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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST BRIAN R. MOLSTAD, M.D., RESPONDENT.	: : : : :	FINAL DECISION AND ORDER 93 MED 124

The parties to this action for the purposes of Wis. Stats. sec. 227.53 are:

Brian R. Molstad
5601 Wentworth Ave. South
Minneapolis, MN 55419

Medical Examining Board
P.O. Box 8935
Madison, WI 53708-8935

Department of Regulation and Licensing
Division of Enforcement
P.O. Box 8935
Madison, WI 53708-8935

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Board. The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Brian R. Molstad, M.D. (D.O.B. February 18, 1945) is duly licensed in the state of Wisconsin as a physician (license #19243). This license was first granted on April 17, 1975.

2. Respondent latest address on file with the Department of Regulation and Licensing is 5601 Wentworth Avenue S., Minneapolis, MN 55419.

3. On or about March 13, 1993, the Minnesota Board of Medical Practice entered an order for temporary suspension of the license of Dr. Molstad prohibiting him from practicing medicine or surgery in any manner in the state of Minnesota. A true a correct copy of the Minnesota Order is attached to this Order as Exhibit A. Exhibit A is incorporated by reference into this Final Decision and Order.

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board has jurisdiction over this matter, pursuant to sec. 448.02(3), Wis. Stats.

2. The Wisconsin Medical Examining Board is authorized to enter into the attached Stipulation, pursuant to sec. 227.44(5) and 448.02(5), Wis. Stats.

3. By the conduct described above, Brian R. Molstad, M.D., is subject to disciplinary action against his license to practice medicine in the state of Wisconsin, pursuant to Wis. Stats. secs. 448.02(3) and Wis. Admin. Code sec. MED 10.02(2)(h) and (q).

NOW, THEREFORE, IT IS HEREBY ORDERED that Dr. Molstad shall not practice medicine or surgery in the state of Wisconsin; and

Dr. Molstad may petition for removal of this restriction on his license to practice medicine upon submission of proof that he has satisfied the terms and conditions for a return to the practice of medicine in Minnesota. The Board in its discretion may require Dr. Molstad to appear before the Board in conjunction with its consideration of a petition under this paragraph. Denial in whole or in part of a petition under this paragraph shall not constitute denial of a license and shall not give rise to a contested case within the meaning of Wis. Stats., sec. 227.01(3) and 227.42.

The rights of a party aggrieved by this Decision to petition the Board for rehearing and to petition for judicial review are set forth on the attached "Notice of Appeal Information".

This order shall become effective upon the date of its signing.

MEDICAL EXAMINING BOARD

By: _____ 21 July 93
A Member of the Board Date

RRH:daw
ATY-2585

STATE OF WISCONSIN
BEFORE THE REAL ESTATE BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	STIPULATION
	:	93 MED 124
BRIAN R. MOLSTAD, M.D., RESPONDENT.	:	

It is hereby stipulated between Brian R. Molstad, M.D., personally on his own behalf and Roger R. Hall, Attorney for the Department of Regulation and Licensing, Division of Enforcement, as follows that:

1. This Stipulation is entered in resolution of the pending Petition for Summary Suspension proceedings concerning Dr. Molstad's license. The stipulation and order shall be presented directly to the Medical Examining Board for its consideration for adoption.

2. Dr. Molstad understands that by the signing of this Stipulation he voluntarily and knowingly waives his rights, including: the right to a hearing on the allegations against him, at which time the state has the burden of proving those allegations by a preponderance of the evidence; the right to confront and cross-examine the witnesses against him; the right to call witnesses on his behalf and to compel their attendance by subpoena; the right to testify himself; the right to file objections to any proposed decision and to present briefs or oral arguments to the officials who are to render the final decision; the right to petition for rehearing; and all other applicable rights afforded to him under the United States Constitution, the Wisconsin Constitution, the Wisconsin Statutes, and the Wisconsin Administrative Code.

3. Dr. Molstad is aware of his right to seek legal representation and has obtained legal advice prior to signing this stipulation.

4. Dr. Molstad agrees to the adoption of the attached Final Decision and Order by the Medical Examining Board. The parties to the Stipulation consent to the entry of the attached Final Decision and Order without further notice, pleading, appearance or consent of the parties. Respondent waives all rights to any appeal of the Board's order, if adopted in the form as attached.

5. If the terms of this Stipulation are not acceptable to the Board, the parties shall not be bound by the contents of this Stipulation, and the matter shall be returned to the Division of Enforcement for further proceedings. In the event that this Stipulation is not accepted by the Board, the parties agree not to contend that the Board has been prejudiced or biased in any manner by the consideration of this attempted resolution.

6. The parties to this stipulation agree that the attorney for the Division of Enforcement and the member of the Medical Examining Board assigned as an advisor in this investigation may appear before the Medical

Examining Board for the purposes of speaking in support of this agreement and answering questions that the members of the Board may have in connection with their deliberations on the stipulation.

7. The Division of Enforcement joins Dr. Molstad in recommending the Medical Examining Board adopt this Stipulation and issue the attached Final Decision and Order.

Brian Molstad — 16 July 93

Brian R. Molstad, M.D. — Date

David P. Bunde, Attorney for Respondent — Date
Fredriksen & Byron
International Center
900 2nd Avenue South
Minneapolis, MN 55402

Roger R. Hall — July 19, 1993

Roger R. Hall, Attorney — Date
Division of Enforcement

RRH:lmf
ATY-2594

Examining Board for the purposes of speaking in support of this agreement and answering questions that the members of the Board may have in connection with their deliberations on the stipulation.

7. The Division of Enforcement joins Dr. Molstad in recommending the Medical Examining Board adopt this Stipulation and issue the attached Final Decision and Order.

Brian R. Molstad, M.D. — Date

David P. Bunde, Attorney for Respondent — Date: 7-19-93

Fredrikson & Byron
International Center
900 2nd Avenue South
Minneapolis, MN 55402

Roger H. Ball, Attorney — Date
Division of Enforcement

WRB:lmf
ATT-2194

MINNESOTA BOARD OF MEDICAL PRACTICE
2700 University Avenue West, #106 St. Paul, MN 55114-1080 (612) 642-0538

CERTIFICATION OF DISCIPLINARY ACTIONS

ORDER DATED March 13, 1993

IN THE MATTER OF: Brian R. Molstad, M.D.

CITY AND STATE OF: Hudson, WI

I, H. Leonard Boche, Executive Director of the Minnesota Board of Medical Practice, Do hereby certify that the attached Board Order is a copy of the original official record on file in the office of the Minnesota Board of Medical Practice. As Executive Director, I am the official custodian of such documents and I have personally compared the attached copy with the original and find it to be a true and correct copy thereof.

H. Leonard Boche

H. Leonard Boche,
Executive Director
Minnesota Board of Medical Practice

(S E A L)

AN EQUAL OPPORTUNITY EMPLOYER
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STATE OF MINNESOTA

OFFICE OF THE ATTORNEY GENERAL

HUBERT H. HUMPHREY III
ATTORNEY GENERAL

GOVERNMENT SERVICES SECTION
525 PARK STREET
SUITE 500
ST PAUL, MN 55103-2106
TELEPHONE (612) 297-2040
FACSIMILE. (612) 297-2576

March 15, 1993

David P. Bunde, Esq.
Fredrikson & Byron, P.A.
International Center
900 - 2nd Avenue South
Minneapolis, MN 55402

Linda F. Close
Assistant Attorney General
525 Park Street, Suite 500
St. Paul, MN 55103

RE: IN THE MATTER OF THE MEDICAL LICENSE OF
BRIAN R. MOLSTAD, M.D.
License No. 20,366

Dear Counsel:

Enclosed herewith and served upon you by U.S. mail in the above subject matter is Order For Temporary Suspension.

Very truly yours,

ROBERT T. HOLLEY
Special Assistant
Attorney General

(612) 297-5938

Enclosure
cc: Meredith Hart
H. Leonard Boche
RTH:vla.holl.fv7

BEFORE THE MINNESOTA

BOARD OF MEDICAL PRACTICE

In the Matter of the
Medical License of
Brian R. Molstad, M.D.
Date of Birth: 2/18/45
License Number: 20,366

ORDER FOR TEMPORARY SUSPENSION

WHEREAS, Brian Molstad, M.D. (hereinafter "Respondent") has been licensed to practice medicine and surgery in the State of Minnesota during all times material herein and is subject to the jurisdiction of the Minnesota Board of Medical Practice (hereinafter "Board");

WHEREAS, the Board is authorized pursuant to Minn. Stat. §§ 147.01 through 147.33 (1992) to license, regulate, and discipline persons who apply for, petition, or hold licenses to practice medicine and surgery in the State of Minnesota and is further authorized pursuant to Minn. Stat. § 214.10 (1992) to review complaints against physicians, to refer such complaints to the Attorney General's Office, and to initiate appropriate disciplinary action;

WHEREAS, based upon the hereto attached affidavits of Paula J. Morphew, Richard Irons, M.D. and Ruth Martinez, the Board believes that Respondent has violated statutes or rules which the Board is empowered to enforce and that Respondent's continued practice would create an imminent risk of harm to others, and that, consequently, a TEMPORARY SUSPENSION of Respondent's license pursuant to Minnesota Statutes, section 147.091, subdivision 4, is warranted;

WHEREAS, on December 4, 1992, Respondent appeared before a Complaint Review Committee to discuss the following:

1. On March 25, 1987, Respondent's Illinois medical license was restricted based on Respondent's high incidence of misdiagnosis while he was an anatomical pathologist at the Chicago Metpath Laboratories, Inc. ("Metpath") during 1984 and 1985. While employed at Metpath, Respondent misdiagnosed at least 106 of the 5000 tissue specimens that he microscopically examined. Respondent's Illinois Order required him to take remedial education in surgical pathology and to undergo a psychological evaluation to assess the impact of stress on his professional judgment. The Illinois Order remained in effect until February 25, 1988;

2. On July 2, 1991, Respondent applied for hospital privileges at District One Hospital ("District One") in Faribault, Minnesota. By letter dated October 17, 1991, District One denied privileges based on Respondent's:

a. Unsatisfactory peer references;

b. Failure to demonstrate current knowledge, judgment and competency;

c. Inability to work well with others;

d. Failure to explain gaps in his employment history; and

e. Holding a large of number of jobs in a relatively short period of time;

3. Prior to 1992 and again during June 1992, Respondent served as a locum tenens for the staff pathologist at North Country Regional Hospital ("NCRH") in Bemidji, Minnesota.

a. During the pre-1992 employment period, Respondent:

1). Performed an autopsy, but failed to clean up afterwards or to close the body, leaving it for cleaning personnel to discover later in the day; and

2). Performed an autopsy on patient #21, 50-year old man who crashed his light plane. When the patient's physician came down during the autopsy, Respondent stated that his patient "had looked like a fly splattered on a windshield."

Respondent also threw a helmet from the accident to an orderly who was not wearing gloves. The helmet had blood and brain tissue on it;

b. During June 1992, Respondent misdiagnosed at least five cases while working at NCRH, including:

1). With respect to patient #1, a 63-year old male, Respondent diagnosed adenocarcinoma following a May 28, 1992, cystoscopy and prostate biopsy. The diagnosis, dated June 2, 1992, resulted in patient #1 and his wife being informed that patient #1 had prostate malignancy. On June 4, 1992, a second opinion was obtained from a Mayo Clinic physician, who diagnosed granulomatous prostatitis. A re-biopsy on June 5, 1992, confirmed the June 4, 1992 diagnosis by the Mayo Clinic physician;

2). With respect to patient #2, a 75-year old male, Respondent's June 15, 1992, diagnosis as benign following a June 11, 1992, cystoscopy and prostate biopsy, was communicated to patient #2. A second opinion was obtained from the University of Minnesota on July 20, 1992, which indicated adenocarcinoma, Gleason pattern 3-4. Subsequently, patient #2 underwent a Bilateral Intracapsular Orchiectomy;

3). With respect to patient #3, a 58-year old male, Respondent's June 26, 1992, diagnosis as benign following a June 24, 1992, cystoscopy and prostate biopsy was communicated to patient #3 on June 29, 1992. On July 20, 1992, a University of Minnesota pathologist rendered a diagnosis of adenocarcinoma, Gleason pattern 3-3. Subsequently, patient #3 underwent a radical prostatoseminovesiculectomy, resulting in a diagnosis of grade 3 adenocarcinoma;

4). With respect to patient #4, a 59-year old female, Respondent diagnosed no malignancy following a breast fine needle aspiration on June 1, 1992. On June 3, 1992, patient #4 underwent a right breast biopsy which resulted in a diagnosis of intraductal carcinoma; and

5). With respect to patient #5, an 18-year old female, Respondent's diagnosis indicated "premature membrane rupture-no inflammation" following a full-term, vacuum assisted delivery. Respondent's microscopic description of the placenta indicated "placenta show no chorioamnionitis. There is no increase in the amount of fibrosis nor calcification present." A re-review of the case was requested by the obstetrician because of the high clinical suspicion of chorioamnionitis. Upon re-review, a diagnosis of "prolonged rupture of membranes, chorioamnionitis, post-partum anemia, viable infant" was made.

c. Following Respondent's misdiagnosis of patient #5, a review was conducted of all 11 placentas examined by Respondent while he was employed at NCRH in June of 1992. The review indicated that Respondent had never examined the membranes of any of the 11 placentas.

d. During the period Respondent was employed at NCRH, Respondent engaged in the following practices with respect to his dictation:

1). Respondent used fictitious patient names, such as Winston Churchill, Holly-Holly-Holly and others, in lieu of real patient names;

2). Respondent transposed patient names and/or specimen numbers;

3). Respondent erroneously identified surgical procedures, such as calling a penectomy "a castration";

4). Respondent made concurrent diagnoses of thrombocytopenia and thrombocytosis;

5). Respondent dictated on the second of two consecutive prostate specimens by directing the transcriber to "do the same for" the second specimen as he had dictated on the first;

6). Respondent made inappropriate comments about genital specimens;

7). Respondent repeatedly identified female patients as "bitches" or "whores" and referred to male patients as "bastards"; and

8). A transcription of a portion of one tape dictated by Respondent during the period of employment at NCRH revealed eight (8) errors in patient names dictated by Respondent. This included patient #2483 which Respondent identified as "Dana Molstad." Respondent concluded this dictation with the statement "That's all there is 'cuz there ain't no more. Thank you."

e. Respondent repeatedly "disappeared" from work, sometimes being absent from the hospital for two to three hours. On more than one occasion, Respondent failed to communicate frozen section diagnoses to the hospital surgeons prior to these unexplained mid-day absences from the hospital.

4. Between January 1986 and June 1987, Respondent was employed at Holy Family Memorial Hospital in Manitowoc, Wisconsin. During this period of employment, Respondent periodically disappeared from the hospital for hours.

5. On December 27, 1990, Respondent applied for hospital privileges at Naeve Hospital in Albert Lea, Minnesota. With respect to patient #6, in October 1992, Respondent examined tissue from a prostate biopsy and misdiagnosed it as benign. Subsequently, it was discovered that it was adenocarcinoma;.

WHEREAS, on December 4, 1992, the Board requested Respondent to submit to a physical and mental evaluation at Abbott Northwestern Hospital, Minneapolis, Minnesota;

WHEREAS, The following information was brought to the attention of the Complaint Review Committee after Respondent's appearance before the CRC:

1. In October 1992, Respondent entered into a contractual agreement with the Rush City Clinic ("Clinic") and the Rush City Hospital ("Hospital"), as a General Practitioner, to provide medical care at the clinic and be on-call in the Emergency Room at the Hospital;

2. On January 6, 1993, Respondent received a 90-day termination notice from the Clinic and Hospital Administrator;

3. On or about February 4, 1993, Respondent was notified by the Hospital/Clinic that he would be paid for the remainder of the 90-day period, however, he should not continue to come to the Clinic or Hospital to provide patient care during the remainder of that time period;

4. From October, 1992 through January 31, 1993, Respondent provided the following care to patients and/or behaved in the following manner while at the Clinic or Hospital:

a. In the fall of 1992, Respondent treated patient #7 who had a foot fracture. This patient complained to staff that Respondent's manner was "clipped" and that she "would like a physician to spend more time explaining things" to her;

b. With respect to the care Respondent provided to patient #8, a 62 year old female, at the clinic, the following was documented in the patient's medical record:

Date		Description
10-26-92	S:	Nausea. Patient presents in a obvious discomfort with nausea for three days but no vomiting. She has eaten almost nothing she has had moderate diffuse abdominal pain it is not relieved by any activity or by eating.
	O:	Diffuse abdominal tenderness. No fever. No organomegally. Multiple surgery scars.
	A:	Probably gastroenteritis.
	P:	Prochoprizine 25 q 4 h plus serum amalyse. Return prn.
10-29-92	S:	Patient has had dark colored urine for two days and significant amount of itching.
	O:	Urinalysis shows 1+ bilirubin. Hemoglobin equals 14.7. A slight yellow color is noted to the sclera but yellow color to the skin.
	A:	Mild hemolysis possibly to drug reaction or a virus.

P: Patient reassured the situation explained. Habitrol prescribed to eliminate smoking.

11-1-92 [Emergency Room: Patient #8 was seen by a physician other than Respondent]

S: Itching all over which has gotten worse since Tuesday when seen at R.C. Clinic. Nausea but no emesis. Has also mid-abdominal pain with this. Weakness. Skin color slightly yellow.
O: Deferred.
P: Labs: CBC, Urinalysis, Total Bilirubin, Electrolytes and Blood Sugar. Take upstairs to a room.
Lab Results: Urinalysis [not available], Total Bilirubin [5.3], Electrolytes [high CO2] and Blood Sugar [174].

11-5-92 Discharged by a physician other than Respondent and transferred to St. Joseph's Hospital with a diagnosis of acute liver involvement due to obstructive jaundice, Diabetes mellitus, type II and Electrolyte depletion syndrome.

Clinic staff told and an Investigator of the Attorney General's Office that patient #8 later informed her that she, the patient, has Pancreatic cancer;

c. On November 12, 1992, patient #9 was examined by Respondent for symptoms of a "bleeding ulcer, ie., abdominal pain, black tarry stools." Respondent ordered an upper GI and x-ray, but failed to order any lab tests. The patient sought further treatment with another physician;

d. On November 12, 1992, Respondent examined patient #10, a 29 year old female diagnosed with an active miscarriage. During a pelvic examination, staff observed Respondent's examination being performed in such a manner as to cause patient #10 to scream. Respondent documented in patient #10's medical record, "Patient very uncomfortable during remainder of pelvic examination." A physician other than Respondent performed a D & C that evening;

e. On November 18, 1992, Respondent examined patient #11, a 79 year old female, who had fallen backwards and hit her head, was not eating regular

meals and was pale. Respondent documented in the patient's medical record that there were no bruises or cuts to the head; lungs were clear and there were no heart murmurs. Tests included: skull and chest x-ray, CBC, MCV and Hemoglobin. Patient #11 had a MCV of 74 and a hemoglobin of 6.3. Respondent diagnosed the patient with a probable iron deficiency anemia and he discharged her to home.

On November 20, 1992, Respondent performed a sigmoidoscopy on patient #11. Respondent, documented in the patient's medical record that the patient had a, "normal rectosigmoid colon". Respondent ordered blood drawn for a riticulocytes count but failed to order a CBC. Respondent discharged her to home.

On November 23, 1992, patient #11 was admitted to the Hospital and was initially seen by Respondent. While in the Hospital, the patient received three pints of blood. On November 24, 1992, Respondent dictated a discharge summary which included a plan for the patient to schedule her next visit in the outpatient clinic in one to two weeks. However, on November 25, 1992, patient #11's care was assumed by another physician and the patient remained in the hospital. The second physician documented that the patient had developed an "ilius type process with emesis, bile colored," and she exhibited a "change of cognitive status" upon standing. On November 29, 1992 the second physician transferred the patient to United Hospital, St. Paul, because of the ongoing nature of her anemia and GI bleed;

f. On December 23, 1992, Respondent saw pediatric patient #12 who had a foreign body in her left knee. Staff observed that Respondent failed to use sterile gloves and placed "sterile" forceps in the child's knee after he first placed the forceps on the exam table;

g. Staff reported a concern with respect to the care Respondent provided, on December 31, 1992, to patient #13 who had a lacerated hand. Staff

observed Respondent suture a portion of a 2-inch long laceration on the patient's thumb and give him instructions on care of the wound. Respondent then instructed staff to apply a dressing and left the room. Staff went to the doctor's lounge and informed Respondent that there was more of the laceration to be sutured. Twenty minutes later, Respondent returned to the patient and finished the suturing;

h. On January 1, 1993, two Emergency Medical Technicians ("EMTs") had been dispatched to the emergency room "to assist with CPR" as patient #14 was being brought to the Rush City Hospital Emergency Room by the Pine City Ambulance.

At 3:20 A.M., the patient arrived with an Esophageal Oral Airway in place. On more than one occasion, the Pine City EMTs told Respondent that they were unsure of the adequacy of the airway and asked Respondent "to evaluate the airway and do intubation." Respondent ignored their request and failed to evaluate or intubate. While a Pine City EMT performed chest compressions, Respondent instructed him to "slow down the compressions." Subsequently, Respondent took over doing the chest compressions at a rate of about 50/minute and continued doing them for sometime, but failed to order any medications or perform defibrillation.

At 3:30 A.M., ten minutes after arrival in the Emergency Room, the patient's peripheral IV line was successfully started.

At 3:33 A.M., Respondent ordered that the patient receive Epinephrine.

At 3:39 A.M., one ampule of Bretylium was administered to the patient.

At 3:45 A.M., the patient was pronounced dead, after multiple defibrillations.

During the emergency, Respondent failed to utilize the assistance of another physician who was available in the Emergency Room;

i. On January 2, 1993, Respondent was on-call in the Emergency Room when patient #15 came into ER unresponsive and with agonal respirations. Respondent failed to respond when the staff tried to reach him by pager. Another physician was called, the patient was stabilized and transferred to St. Paul Ramsey Medical Center;

j. On January 7, 1993, patient #16 sustained burns in a fire. When the patient's parents brought him to the Emergency Room, where Respondent was on-call, Respondent stood with his back to the wall, providing no care to the patient. When the parents told Respondent that they had given the patient two Tylenol #3, Respondent replied, "Well, I'm older than he is and I've taken four at a time and it didn't hurt me; maybe we can give him one more." Respondent continued to stand with his back to the wall while the patient tried to get relief by splashing himself with cold water. Nothing was done for the patient until the nurse appeared and took charge.

k. On January 22, 1993, patient #17 wrote a letter of complaint to the Clinic. According to the complaint, the patient had seen Respondent on two occasions; Respondent's attitude was "demeaning, as though [she] was stupid" and, although Respondent treated her symptoms, he failed to look for the underlying cause of her headaches;

l. On January 27, 1993, Respondent saw patient #18, a 60 year old female, who was diagnosed with a vaginal yeast infection. During the pelvic exam, staff observed Respondent hurt the patient so badly that the patient screamed. Respondent inserted a speculum without telling the patient. Respondent later left the speculum hanging in the patient's vagina while he turned his stool away from the

examination table. He then performed a digital examination instead of using a Q-tip for a wet smear. Meanwhile, the patient was "sobbing". Respondent then walked out without saying anything to the patient. After consoling the patient, staff followed Respondent into his office and said: "Why did you do that? You hurt her." Respondent just said, in a high voice, "sorry, sorry.";

m. On January 29, 1993, Respondent examined patient #19, an 86 year old male, who complained of abdominal pain and "not feeling good". Respondent documented in the patient's medical record that his lungs were clear, and his abdomen exhibited no tenderness or rebound. Respondent noted the patient's inguinal hernia and enlarged prostate, but failed to specify a diagnosis. Respondent ordered a urinalysis, chemistry profile, sigmoidoscopy, barium enema, upper GI and one other test, documentation which is illegible, to be performed on patient #19.

On February 1, 1993, patient #19 was examined by his primary physician and admitted to the Hospital. The admission diagnosis was gastroenteritis, questionable obstruction. The discharge diagnosis was high grade small bowel obstruction and possible occult tumor. On February 5, 1993, patient #20 was transferred to Cambridge Hospital for possible surgery;

n. Staff documented concern about the care Respondent provided to patient #20 who had a blood pressure of 240/110. Patient #20 was started on antihypertensive medication, but was instructed by Respondent to return in one month when she needed to return in one week;

o. On one occasion, staff observed Respondent care for a female patient who had a cyst in the genital area. Respondent injected a local anesthetic and started lancing the cyst immediately. The patient said, "I feel that," but

Respondent continued the procedure rather than wait for the local anesthetic to take effect;

p. On one or more occasions, staff observed Respondent state, "women like pain";

q. On one or more occasions, staff observed Respondent state, "women like to be treated rough";

r. On one or more occasions, outside of the examination rooms, staff observed Respondent make unkind editorial comments about patients;

s. Staff observed Respondent repeatedly refer to his patients as victims, asking, "Where is the next victim/Are there any more victims?";

t. On one or more occasions, Respondent came to work late and took long lunches, requiring patients to wait for him;

u. On one or more occasions, Respondent "disappeared" from the the Emergency Room when on-call, sometimes failing to provide coverage;

v. On one or more occasions, Respondent failed to respond tc his pager when staff paged him while he was on-call;

w. On one or more occasions, after Respondent had worked with staff all morning, he asked, "Who is my nurse today?";

x. On one or more occasions, after Respondent worked a half-day in the Clinic, he asked, "which are my examining rooms?";

y. On one occasion, a Staff member who had not met Respondent, observed Respondent outside of the clinic walking back and forth in an agitated manner and behaving in such a manner that assumed he was a psychiatric patient whose behavior would necessitate admission to the Hospital that night;

z. On or about November 13, 1992, Respondent was at the Clinic and had one more patient to see before leaving. Respondent left the Clinic to see a

patient in the Emergency Room and when he was done in the Emergency Room, he went to lunch instead of returning to care for the patient waiting at the Clinic. The Clinic patient had to go home without being seen by Respondent;

6. On one or more occasions, Respondent wrote a prescription for Tylenol #3 for himself;

7. On February 1, 1993, Respondent was admitted to Abbott Northwestern Hospital for a physical and mental evaluation by Richard Irons, M.D. Upon admission to the Professional Assessment Program ("Program"), Respondent submitted to a urine drug screen. The screen was considered to be invalid due to the specimen temperature being below reference range at the time of collection and was sent in with a reported temperature of 88 degrees. This finding leaves open the possibility that the specimen might have been tampered with by either dilution or by substitution. While Respondent was a patient in the Program, Respondent had unexplained absences from the unit. During the Program, there were discrepancies in some of the information that Respondent provided to staff.

Prior to Respondent's discharge from the program, hospital staff informed Respondent of the invalid urine screen and asked Respondent to produce another specimen. Respondent stated that he could do this and, according to protocol, a male staff was obtained to observe the collection. In the bathroom, Respondent threw the cup in the wastebasket and stated that he could not urinate. Staff encouraged Respondent to let them know when he would be able to urinate. Within thirty minutes, when the nursing staff looked for Respondent, staff discovered that Respondent's clothes were gone and he had left the hospital without completing the discharge process or providing the urine specimen;

8. The Board's consultant determined that because of Respondent's level of defensiveness, the assessment team was unable to definitely exclude the possibility of a

significant DSM AXIS I mental illness due to his pathological level of denial and lack of cooperation with the assessment process;

9. The Board's Consultant determined that Respondent's characterologic structure represents a significant handicap in his personal and professional life. It leaves Respondent vulnerable to minor and possibly major lapses in judgment. In Respondent's effort to defend himself, he has the propensity to harm others if he is functioning in a fiduciary capacity;

10. Based on the information available from the assessment, the Board's consultant, has diagnosed Respondent as and AXIS II: Narcissistic Personality Disorder. Board's consultant was unable to rule out an occult chemical dependency with an extremely high level of denial, based upon the inconsistent history, unexplained absences from the unit, as well as allegations of absences from work, allegations of unusual behavior, and Respondent's refusal to provide us with a urine drug screen prior to discharge (which, in the opinion of the Board's consultant, is equivalent to a positive drug screen);

11. On February 5, 1993, Respondent contacted Ramsey County Medical Center ("RCMC") to express an interest in having them train him to perform abortions;

12. From February 5 to February 24, 1993, Respondent repeatedly telephoned the RCMC, attempting to speak to various physicians. Respondent refused to leave a telephone number, as the physicians were unavailable to take the call. Clinic staff felt harassed by Respondent's continuous telephone calls; and

13. Respondent has contacted the Duluth Women's Health Center expressing an interest in having the Center train him in performing abortions if they agreed to hire him as a staff physician.

WHEREAS, on March 13, 1993, the above-entitled matter came on for consideration by the Board;

WHEREAS, Linda F. Close, Assistant Attorney General, was present as counsel to the Complaint Review Committee. Respondent was present and represented by counsel. Robert T. Holley, Special Assistant Attorney General, was present as counsel to the Board;

WHEREAS, based upon its consideration of this matter, the Board makes the following ORDER:

1. IT IS HEREBY ORDERED that the Respondent's license to practice medicine and surgery in the State of Minnesota is temporarily SUSPENDED pursuant to Minn. Stat. § 147.091, subd. 4 (1992). During the period of suspension, Respondent shall not in any manner practice medicine or surgery in this state. The suspension shall take effect immediately and shall remain in effect until the Board issues a final decision in the matter after a hearing;

2. IT IS FURTHER ORDERED that the terms of this suspension are adopted and implemented by the Board this 13th day of March, 1993.

MINNESOTA BOARD OF
MEDICAL PRACTICE

Meredith Hart

AFFIDAVIT OF SERVICE BY MAIL

RE: IN THE MATTER OF THE MEDICAL LICENSE OF
BRIAN R. MOLSTAD, M.D.
License No. 20,366

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

Vicki L. Armstrong, being first duly sworn, deposes and says:

That at the City of St. Paul, County of Ramsey and State of Minnesota, on the 15th day of March, 1993, she served the attached **ORDER FOR TEMPORARY SUSPENSION** by depositing in the United States mail at said city and state, a true and correct copy thereof, properly enveloped, with first class postage prepaid, and addressed to:

David P. Bunde, Esq.
Fredrikson & Byron, P.A.
International Center
900 - 2nd Avenue South
Minneapolis, MN 55402

Vicki L. Armstrong

Subscribed and sworn to before me
this 15th day of March, 1993.

Kathleen K. Sundstrom
Notary Public

KATHLEEN K. SUNDSTROM
Notary Public, Ramsey Co., Minn.
My Commission Expires January 31, 1996

AFFIDAVIT OF PERSONAL SERVICE

RE: IN THE MATTER OF THE MEDICAL LICENSE OF
BRIAN R. MOLSTAD, M.D.
License No. 20,366

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

Vicki L. Armstrong, being first duly sworn, deposes and says:

That on the 15th day of March, 1993, she served the attached **ORDER FOR TEMPORARY SUSPENSION** by handing to and leaving with Linda F. Close, Assistant Attorney General, at the Office of the Attorney General, Government Services Division, 525 Park Street, Suite 500, St. Paul, MN 55103, a true and correct copy thereof.

Vicki L. Armstrong

Subscribed and sworn to before me
this 15th day of March, 1993.

Kathleen K. Sundstrom

KATHLEEN K. SUNDSTROM
Notary Public, Ramsey Co., Minn.
My Commission Expires January 31, 1996

National Practitioner Data Bank
P.O. Box 6048
Camarillo, CA 93011-6048

ADVERSE ACTION REPORT

OMB NO. 0915-0126
EXP. DATE 3/31/91

93MC12

FOR DATA BANK USE ONLY

Document Number of Previous Report (To be entered by Reporting Entity only when submitting a "Correction or Addition" or "Void Previous Report.")

SECTION A -- REPORTING ENTITY INFORMATION

1. Data Bank ID (15): 2242752000000010
2. Type of Report: [X] Initial Report [ ] Correction or Addition [ ] Revision to Action [ ] Void Previous Report
3. Type of Adverse Action Taken: [X] Licensure [ ] Clinical Privileges [ ] Society Membership
4. Entity Name (40): Minnesota Board of Medical Practice
5. Street Address (40): 2700 University Ave. W., Suite 106
6. City (28): St. Paul
7. State (2): MN
8. Zip Code (5 or 9): 55114-1080

SECTION B -- PRACTITIONER INFORMATION

Add'l Info. (see instructions)

9. Practitioner Name Last (25): Wolstad
First (15): Brian
Middle (15): Rolf
Suffix (3):
10. Other Name Used Last (25):
First (15):
Middle (15):
Suffix (3):
11. Organization Name (40):
12. Work Address (40): Brian Rolf Wolstad
13. City (28): 325 Locust #363
14. State (2): MI
15. Zip Code (5 or 9): 64016
16. Country (if not U.S.) (10):
17. Home Address (40):
18. City (28): 325 Locust #363
19. State (2): MI
20. Zip Code (5 or 9): 64016
21. Country (if not U.S.) (10):
22.a. License Number (16): 20-366
22.b. State of Licensure (2): MN
22.c. Field of Licensure (3): 010
23. Date of Birth (mm/dd/yy): 02/18/45
24. Social Security Number (U.S.) (9): 477-46-9265
25. Federal DEA No. (12):
26.a. Professional School Attended (40): University of Minnesota
26.b. Year of Graduation (4): 1971

SECTION C -- ADVERSE ACTION INFORMATION

27. Date of Action (mm/dd/yy): 02/12/93
28. Adverse Action Classification Code (5): 280-00
29. Length of Action (in months): 008
30. Effective Date of Action (mm/dd/yy): 03/15/93
31. Description of the acts or omissions or other reasons for the action taken, and if known and if applicable, the reasons for surrender of clinical privileges (600)

Other Reason - Not Classified

SECTION D -- CERTIFICATION

I certify that the reporting entity or individual identified in Section A of this report is authorized, under the provisions of P.L. 99-660, as amended, and as specified in 45 CFR Part 60, to provide this information to the National Practitioner Data Bank. I further certify that the reporting entity or individual has authorized me to submit this report to the Data Bank and that the information provided is true and complete.

WARNING: Any person who knowingly makes a false statement or misrepresentation to the National Practitioner Data Bank is subject to a fine and imprisonment under Federal statute.

32. Printed Name of Authorized Representative (40):
33. Title of Authorized Representative (40): Review Unit Supv.
34. Telephone Number (15): 612-642-0538 ext.
35. Signature Date (mm/dd/yy): 4/6/93
36. Signature of Authorized Representative: [signature]

WHITE-DATA BANK YELLOW-STATE MEDICAL OR DENTAL BOARD PINK-OTHER STATE LICENSING BOARD GOLD-REPORTING ENTITY

HRSA-530 (3/90)

NOTICE OF APPEAL INFORMATION

(Notice of Rights for Rehearing r Judicial Review, the times allowed for each, and the identification of the party to be named as respondent)

The following notice is served on you as part of the final decision:

1. Rehearing.

Any person aggrieved by this order may petition for a rehearing within 20 days of the service of this decision, as provided in section 227.49 of the Wisconsin Statutes, a copy of which is attached. The 20 day period commences the day after personal service or mailing of this decision. (The date of mailing of this decision is shown below.) The petition for rehearing should be filed with the State of Wisconsin Medical Examining Board.

A petition for rehearing is not a prerequisite for appeal directly to circuit c urt through a petition for judicial review.

2. Judicial Review.

Any person aggrieved by this decision has a right to petition for judicial review of this decision as provided in section 227.53 of the Wisconsin Statutes, a copy of which is attached. The petition should be filed in circuit court and served upon the State of Wisconsin Medical Examining Board.

within 30 days of service of this decision if there has been no petition for rehearing, or within 30 days of service of the order finally disposing of the petition for rehearing, or within 30 days after the final disposition by operation of law of any petition for rehearing.

The 30 day period commences the day after personal service or mailing of the decision or order, or the day after the final dispositi n by operation of the law of any petition for rehearing. (The date of mailing of this decision is shown below.) A petition for judicial review should be served upon, and name as the respondent, the following: the State of Wisconsin Medical Examining Board.

The date of mailing of this decision is July 30, 1993.

227.49 Petitions for rehearing in contested cases. (1) A petition for rehearing shall not be a prerequisite for appeal or review. Any person aggrieved by a final order may, within 20 days after service of the order, file a written petition for rehearing which shall specify in detail the grounds for the relief sought and supporting authorities. An agency may order a rehearing on its own motion within 20 days after service of a final order. This subsection does not apply to s. 17.025 (3) (e). No agency is required to conduct more than one rehearing based on a petition for rehearing filed under this subsection in any contested case.

(2) The filing of a petition for rehearing shall not suspend or delay the effective date of the order, and the order shall take effect on the date fixed by the agency and shall continue in effect unless the petition is granted or until the order is superseded, modified, or set aside as provided by law.

(3) Rehearing will be granted only on the basis of:

(a) Some material error of law.

(b) Some material error of fact.

(c) The discovery of new evidence sufficiently strong to reverse or modify the order, and which could not have been previously discovered by due diligence.

(4) Copies of petitions for rehearing shall be served on all parties of record. Parties may file replies to the petition.

(5) The agency may order a rehearing or enter an order with reference to the petition without a hearing, and shall dispose of the petition within 30 days after it is filed. If the agency does not enter an order disposing of the petition within the 30-day period, the petition shall be deemed to have been denied as of the expiration of the 30-day period.

(6) Upon granting a rehearing, the agency shall set the matter for further proceedings as soon as practicable. Proceedings upon rehearing shall conform as nearly may be to the proceedings in an original hearing except as the agency may otherwise direct. If in the agency's judgment, after such rehearing it appears that the original decision, order or determination is in any respect unlawful or unreasonable, the agency may reverse, change, modify or suspend the same accordingly. Any decision, order or determination made after such rehearing reversing, changing, modifying or suspending the original determination shall have the same force and effect as an original decision, order or determination.

227.52 Judicial review; decisions reviewable. Administrative decisions which adversely affect the substantial interests of any person, whether by action or inaction, whether affirmative or negative in form, are subject to review as provided in this chapter, except for the decisions of the department of revenue other than decisions relating to alcohol beverage permits issued under ch. 125, decisions of the department of employe trust funds, the commissioner of banking, the commissioner of credit unions, the commissioner of savings and loan, the board of state canvassers and those decisions of the department of industry, labor and human relations which are subject to review, prior to any judicial review, by the labor and industry review commission, and except as otherwise provided by law.

227.53 Parties and proceedings for review. (1) Except as otherwise specifically provided by law, any person aggrieved by a decision specified in s. 227.52 shall be entitled to judicial review thereof as provided in this chapter.

(a) 1. Proceedings for review shall be instituted by serving a petition therefor personally or by certified mail upon the agency or one of its officials, and filing the petition in the office of the clerk of the circuit court for the county where the judicial review proceedings are to be held. If the agency whose decision is sought to be reviewed is the tax appeals commission, the banking review board or the consumer credit review board, the credit union review board or the savings and loan review board, the petition shall be served upon both the agency whose decision is sought to be reviewed and the corresponding named respondent, as specified under par. (b) 1 to 4.

2. Unless a rehearing is requested under s. 227.49, petitions for review under this paragraph shall be served and filed within 30 days after the service of the decision of the agency upon all parties under s. 227.48. If a rehearing is requested under s. 227.49, any party desiring judicial review shall serve and file a petition for review within 30 days after service of the order finally disposing of the application for rehearing, or within 30 days after the final disposition by operation of law of any such application for rehearing. The 30-day period for serving and filing a petition under this paragraph commences on the day after personal service or mailing of the decision by the agency.

3. If the petitioner is a resident, the proceedings shall be held in the circuit court for the county where the petitioner resides, except that if the petitioner is an agency, the proceedings shall be in the circuit court for the county where the respondent resides and except as provided in ss. 77.59 (6) (b), 182.70 (6) and 182.71 (5) (g). The proceedings shall be in the circuit court for Dane county if the petitioner is a nonresident. If all parties stipulate and the court to which the parties desire to transfer the proceedings agrees, the proceedings may be held in the county designated by the parties. If 2 or more petitions for review of the same decision are filed in different counties, the circuit judge for the county in which a petition for review of the decision was first filed shall determine the venue for judicial review of the decision, and shall order transfer or consolidation where appropriate.

(b) The petition shall state the nature of the petitioner's interest, the facts showing that petitioner is a person aggrieved by the decision, and the grounds specified in s. 227.57 upon which petitioner contends that the decision should be reversed or modified. The petition may be amended, by leave of court, though the time for serving the same has expired. The petition shall be entitled in the name of the person serving it as petitioner and the name of the agency whose decision is sought to be reviewed as respondent, except that in petitions for review of decisions of the following agencies, the latter agency specified shall be the named respondent:

1. The tax appeals commission, the department of revenue

2. The banking review board or the consumer credit review board, the commissioner of banking.

3. The credit union review board, the commissioner of credit unions.

4. The savings and loan review board, the commissioner of savings and loan, except if the petitioner is the commissioner of savings and loan, the prevailing parties before the savings and loan review board shall be the named respondents.

(c) A copy of the petition shall be served personally or by certified mail or, when service is timely admitted in writing, by first class mail, not later than 30 days after the institution of the proceeding, upon each party who appeared before the agency in the proceeding in which the decision sought to be reviewed was made or upon the party's attorney of record. A court may not dis[illegible] the proceeding for review solely because of a fai[illegible]ve a copy of the petition upon a party or the pa[illegible] attorney of record unless the petitioner fails to serve a person listed as a party for purposes of review in the agency's decision under s. 227.47 or the person's attorney of record.

(d) The agency (except in the case of the tax appeals commission and the banking review board, the consumer credit review board, the credit union review board, and the savings and loan review board) and all parties to the proceeding before it, shall have the right to participate in the proceedings for review. The court may permit other interested persons to intervene. Any person petitioning the court to intervene shall serve a copy of the petition on each party who appeared before the agency and any additional parties to the judicial review at least 5 days prior to the date set for hearing on the petition.

(2) Every person served with the petition for review as provided in this section and who desires to participate in the proceedings for review thereby instituted shall serve upon the petitioner, within 20 days after service of the petition upon such person, a notice of appearance clearly stating the person's position with reference to each material allegation in the petition and to the affirmance, vacation or modification of the order or decision under review. Such notice, other than by the named respondent, shall also be served on the named respondent and the attorney general, and shall be filed, together with proof of required service thereof, with the clerk of the reviewing court within 10 days after such service. Service of all subsequent papers or notices in such proceeding need be made only upon the petitioner and such other persons as have served and filed the notice as provided in this subsection or have been permitted to intervene in said proceeding, as parties thereto, by order of the reviewing court.