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UNITED STATES OF AMERICA

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, v. GERALD GREEN and PATRICIA GREEN, Defendants.	CR No. 08-59(B)-GW GOVERNMENT'S NOTICE OF SUPPLEMENTAL SENTENCING EVIDENCE; EXHIBIT Hearing Date: July 1, 2010 Hearing Time: 9:30 a.m.

Plaintiff United States of America, through its counsel of record, the United States Attorney's Office for the Central District of California, and the Fraud Section, United States Department of Justice, Criminal Division, hereby gives notice of the filing of the attached letter from Dr. Michael J. Gurevitch, M.D. ("Dr. Gurevitch Letter," attached hereto as Exhibit 10).

The Dr. Gurevitch Letter is based upon a review of defendant GERALD GREEN's medical records from his March 2010 visit to

Cedars Sinai hospital (provided to the government pursuant to this Court's June 1, 2010 order), as well as of the letters defendants GERALD GREEN and PATRICIA GREEN ("defendants") previously submitted to this Court from Sheldon Reiss, M.D., defendant GERALD GREEN's doctor.

For the Court's ease of reference, listed below are the docket entries and relevant page numbers of the government's previous filings regarding defendant GERALD GREEN's medical condition and the ability of the Bureau of Prisons to treat such condition. The government incorporates herein by reference these filings and maintains the position that the Bureau of Prisons can address and treat defendant GERALD GREEN's specific medical needs and that defendant PATRICIA GREEN is not a necessary caretaker.

- DE[1] 319 — Pg. 37-39 and attached Declaration of Carlos Deveza.
- DE 334 — Pg. 26 (referencing medical condition of FCPA defendant in United States v. Shu Quan-Sheng, 08-CR000194 (E.D. Va. 2008)).
- DE 336 — Pg. 1-10 (including discussion of case law pertaining to sentencing variances based on medical conditions), and attached Supplemental Declaration of Carlos Deveza.
- DE 344 — Attached Second Supplemental Declaration of Carlos Deveza.
- DE 346 — Pg. 11-14 (referencing care-taker claims of FCPA defendant in United States v. Jumet, 09-CR-397 (E.D. Va. 2009)).

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[1] "DE" denotes docket entry.

The government respectfully requests the opportunity to supplement its position as to sentencing as necessary.

DATED: June 17, 2010

Respectfully submitted,
ANDRÉ BIROTTE JR.
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/s/
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EXHIBIT 10

TO

GOVERNMENT'S NOTICE OF SUPPLEMENTAL SENTENCING EVIDENCE

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6-13-2010

Judge George H. Wu
United States District Court
Central District of California
312 N. Spring St, Department 10
Los Angeles, CA 90012

Re: Gerald Green
DOB: 1-10-1932

Dear Judge Wu,

I have been asked by the Department of Justice to review the records and render an opinion regarding the diagnosis, treatment, and ongoing care needs of a 78 year old man, with diagnosed moderate to severe emphysema. I have not spoken to or examined this patient, nor do I know or have made contact with any of his attending physicians The comments to follow are based solely on my evaluation of the written record, and are based on my years of experience in taking care of many similar patients as a pulmonary physician since 1987.

Prior to my becoming a physician in 1982, I was a respiratory therapist, having trained at the UCLA medical center, and also was exposed to and took direct care of many similar patients

I have reviewed the letters and statements as provided by Dr. Sheldon Reiss, who has provided excellent care of this patient since 1996. In general I tend to agree conceptually with his treatment and thoughts, but wish to point out certain statements made by Dr. Reiss in his letters that seem to exaggerate or overstate the importance of some things as they relate to the care and treatment of Mr. Green or any patient with a similar degree of emphysema.

In general these patients are regimented with medications that attempt to keep open as many of the bronchial tubes as possible, minimize inflammation and decrease production of secretions. Antibiotics are often required intermittently when signs of a bronchial infection seem likely, and oxygen is provided to keep the body's oxygen levels in the normal range to protect other organs. The bigger problem in this disease is really getting rid of the waste product gases such as carbon dioxide, and this requires ventilation (ie must be able to move air in and out) as well as oxygenation which gets the oxygen in. Of all the treatments provided to such patients, it is interesting that only the oxygen has ever been proven to prolong life. All the other treatments aim to improve the quality of life and functionality as these patients have limited ability to ventilate.

The emphysema portion of this disease "COPD" really describes damage that has already occurred to the air sacs of the lung. There are no treatments to regenerate or improve those that have already been destroyed. It should be emphasized again that all the treatments discussed are mainly to keep the air passages leading to those still viable air sacs as open as possible.

There is little doubt that patients like Mr. Green do better with consistency of care, which provides for them to receive regular treatments which are fairly standardized. Of interest to me however is the emphasis Dr. Reiss places on "steam therapy". There is no question that humidification of secretions is important to minimize their viscosity and assist in their clearance out of the lung. As a respiratory therapist and pulmonary physician I too am aggressive at recommending treatments that include mucolytics (medication or treatments that thin the mucus) taken as pills or liquid as well as inhalational treatments that may include heated aerosol therapy ie steam. There is no literature or standard of care that I am aware of that prescribes steam therapy "in a steam room" the way Dr. Reiss has described, nor does it have the significance or importance to his overall care that is being implied.

Dr. Reiss on one hand describes the importance of not being in crowded environments where there may be ill persons, but yet encourages the steam treatments not in his home, but presumably in a room/place that would seemingly be in a public area/gym etc, where he would likely not be alone and in a humid environment that may support the growth of mold/bacteria etc., to which he should not be subjected.

Although it is also acknowledged that respiratory conditions may be aggravated by cold temperatures, it seems a stretch for Dr. Reiss to suggest that moving to an area that seasonally has a colder climate may be a potential for exacerbating his patients illness, unless of course he would be living in the out of doors. It should be noted that both Dr. Reiss and myself trained in Chicago where the cold wind and temperatures are extreme, and both of us I'm sure took care of many patients with COPD/emphysema in these environments. It is ironic that in these areas the indoor temperatures are often warmer and better controlled than in most areas of Southern California where indoor buildings are less insulated and often feel colder during the winter months. The reality is that as Dr. Reiss describes, this disease known as COPD/Emphysema waxes and wanes, often with exacerbations (worsening of condition) that cannot be tied to any specific treatment or lack thereof, time of the year, temperature, humidity etc.

Mr. Green's latest admission to Cedars-Sinai Hospital is a good example of just that. Mr. Green was seen on March 29, 2010 in the office of Dr. Reiss complaining of some increased cough and wheeze. On examination, slight wheezing is noted, his chest x-ray shows no acute change, just "hyperinflation" and he is given an intramuscular injection of Kenalog. (A steroid anti-inflammatory) Later that same day, when the patient called and states he is not feeling better, he is sent to the emergency room where he receives another dose of steroid (this time by vein) and then is subsequently directly admitted at the request of Dr. Reiss. In review of all his orders, he is placed on his own usual medications. He is given no intravenous fluids, and no intravenous antibiotics. His whole treatment during the admission was the inhalation of bronchodilators as he does at home, with the administration of intravenous steroids, similar to the injection he received in the office earlier that day, or like the pills that he would take in a tapering fashion at the time of his discharge. No steam therapy was ordered (or available) In reviewing the laboratory data that was obtained, everything was essentially normal and the emergency room physician documents only some "expiratory wheezes" and states that his room air oxygen saturation is 91%. His heart rate was 102, respiratory rate 24 and he had no fevers or chills but did have a cough that was nonproductive.

The accepting nurse when receiving this patient documents no complaints of shortness of breath and notes that he is feeling a lot better (by the patient's own admission) with minimal small expiratory wheeze in the right upper lobe. The following day, the nurse charts that he has a good appetite and is ambulating without assistance while his family is at the bedside. He is

ultimately discharged on the third day after receiving a steroid taper with the diagnosis of "exacerbation of COPD" The fact is that he was already better by the time he got up to his room as is noted by the accepting floor nurse, and one questions why he was even subsequently admitted for 2 additional days as it was becoming clear that the steroid injection given in the office of Dr. Reiss and then followed up again in the emergency room clearly had begun to take effect. A final diagnosis of "exacerbation of COPD" was stated, but is not an accepted Medicare diagnosis, unless it is supported by a statement of what the exacerbating cause was felt to be, ie bronchitis, pneumonia, however this documentation is lacking.

It seems somewhat contradictory that based on the factors cited most important to Dr. Reiss in the care of his patient's like Mr. Green, that despite nothing acute or critical being found on his initial work up (and that he was already responding to the treatment provided) that Dr. Reiss would still want him hospitalized after his ER assessment. This exposed the patient to other potentially ill or contagious patients, multiple hospital personnel and resistant strains of bacteria. It would most likely have caused added anxiety and stress to the patient and his family and provided unfamiliar caregivers, a treatment plan not entirely the same as he would have at home and no steam room.

Dr. Reiss describes the importance of a caregiver to monitor Mr. Green when he sleeps to assure an ongoing and unobstructed flow of oxygen. This type of monitoring does not occur on a general medical ward in any hospital and although his oxygen level may drop when off the oxygen, it's not to life threatening levels that would have immediate consequences based on oxygen saturation readings that have been provided. If it were that important, Mr. Green would have been admitted to a critical care unit or have a hired sitter to monitor his respirations and to note if and when his cannula might come off or have its oxygen flow interrupted.

Granted again that although consistency of care is important, whether that caregiver is one's wife or attendant/nurse who is familiar with the patient's situation and disease probably makes little difference over time in this particular circumstance.

In summary, it is my opinion that this patient does suffer from significant lung disease that requires routine treatments and monitoring. For the most part I agree with the statements provided by Dr. Sheldon Reiss in terms of his basic medical needs, consistency of therapy etc, but do take exception with the importance to which he places on certain issues that lack substantiation.

Respectfully submitted,

Michael J Gurevitch, MD
Director of Respiratory Therapy and Pulmonary Lab
Huntington Memorial Hospital, Pasadena, CA