final disposition of his malpractice case.

After a trail that ran intermittently for 18 months, an administrative law judge last month ruled Gooberman and his colleague were innocent of malpractice and generally had acted in good faith, but had violated some record-keeping rules.

The Judge recommended brief suspensions of their medical licenses.

But Gooberman says their attorney will argue before the same Board of Medical Examiners, which has the final say, that a suspension is unwarranted.

Doctor Detox Takes Another Hit

By Maximillian Potter

PHILADELPHIA MAGAZINE
JANUARY 2000 ISSUE

Dr. Lance Gooberman can't believe what he sees. Stopping just inside the open doorway of his attorney's conference room to hike up his pants and his courage, he guesses there must be at least three TV crews and a dozen photographers and newspaper reporters. For most of the past four and a half years, he reminds himself, the media has been loving him, especially the television people. Many of them reported on his "rapid opiate detox" as a breakthrough alternative for junkies wanting to get clean. And so what if Geraldo Rivera isn't Dan Rather? He still credited Gooberman on national TV with inventing "a magic bullet" to fight heroin addiction.

But now that New Jersey state officials are coming down on him with a sledgehammer, Gooberman hopes this press conference will rally media support and make junkies aware they are losing what he considers a proven jump-start to getting straight.

At a time when thousands of heroin addicts need his services, he can't understand why the state's attorney general just forced him to stop performing ROD, or why the New Jersey board of medical examiners wants to revoke his license.

The 48-year-old doctor, a short, muscular man with pale, freckled skin, a red beard and receding red hair, feels the droplets of sweat beading on his forehead. The anxiety pangs rabbit-punching his gut now are nothing compared to the hell he experienced during that insane period years ago, when he almost

lost everything, including his life. I'm still better off today, no matter what, Gooberman keeps telling himself.

Hands and voice trembling, he reads his statement: He's treated more than 2,000 patients with rapid opiate detox. ... Other physicians are performing the procedure. ... He dreams of the day when ROD is available throughout the tri-state area. ... Last week's newspaper reported that in 1996, heroin caused 60 percent of all overdose deaths in the eight-county Philadelphia region ... and ROD seems to be one of the country's best shots at stopping heroin-related deaths.

To personify the power of heroin and his success in fighting it, Gooberman introduces 50-year-old Richard and 20-year-old Stephanie. Richard is a tall, tanned laborer from Wildwood, and Stephanie, clad in black, with ornate rings on every finger, lives in Philadelphia.

Richard says that before visiting Gooberman's clinic, he had been addicted to heroin for 30 years. "I went through his procedure ... and went home. I felt a little sick for a few hours, but nothing like before, when I tried to detox myself. I can say that from then on my life has changed. ... My family is talking with me instead of hiding stuff from me. I'm not a crook. I'm working steady. Saving money. Pay my own bills."

Richard then reaches for the box of tissues in front of him; when he dabs his eyes, the flashbulbs pop, pop, pop, followed by the sound of advancing film.

They're getting it, Gooberman tells himself. They're getting it.

"I thought," Richard says, "I was going to die on drugs."

Stephanie says she started on heroin when she was 15 and that to support her habit, "I had to become, like, a prostitute and all that." She got kicked out of school, got locked up. Like Richard, she tried other ways to get off smack. Finally, 10 months ago, she went to Gooberman for ROD, and she says she has stayed clean since. "I just want to say thanks to Dr. Gooberman," she announces. "Because if it wasn't for him, I don't know where I'd be right now."

Then the reporters' questions come. They all want to know more about the six Gooberman patients who

died shortly after having ROD.

Gooberman turns briefly to exhale his disgust. Jesus, he wonders, weren't they listening to Richard and Stephanie? Doesn't anyone get it?

He wants to jump up and scream that he never gambled with his patients' lives. He gave all 2,000-plus of them excellent care, dammit! Including the ones who died.

But Gooberman behaves like the calm, quiet client his lawyer has begged him to be. His few responses are measured and emotionless.

He'll work through the stress at his next 12-step meeting.

It's a Sunday morning in November, weeks after his press conference, and Gooberman has brought me to a meeting of recovering addicts in South Jersey.

His Lexus sedan isn't the only car of its kind in the parking lot, but it is the only one with a license plate reading DTX DOC. The heroin addicts in attendance include several middle- to-upper-class fathers and mothers, a former famous r&b singer, a local politico, and a clean-cut gray-haired man wearing tan corduroys and a maroon ALASKA sweatshirt.

When the floor is opened, the gray-haired man says he has spent the past three days sleeping in a bus station. "I haven't seen my family, I haven't seen my grandchildren, in days," he says. Then he cries, literally cries, for help.

When the man finishes, a few people jot down their phone numbers on a piece of paper for him, while the rest of the room claps to show support. There are tears and shouts: "It's okay, man." "You can make it." "We've all been there, brother."

The detox doc is clapping, too. "It's all right, man," he says, almost as much to himself as to the newcomer.

Ever since the attorney general's office and the medical board accused him of "gross and repeated malpractice, negligence and incompetence," Gooberman says, he's been attending about seven meetings a week. Usually he comes to "get spiritual," but today he is here to provide a glimpse of what it's like to be a junkie; to show me how desperate

addicts are to exorcise the chemical evil from their bodies, for their own sake and for their families; to show me what he went through and why he believes his controversial procedure is necessary.

Gooberman grew up the eldest of four kids-he has two brothers, a chiropractor and a pediatrician, and a sister-in Pennsauken, New Jersey. His father, Herbert, drove a truck, delivering bread and snacks to mom-and-pop stores around South Jersey; his mother, Bernice, worked as a secretary at American Honda. Herbert and Bernice were loving, religious working-class parents who provided their children with a solid, stable home life.

Yet at Pennsauken High, as Gooberman was taking his first steps toward becoming a doctor-by working as an orderly and meeting his future wife, Marcia Olsson, in Spanish class-he was also beginning a long, destructive affair with drugs. In order to lose weight for the wrestling team, Gooberman started dipping into his father's amphetamine prescription. "I dropped from wrestling in the 136-pound weight class to wrestling at 106 pounds," he says. "I was throwing guys all over the mat."

Throughout high school, everyone knew Gooberman wanted to be a doctor-his nickname was "Doc"-so it was no surprise that he went off to college planning to major in premed. He says he made the dean's list his freshman year at Ohio's Findlay College, but he missed Marcia, his high-school sweetheart, then at Rutgers. Gooberman came home and got jobs working on an ambulance crew and as an orderly in the E.R. at Cherry Hill Hospital (now Kennedy Hospital). He was still using amphetamines and now smoking a lot of pot.

In 1972, two years after graduating from high school, he and Marcia got married. Marcia wasn't sure what she wanted to do with her life, and her husband, still interested in all things medical, convinced her to go to radiology school. A year later, Marcia wanted to be a doctor as much as Gooberman did. In retrospect, Marcia, now Dr. Marcia Mastrin, a general practitioner in Cherry Hill, says Gooberman's urging her to go into medicine "was one of the good things about the relationship." Together, the pair enrolled in Camden County Community College and took premed courses.

They were B-plus students, which they knew wasn't

going to get them into American medical schools. Around that time, however, Gooberman met some medical students from Mexico who were interning at Cherry Hill Hospital. The Mexicans suggested he and his wife head south of the border.

They enrolled in a private med school in Guadalajara for one year, then transferred to the University of Ciudad Juãrez. Gooberman's mother, Marcia says, paid their tuitions. To get through med school, Gooberman continued to depend on the amphetamines that had helped him win wrestling matches.

After graduating in 1978, the couple returned to the States and moved to Wilmington, Delaware, so Gooberman could intern at Wilmington Medical Center. Now that he was working in a hospital, he says, he stopped doing drugs. He wouldn't remain clean and sober for long.

In 1980, just as Gooberman was starting his residency at Camden's Cooper Medical Hospital, his marriage began to fall apart. Although Marcia now says, "Lance and I were always two very different people," she adds that things got really bad because her husband was always at the hospital, and she felt left behind. Gooberman says the relationship collapsed when his wife, four months pregnant, told him she'd been having an affair. Marcia denies ever having the affair.

Gooberman maintains that the day after he learned of the alleged infidelity, he turned to alcohol. He boozed hard for the next three years, and says he then began "fooling around" with women. After he finished his residency, the new M.D. and his unhappy family moved to Cherry Hill, and he established a private practice in Merchantville. He became one of the first doctors in South Jersey to sign on with U.S. Healthcare, which fueled an incredibly successful practice. But Gooberman's marriage was failing fast. Neither Marcia nor he can remember whether their worsening relationship led him to use more serious drugs, or vice versa.

The young doctor resumed taking amphetamines on a daily basis and also started shooting Valium and free-basing cocaine. He had a wide variety of pipes in his bedroom. He quickly stopped free-basing, though, because it was making him impotent. (By this time, both Gooberman and his wife had developed

separate, steady relationships.) "I didn't think I had a drug problem," he says now, "because I was showing up for work every day. And of course, I could see 80 patients a day and go make my rounds at the hospital at 2 a.m., because I wasn't sleeping."

Then the doc started to lose it. One night in 1986, Gooberman, totally high, with who knows what drugs and distorted emotions surging through his veins, got into an argument with Marcia and ripped a door off its hinges. Shortly thereafter, Marcia obtained a restraining order and filed for divorce. Gooberman, stoned behind the wheel of his sports car, hit an icy patch and smashed into a guardrail near Cuthbert Boulevard, not far from his office. "I remember the trooper-his name was Frank, he was one of my patients-asking me, 'Are you okay?'" Gooberman says. "I said, 'Yeah, but where's my car?' He said, 'You're sitting in it.'"

Gooberman decided it was time to get clean. He borrowed the key to a friend's house in Jacksonville, Florida, and hopped on a plane. He says he took bags "filled with all kinds of drugs," including adrenaline-"figuring if I couldn't detox myself, there'd be enough in there to kill myself." He almost accomplished that.

He spent days, maybe weeks, in Florida-he was so whacked that he doesn't remember how long he was there, shooting up "all kinds of stuff." He even skin-popped the adrenaline-but instead of killing him, it gave him a buzz. He shot himself up until, he says, "I couldn't hit veins anymore. My fingers were like sausages, because the Valium was blowing the veins." He got on a plane and flew to a friend's place in El Paso. The friend took Gooberman to a hospital. "Somehow it was agreed upon," Gooberman says, "that I would fly back here to Philadelphia and get help. The [doctors] said if I would get on the plane and go back, they would give me any [drugs] I wanted."

Because Gooberman's veins had virtually disappeared, the treating physician installed a heparin lock-an IV hookup that goes directly into a vein-so he could self-medicate on the plane ride home. In the air, Gooberman went into the bathroom every 10 minutes and took more drugs. "Not to get high. I was trying to stop the itching. The itching was un-fucking-believable," he says of the side effect of his binge.

A doctor friend met Gooberman at the airport and took him to the Institute at Pennsylvania Hospital the next day. He was transferred to the E.R. and hooked up to a heart monitor. Gooberman heard an arrhythmia on the machine and asked who else was plugged in. "Nobody," said his doctor friend. Gooberman knew he was in trouble.

"I was in the Poconos with my friend and her daughter and my son when I got the call," says Marcia. "But by then, I didn't care. ... I was the one who held the practice together while he was off wherever he was. Some nights, I had to choose between eating or sleeping. No, by then I didn't care about him."

At the hospital, Gooberman asked the attending physician who was going to take care of him: A cardiologist for the arrhythmia? A hematologist for his blood that wasn't clotting? A dermatologist for the itching? "No," the doctor informed him. "A general internist."

"Bullshit," Gooberman said. "I am a general internist. I'm a great one, and I don't know what the hell to do for me."

"We're going to have a sober internist look at you," the doctor responded.

Gooberman was admitted to a psychiatric unit for a few days, put on antipsychotic medication, and transferred to a psychiatric hospital. He stayed for 42 days before leaving in April 1987.

"I remember when I was sitting in that psychiatric hospital, all I wanted was for the itching to stop," Gooberman says.

We're sitting in the den of his contemporary colonial home on a picture-perfect tree-lined street in Haddonfield. On the way in, Gooberman gave me a tour, pointing out decorative touches like the collection of decoy ducks on the mantle and the brass brackets adorning the wall. "She thinks of this stuff," Gooberman says proudly, referring to his second wife, Barbara Smith, whom he met through friends in 1992; they married a year and a half later.

At the moment, Barbara Smith, a former CPA pursuing her MBA at Drexel, is in the kitchen, making blueberry and chocolate-chip pancakes for her

teenage son and his friends. Smith, divorced and with three children of her own, exudes maternal warmth and sincerity; she's the kind of woman who makes Gooberman feel he can't be all bad if she loves him.

The conversation we are having, in this setting, seems like a drug-induced trip itself. "The itching," Gooberman says again, scratching his thick forearms. "You have no idea what that's like. When you're in a position like that, let me tell you-money is not important; relationships are not important. Nothing means anything, because you can't escape your skin."

After he left the psychiatric hospital, Gooberman took about six months off. He went to N.A. meetings, and he got a sponsor. As soon as he regained reading comprehension, Gooberman says, he immersed himself in addiction-treatment literature and attended conferences conducted by the American Society of Addiction Medicine. He wanted to learn all he could about the disease that had gotten under his skin.

He took ASAM courses and eventually passed the exam to become an ASAM member. When he resumed practicing medicine, he spotted cases of drug addiction all around him. He started seeing the symptoms in the primary-care patients who would came to his office in the morning and in some of his afternoon consults at local hospitals. In time, he says, he got quite good at taking care of drug addicts, particularly at detoxifying them. But he felt hospitals weren't doing very well with opiate addicts.

"Number one, they wouldn't come into the hospital, because they were afraid of the discomfort," he says. "Number two, they didn't hang around when they did come in, because we couldn't keep them comfortable. And number three, they'd relapse right after they left."

Then an ASAM member told Gooberman about a procedure he had seen in Austria, called rapid opiate detox. As the name boldly states, rapid opiate detox-sometimes called "ultra-rapid opiate detox"-quickly flushes opiates found in heroin out of an addict's system. While an "opiate" is defined as a narcotic derived from opium, there are natural opiates in the body, called "endorphins." Both endorphins and the opiates in heroin are "agonists," meaning they lock onto and stimulate brain receptors that send "pleasant" charges-the sort of euphoric sensations

you experience during sex, or when eating chocolate. Heroin induces a bliss far surpassing anything natural stimulants can deliver.

The difference, of course, is that endorphins don't wreak havoc on the body's precarious chemistry, or cause brain damage, fatal cardiac arrest or respiratory problems, the way heroin can.

Once heroin establishes a new chemical equilibrium in the body, living without it is unbearable. During the initial phase of natural opiate withdrawal-quitting cold turkey-the addict is overwhelmed by flu-like symptoms: sweating, nausea, vomiting, diarrhea, fever, and sometimes a relentless itching. These frequently drive an addict to abandon detox.

In the 1950s, researchers developed methadone withdrawal. In this alternative, still used today, a doctor substitutes the less addictive synthetic narcotic for heroin and then slowly decreases the dosage to avoid the painful withdrawal symptoms. Methadone doesn't create a high, but it does suppress the craving for heroin. Unfortunately, methadone treatment has a high relapse rate and tends to morph into a program of "methadone maintenance." Critics say this merely trades one addiction for another at taxpayers' expense.

In the 1980s, Yale researchers found that if they injected patients with certain "opiate antagonists," they could induce rapid and brief withdrawal. The drug naltrexone stripped heroin from the receptors immediately and suppressed the craving for it for hours.

A few years later, in 1988, Austrian Dr. Neil Loimer made the Yale rapid opiate detox method much more speedy and comfortable by inducing the procedure while the addict was under a general anesthetic. (Ironically, this technique was a throwback to a "hibernation therapy" of the 1940s, which kept the patient asleep for one to three days.)

Gooberman read literature and consulted with addiction specialists on this new technique. Eventually, he tried to find a hospital that would allow him to try the procedure. West Jersey Hospital said no; Cooper Medical Center in Camden said yes. Gooberman began performing RODs in the intermediate intensive care unit at Cooper Medical Center.

Dr. Carolyn Bekes, who headed the critical units at the time and gave Gooberman permission to conduct the new detox approach, remembers that he performed about 25 RODs, trouble-free, in the year he was there. Medicaid paid the per-patient cost of $3,200. Although ROD took only a few hours, Medicaid lumped all detoxes into one rate category based on a five-day stay. Of the $3,200, Gooberman was paid only about $32. That was not, however, why Gooberman left Cooper and began doing RODs at his primary-care office, according to Bekes. She says he was simply finding it hard to get the hospital to admit his patients, who didn't technically qualify as emergencies, for the procedure. Cooper needed the beds.

With little published information on ROD, the FDA wouldn't approve it. But Gooberman wasn't violating any medical codes of conduct per se. A medical license gives physicians the right to do anything in their offices as long as they don't break any laws or put their patients "at undue risk." That latter phrase leaves wide room for interpretation.

By 1995, the two or three RODs Gooberman performed at his Merchantville office each weekend commanded more time and office space. Gooberman says he had junkies begging for help.

In those first few months, he saw firsthand the problem with oral naltrexone. A traditional naltrexone pill only blocks the effects of heroin for 24 to 48 hours. To go on neutralizing the drug, an addict must follow a strict dosage schedule. Many junkies simply stop taking the pills and relapse.

Gooberman considered the birth control drug Norplant, which is inserted under the skin and released into the blood over time. He consulted with an in-vitro fertilization specialist, talked to a pharmacist-and a new approach was born. Gooberman created a thimble-size "pellet," containing one full gram of naltrexone, which he inserted under the patient's skin. The pellet slowly dissolved into the bloodstream for up to 30 days. Much to his wife's chagrin, Gooberman used himself as his first test patient.

Inserting a new pellet when the first one wore off became an adjunct Gooberman business-and, at $300 a pop, a meaningful source of income. Gooberman invited television and newspaper

journalists to witness and report on his procedure. The journalists came and interviewed some of Gooberman's many satisfied customers.

The doctor put up billboards in ghettos where addicts buy their fixes, and on I- 95 and the Ben Franklin Bridge, roads their families might travel.

The conservative CPA in Barbara didn't approve of her husband's marketing. "I just didn't like that his colleagues were giving him such a hard time," she says. "It didn't feel right. It was too risky. Just like Lance injecting himself with the naltrexone."

Now, however, Barbara sees things differently, thanks to Pete Musser, the CEO of Safeguard Scientific. Musser recently spoke to one of her MBA classes at Drexel-a course in entrepreneurship. "Pete said there are two kinds of people in this world," Barbara says. "He said there are Tiggers, and there are Eeyores. The Tiggers are the risk-takers, the ones who are successful; the Eeyores are the ones who always look for reasons not to take risks. Lance is a Tigger."

For a while, that Tigger aggressiveness paid off.

At the time, heroin use was surging. The National Institute on Drug Abuse's most recent report had found a national rise in heroin use. NIDA conservatively estimated that the number of addicts had jumped from 68,000 in 1993 to 325,000 in 1997; and warned that eighth-, 10th- and 12th-graders were increasingly experimenting with the drug. The number of opiate addicts in the United States, according to the NIDA study, was probably north of 800,000.

More and more affluent suburbanites were trying the drug for two reasons: price and purity. At $10 a dose, heroin was cheaper than cocaine, pot, even a six-pack of decent beer. And because the drug was becoming so pure-the heroin sold on Philly streets was, and is, some of the most potent in the country-it could be snorted or smoked, enticing those who might not risk injecting the drug for fear of contracting HIV.

As heroin became more popular, so, too, did Gooberman's ROD practice.

But then his patients started dying.

Michael Cary Jaslow's parents, Edward and Joan, will say very little about their 44 -year-old son's death or his drug problem-how he got hooked on heroin, how long he had used, what other detox methods, if any, he tried. They are reluctant partly because they are considering filing suit, and partly because it's still too painful.

Reached by phone, Joan almost immediately crumbles into tears. "I just visited his grave yesterday," she says. "I just can't ... I will tell you this-there is nothing worse than having your son die in your arms."

What is certain about Jaslow, in addition to the fact that he left behind a brother and two grief-stricken parents, is that he was a graduate of Plymouth-Whitemarsh High School, where he wrestled on a championship team. Eventually, he joined his family's company, Jaslow Dental Laboratory, Inc., in Jenkintown, and became a vice president. The fair-haired exec had an active social life, dating frequently, and donated money to animal-rights organizations.

At some point, he became a functional heroin addict. According to his father, Jaslow never missed a day of work and showed no physical signs of his addiction. And on March 16, 1998, not long after Jaslow saw one of the half-dozen billboards Gooberman had posted around the Delaware Valley-and saw the doctor on television-he scheduled an appointment at Gooberman's office. He paid somewhere between $2,500 and $3,600, depending on the amount of drugs he had in his system, to undergo rapid opiate detox.

After a certified nurse anesthetist put Jaslow under at 8 a.m. on that spring day, he was intubated to keep his airway open. Gooberman's associate, Dr. Michael Bradway, then injected him with a handful of medications such as antidiarrheal octreatide, an anti-emectic to stem vomiting, and clonidine and benzodiazepines for other withdrawal symptoms. Finally, Bradway made a small incision in Jaslow's abdomen and injected the naltrexone pellet.

Jaslow awoke almost four hours later, at 11:45 a.m. If his ROD was anything like the many featured in the television shows and news reports, a nurse, or an orderly, or a doctor, or perhaps all three, greeted the groggy Jaslow as he opened his eyes. One of them

coached him to bend his arms and take it easy, told him he still might experience some withdrawal symptoms, but proclaimed something like, "You're clean now. You have a chance to start over."

As soon as Jaslow could shuffle for about 300 feet, Gooberman's staff permitted him to leave with a guardian, who had signed a contract with the clinic promising to stay with Jaslow for the next 48 hours.

Eighteen hours later, Jaslow died in his mother's arms. Neither the New Jersey Attorney General's office nor the Montgomery County Coroner's office will reveal his specific cause of death. (In many countries, autopsies are not public record.)

Jaslow wasn't the first Gooberman patient to die within hours of undergoing ROD. In September 1995, just as Gooberman was beginning to perform the procedure regularly at his office, Pottstown's 41 -year-old Gerry Wolfe died from "acute necrotizing pneumonia" three days after ROD. The coroner reportedly said it was "possible" that Wolfe's pneumonia could have been caused by an improperly inserted or a contaminated breathing tube.

Two days before Christmas 1996, wealthy 43 -year-old contractor Frank Stavola Jr. of North Jersey, died less than eight hours after he underwent ROD. Cause of death, according to an official: pulmonary edema due to drug abuse.

Three months later, a 31 -year-old patient died about 10 hours after leaving the clinic. (The New Jersey State A.G.'s office has managed to keep the identities of two of the dead patients confidential.) Then, three months after Jaslow's death, a 50 -year-old patient became the fifth Gooberman ROD mortality, about eight hours after the procedure. Finally, last June, 20 -year-old Lisa Ann Flowers died of a heart attack "following rapid opiate detoxification," according to the Ocean County prosecutor's office, about 18 and a half hours after ROD.

Mark Herr, a spokesman for the New Jersey Attorney General's office, says Wolfe's death certainly made his office curious, but not suspicious. The truth, he says, was that, under those vague semantics of "undue risk," there wasn't much the A.G.'s office could do. "We became concerned when the others started dying," he says.

Now, armed with the six deaths and reports that several other patients went to emergency rooms, attorneys for the state claim Gooberman and his employee, Bradway, were "a clear and imminent danger to the public's health, safety and welfare" and engaged in "gross and repeated malpractice, negligence and incompetence."

In the complaint it filed last September, the state specifically alleged that there are no objective studies proving the effectiveness of the pellet or ROD; that Gooberman failed to properly screen his ROD patients; that he failed to clearly identify death as a risk factor in the informed consent form signed by patients; and that he failed to provide adequate aftercare for his patients.

Gooberman's attorney denies all of the charges and says his client learned of each of the deaths shortly after they occurred, when his staff made the standard follow-up phone calls to check on patients. Within 24 hours of hearing about each of the deaths, Gooberman's attorney says, she notified the medical board, as required by law.

"It hasn't been shown that there is a relationship between having had the procedure and having died," Gooberman says. "It's unfortunate when anyone dies. ... But this happened over the span of five years, and these were very sick people."

He says that at least three of the patients who died had taken cocaine shortly after the procedure, which he absolutely warns his patients could kill them and is outlined in the informed consent he makes them sign.

Gooberman also points out that he has treated more than 2,150 patients. "A lot of the patients who come to see me, their [loved ones] are losing them, anyway. ... A mother and son came into my office, and I was trying to explain the risks and benefits of the procedure before I did it on her son, and [the mother] wasn't listening. I got angry. I said, 'Listen, this is important.' ... She said, 'Don't tell me how important this is. This is my second son. My first one is gone already. I don't care what the risks are, I don't want to lose him.'"

A handful of doctors is performing ROD around the country, in places like Denver and Los Angeles, and there is an outpatient ROD clinic in Connecticut

similar to the one Gooberman ran. While prominent physicians in addiction medicine continue to debate the effectiveness of ROD, nearly all seem to agree Gooberman has crossed a line. "I know all about Dr. Gooberman and what's going on over there. Gooberman is a creep," Dr. Colin Brewer says from his London office. Brewer, a respected pioneer of ROD, first employed the antidiarrheal octreatide in the procedure and actually visited Gooberman's office a few years ago. "Gooberman is a one-size fits-all chap," he says. "Not everyone who goes to see Dr. Gooberman needs ROD.

"The treatment is useful," Brewer continues, "but people like Gooberman are giving it a bad name by poor patient selection and preparation and rampant commercialism, as well as by prematurely discharging patients."

"General anesthesia," says Dr. James W. Cornish, an assistant professor of psychiatry and the director of the pharmacotherapy division at the University of Pennsylvania, "carries risk all by itself. Generally, detoxification has no lethality. And when you introduce anesthesia, you might be introducing an undue risk." According to Cornish, current data show that one in five of all patients who undergo anesthesia have a bad result. "And if you look at the literature," he says, "any [detox] associated with anesthesia was looked at as experimental."

Dr. Herbert Kleber is a professor of psychiatry and the director of the division on substance abuse at Columbia University and one of those physicians responsible for the ROD advancements made at Yale. Almost since the day Gooberman went into business four years ago, Kleber has been his most vocal critic. Although Kleber will not offer on-the-record comments about Gooberman now-because the A.G.'s office has hired him as a chief witness-in 1998, he published an editorial in The Addiction Journal that seemed to target the Merchantville doc. Kleber wrote: "While some see [RODs] as a 'magic bullet,' a miracle breakthrough, others see them as a shameless exploitation of the addict and the general public, use of a technique with potential serious morbidity and mortality for a condition-opiate withdrawal-that, while painful, is not associated with mortality."

Each of these detractors, however, can be perceived as having an ulterior motive. Brewer and Gooberman,

for example, are currently embroiled in a squabble over a patent for the ROD methodology employing the antidiarrheal drug. Brewer says Gooberman duped him into cooperating with his efforts to patent the procedure.

"Contrary to all his assurances," the British doc says, "Gooberman has taken out a restrictive patent. If I were practicing in the States, which I have no intention of doing, I would be unable to use octreatide in the detoxification. I have, for the public good, filed a counter-patent. It's not for financial motivation. I'm doing my bit to stop Gooberman and his disgusting Americanism."

For the past seven years, Cornish has been working with a company called BioTek, testing his own long-lasting form of naltrexone. Cornish believes he has an injectible that, just as Gooberman claims of his pellet, will suppress heroin craving for 30 days. "We have followed the traditional path for carrying out studies under guidance from the FDA," Cornish says. "As far as I know, Dr. Gooberman has not."

And last September, NIDA awarded Kleber a $2.5 million grant to study ROD. In fact, the editorial he wrote that same year could be read as one big grant application built on bashing Gooberman. "He just got $2.5 million," Gooberman says, referring to Kleber. "He's the one who stands the most to gain if the board shuts me down. Then he can get into the ROD business."

Kleber denies any link between his editorial and the grant money.

But these competing interests hint at something more than coincidence and may support Gooberman's theory that he is being unfairly persecuted for reasons bigger than what meets the eye.

While treating people like addicts is the cornerstone of the Hippocratic oath, the reality is that millions of people are dying, sometimes literally, to get off heroin, and anyone who comes up with the most advanced, most effective treatment stands to make big bucks-or, at the very least, ride a high of prestige.

To achieve that end, addiction-treatment physicians and researchers must look to federal and state agencies for research capital, as Kleber has done, or go to the private sector, like Cornish. They must

adhere to protocol and be patient. Or they could challenge the medical establishment and take risks, but never any undue risks.

On the wall of his den, Gooberman has a picture of himself flying a paraplane-one of those single-engine things with a parachute instead of wings. In the photograph, he's dressed in what looks like a silver astronaut costume, heading right toward the camera, high above a body of water. An inscription along the bottom of the picture reads: SOMETHING ABOUT TAKING RISKS.

The picture reminds Gooberman of a time when he took off in his paraplane, high on Valium and "maybe some other stuff." He was going to show his buddies what it was to "really get high." He cruised to 2,300 feet, soared over the Commodore Barry Bridge and headed directly for the airport. "So there I am with a 727 coming out of Philadelphia International, and I figure I got the right of way," he says.

He laughs as if to say, I know it's not funny, then continues his story: "I start yelling at the pilot of the 727, not that he could hear me. Thank God he changed course and went up. He didn't even need to hit me; the wash from his engines would have dumped the air out of my shoot. On my way back across the Delaware River, I ran out of gas and crash-landed in a cornfield, bent my front wheel. That was probably the craziest thing I ever did."

Right now, that's for a judge to decide.

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State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION
OAL DKT. NO. BDS 10905-99S
AGENCY DKT. NO. --
DAVID SAMSON, ATTORNEY GENERAL OF NEW JERSEY,
Complainant,
v.
LANCE L. GOOBERMAN, M.D., AND
DAVID BRADWAY, M.D.,
Respondents.

Douglas J. Harper, Deputy Attorney General, for complainant (David Samson, Attorney General of New Jersey, attorney)

John S. Sitzler, Esq., for respondent Lance L. Gooberman, M.D.

Michael E. Riley, Esq., and Irwin L. Lifrak, Esq., appeared for respondent David Bradway, M.D., during the hearings (Riley & Lifrak, attorneys); David Bradway, M.D., filed a pro se brief

Record Closed: June 19, 2002 Decided: November 15, 2002

BEFORE JEFF S. MASIN, ACTING CHIEF ALJ:

SUMMARY

This case has presented a number of difficult issues that require consideration of the proper role and limits of innovation and the weighing of risks and benefits of a potentially beneficial procedure. Two physicians whose prior life experiences have included serious difficulties with addiction have sought to apply their understandings of this terrible affliction and of emerging treatment possibilities to the treatment of others who need help. In doing so, Drs. Gooberman and Bradway have in some instances pushed the envelope. Dr. Gooberman, as the physician who initiated the UROD practice and taught it to Bradway, and as the overall operator of the treatment facility, no doubt bears the primary responsibility for the practice. However, Dr. Bradway is, of course, responsible for the professional decisions he made and actions he took, or failed to take.

i want to:
- be detoxified
- contact dr. gooberman
- learn more about pellets
- get a license to make pellets
- hire dr. gooberman as an expert

I agree with Judge Lefelt's thought, expressed in Murray v. State Health Benefits Commission, supra, that litigation is indeed a "poor vehicle" for determining whether alternative, innovative, non-traditional forms of medical treatment are medically sound. The litigation forum is perhaps better suited to the more traditional determination of whether practitioners have violated existing, well-understood and accepted standards of care then to a resolution of whether a controversial new form of treatment is medically acceptable. In medicine, evolving understandings of the workings of medicines, physiology and other aspects of science will often alter the perceptions and even the well-accepted understandings of what works, what does not work, what helps and what harms. What is acceptable practice today may be found to be unacceptable next week, next year. Indeed, as this decision has been in preparation, new information has emerged on such issues as replacement hormone therapy that may shake the practice of medicine in regard to issues of women's health. This is but one example of how evolutionary medical science can be. Further, as this decision was all but completed, a new report of a randomized study comparing forms of treatment was published and offered in evidence by motion to reopen. No doubt other such studies will appear. Nevertheless, even in regard to as new a method of practice as UROD, still in its infancy despite its growth and acceptance by such organizations as ASAM, it is essential that the State, through the Board of Medical Examiners, exercise oversight over the medical profession to assure, as much as it can within the limitations of knowledge available at any given time, that the public is protected from dangerous medical practice, while at the same time, being cautious to avoid applying too stringent a control on innovation. Here, the extensive record developed leads to some conclusions that favor the work of the respondents and some that do find their work deficient when measured against appropriate standards.

I CONCLUDE that, as practiced by the respondents, UROD cannot be said to be a per se inappropriate or especially dangerous procedure. Nevertheless, as with many other medical procedures involving anesthesia and other medical procedures, some limited number of persons will unfortunately die during or shortly after the procedure, despite its relative safety and the performance of the procedure in a responsible manner. No doubt, not every decision a physician makes as to method of practice during the early stages of the practice of a new, alternative medical procedure will be either the most conservative or the most successful. Nevertheless, I CONCLUDE that in this case the respondents acted in good faith and, except for the limited exceptions noted, within the ambit of acceptable medical standards of care for both addiction medicine and anesthesiology, as well as the new and evolving method they chose to offer to a population highly in need of assistance. While there is sufficient evidence to persuasively establish a number of violations of professional and regulatory standards, I CONCLUDE that, on the whole, the practice of UROD by each doctor did not involve

substantial negligence, malpractice or professional misconduct, or gross negligence, malpractice or misconduct.

I CONCLUDE that the complainant has proven both a temporal link and a causal relationship between UROD and the events that resulted in the deaths of some patients and the serious non-fatal consequences that required the hospitalization of two patients. However, the complainant has failed to prove by a preponderance of the credible evidence that the respondents' conduct in providing UROD, or their alleged failure to act in certain ways, was substantially responsible for the deaths. I CONCLUDE that these deaths occurred either because some of the patients, acting in defiance of warnings, used cocaine after the UROD and suffered fatal arrhythmias, or, in other cases, simply could not withstand the stresses of withdrawal and suffered fatal arrhythmias, or died of aspirative pneumonia that occurred not as a result of any improper conduct by the respondents. Thus, intervening events may well have occurred in the Stavola and Beigelman cases. I further CONCLUDE that while the stress of withdrawal did prove too much for a very limited number of compromised patients, the complainant has not proven by a preponderance of the credible evidence that UROD as practiced by Drs. Gooberman and Bradway involved the use of a combination of drugs that exposed patients to any undue risk of harm so long as they were properly managed during the procedure and were appropriately discharged and, as necessary, provided with follow up support during the ongoing withdrawal process.

Based upon the discussions above, I CONCLUDE that the complainant has established by a preponderance of the credible evidence that the respondents' practice of UROD has failed to meet several requirements of the standard of good medicine. Additionally, they have violated certain specific requirements of the regulatory code. More specifically, even though dipstick screening was available, the respondents' failed to continue to screen patients for cocaine use. They improperly sought to have patients waive their rights to confidentiality as a part of the consent form. Dr. Gooberman failed for some indeterminate period to properly advise prospective patients that UROD was an experimental procedure, so as to properly advise them before they gave informed consent to being treated. They failed to prepare adequate records of both anesthesia and antagonist administration, as well as post-anesthesia discharge notes, as required after June 15, 1998.

Penalty

N.J.S.A. 45:1-21 permits the Board of Medical Examiners to revoke or suspend any license issued by it to a physician if the preponderance of the credible evidence establishes the physician has engaged in acts or practices that involve gross negligence, gross malpractice or gross incompetence, or repeated acts of negligence, malpractice or incompetence, or actions that constitute professional misconduct or are in violation of any act or regulation administered by the Board. In addition to such penalty or as an alternative,

N.J.S.A. 45:1-22 provides that any person who violates any provision of an act or regulation administered by a professional board may receive a letter of warning, reprimand, or censure, may be assessed civil penalties and may be ordered to cease and desist from future violations or take affirmative corrective action with regard to any act or practice found unlawful. N.J.S.A. 45:1-25 provides that any person who violates any provision of an act or regulation administered by the Board shall, in addition to any other sanctions provided, be liable to a civil penalty of not more than $2,500.00 for a first offense and not more than $5,000.00 for a second and each subsequent offense. Each separate transaction shall constitute a separate offense, but "a second or subsequent offense shall not be deemed to exist unless an administrative or court order was entered in a prior, separate and independent proceeding." In addition, in any action that is brought pursuant to the statute, the Board "may order the payment of costs for the use of the State."

I CONCLUDE that there is no basis for the imposition of the ultimate sanction of revocation of either physician's medical license. The extremely serious allegations regarding the employment of a purportedly unethical and medically unwarranted procedure and the charge that these respondents' grossly negligent and/or repeatedly negligent and/or incompetent practices and misconduct caused or contributed to the deaths of seven persons and the serious illness of "dozens" of persons have not been proven by the requisite standard of proof. The suggestions and implications that they were simply grinding out ethically tainted UROD procedures and then were not seeking to reasonably assist their patients post-procedure in the attempt to stay abstinent have been demonstrated to be incorrect charges.

Despite the failure of the complainant to prove the most serious charges, clearly several violations have been established. There are obvious failures in regard to the records produced and a failure to comply with medical record requirements. The respondents were each responsible, as professionals and as supervisors, to assure that they and those under their authority properly recorded the events required to allow a complete and understandable record of the treatment rendered. It is vitally important that the records of a patient's treatment, including and perhaps especially so those relating to surgical and anesthetic procedures, clearly indicate the drugs utilized, the method of administration, the dosage and the timing of such administration. While there is apparently no firmly established formulation for the records that identify these matters, the doctors were responsible to see that these matters were properly recorded. The failure to do so, while not shown here to have contributed to or to have disguised any negligence, nevertheless is a serious failure. Each respondent shall pay a civil penalty of $2,500 for this violation.

The attempt to publicize the procedure through the possible use of patients' identities, even if for wholly positive reasons to alert the public that UROD was available (and no doubt also to bolster Dr.

Gooberman's, and later also Dr. Bradway's practice), may have gotten in the way of the doctors' responsibility to properly protect the confidentiality of their patients. The patients should never have been placed in the position of having to affirmatively opt out of possible future use of their experience, and perhaps their identity, at a time when they were quite likely not at their sharpest and no doubt under some emotional and physical strain. Again, this violation has not been shown to have had any affect upon patient care. Each physician shall pay a civil penalty of $1,500 for this offense.

While the record does not allow for a definitive determination, I strongly believe that Dr. Gooberman's failure to advise the early patients of the "experimental" nature of UROD did not actually lead to anyone undergoing the procedure who would not have otherwise done so. Further, at some time during the four years and over 2,000 procedures, the need to refer to it as an experiment ended. Nevertheless, given the importance of fair and open dealings with patients and prospective patients, Dr. Gooberman shall pay a civil penalty of $2,500 for this offense.

Violations regarding EKGs for patients over forty and even for not continuing the use of dipsticks to screen for cocaine use are important failures. On this record, it is impossible to determine with any degree of probability that any particular patient was harmed by the failure to perform these tests; however, the failure may have increased the risk to which individuals were subjected. As such, each respondent shall be liable for a civil penalty of $2,500 for failure to use dipsticks and $2,500.00 for failure to perform EKG's on patients over the age of 40 as a routine pre-screening device.

While in the overall scope of the charges, the charges that were sustained are limited, nevertheless, they occurred multiple times and denote a less than completely careful approach to the serious work involved. Based upon the findings and conclusions and in view of the violations of good medical practice and appropriate standards of care, I CONCLUDE that each respondent shall be suspended from practice for a period of six months. In addition, Dr. Gooberman shall pay a total of $11,500.00 in civil penalties. As the record of this case demonstrates that Dr. Bradway was previously sanctioned by the Board for serious violations of its rules and regulations, an additional penalty of $5,000.00 is imposed. Dr. Bradway shall pay a total of $14,000 in civil penalties. In addition to these sanctions, each respondent must enroll and successfully complete class(es) or course(s) designated by the Board that address issues of informed consent, patient confidentiality, screening procedures for anesthesia procedures and record keeping requirements. Further, upon the completion of their suspensions, each physician shall be placed on administrative probation for a period of two years, during which they may be subject to review of their record keeping, and should they resume UROD or any other anesthesia based procedures, their pre-procedure screening protocols.

Each physician will be equally responsible for the payment of costs of

investigation. However, the bulk of the most serious charges have not been sustained. Without doubt, these charges constituted the greatly substantial elements that were the subject of the Board's investigation and were the driving forces behind a very long and highly complex trial. I CONCLUDE that it would be manifestly unfair and inequitable for the respondents to have to pay all of the Board's costs. Instead, the respondents shall pay one-third of the Board's costs and attorneys fees. It is SO ORDERED. Counsel for the Board shall file affidavits with the Board regarding costs and fees and the Board will presumably make a final order regarding the allocation of costs.

I hereby FILE my initial decision with the BOARD OF MEDICAL EXAMINERS for consideration.

This recommended decision may be adopted, modified or rejected by the BOARD OF MEDICAL EXAMINERS, which by law is authorized to make a final decision in this matter. If the Board of Medical Examiners does not adopt, modify or reject this decision within forty-five (45) days and unless such time limit is otherwise extended, this recommended decision shall become a final decision in accordance with N.J.S.A. 52:14B-10.

Within thirteen (13) days from the date on which this recommended decision was mailed to the parties, any party may file written exceptions with the EXECUTIVE DIRECTOR OF THE BOARD OF MEDICAL EXAMINERS, 140 East Front Street, 2nd Floor, Trenton, New Jersey 08608, marked "Attention: Exceptions." A copy of any exceptions must be sent to the judge and to the other parties.

DATE JEFF S. MASIN, ACTING CHIEF ALJ

Receipt Acknowledged:

DATE BOARD OF MEDICAL EXAMINERS

Mailed To Parties:

DATE OFFICE OF ADMINISTRATIVE LAW