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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	FINAL DECISION AND ORDER
DAVID MORRIS, M.D., RESPONDENT.	:	LS9107032MED

The State of Wisconsin, Medical Examining Board, having considered the above-captioned matter and having reviewed the record and the Proposed Decision of the Administrative Law Judge, makes the following:

ORDER

NOW, THEREFORE, it is hereby ordered that the Proposed Decision annexed hereto, filed by the Administrative Law Judge, shall be and hereby is made and ordered the Final Decision of the State of Wisconsin, Medical Examining Board.

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

Dated this 18 day of December, 1992.

B. Jan Nevinski

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	PROPOSED DECISION
DAVID MORRIS, M.D., RESPONDENT	:	Case No. LS 9107032 MED

The parties to this action for purposes of §227.53, Stats., are:

David Morris, M.D.
615 South 10th Street
La Crosse WI 54601

Wisconsin Medical Examining Board
Department of Regulation and Licensing
P.O. Box 8935
Madison WI 53708

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

A hearing was held in this matter on January 21-January 24, 1992, at 1400 East Washington Avenue, Madison, Wisconsin. The Division of Enforcement was represented by attorney Roger Hall. Respondent David Morris appeared in person, with attorney Terence R. Collins of the law firm Cameron, Collins & Quillin, Ltd., 1206 Caledonia Street, La Crosse, WI 54603.

Based on the proceedings and the record in this matter, the administrative law judge recommends that the Medical Examining Board adopt the following Findings of Fact, Conclusions of Law, Order, and Opinion as its Final Decision in this matter.

FINDINGS OF FACT

1. David Morris, M.D , ("Respondent") is a physician licensed to practice medicine and

surgery in the state of Wisconsin, pursuant to a license granted November 30, 1956.

A. 1965-1974

2. This case involves only one patient. Dr. Morris provided medical care and treatment for the patient in this case from approximately 1965 to July 30, 1987. Between 1965 and June 1974, the patient's primary physician was Dr. C. Norman Shealy, but Dr. Morris and several other physicians provided care for her on an intermittent basis. Dr. Morris was treating her allergies during some part of this period continuing through June 1974.

3. After Dr. Shealy left the La Crosse area in late 1973 or early 1974, Dr. Morris became the patient's primary physician. At the time Dr. Morris took over her treatment for chronic pain, the patient was on a regime of self-medication, pursuant to prescription, including injectable Talwin p.r.n., Seconal, and a variety of other prescription medications.

4. Dr. Morris became the patient's primary physician because no other La Crosse physician would accept the patient on a long term basis. By June 1974, the patient's records indicate that she had a well known reputation in the medical community as a particularly difficult patient with substantial emotional and psychological problems in addition to her physical problems.

5. As a result of a low back injury which was treated by surgical intervention, and then exacerbated by an automobile accident several years previous to her beginning treatment with Dr. Morris, the patient in this case suffers from severe and unremitting low back pain and accompanying sleep disorders, and to a reasonable degree of medical certainty, will continue to suffer severe intractable pain and accompanying sleep disorders for the rest of her life.

6. The patient was, at the time she began long-term pain management with Dr. Morris, already suffering from emotional difficulties relating to a dysfunctional marriage and family situation, and a significant emotional response to her chronic pain. She was diagnosed with depression on several occasions, and from time to time was hospitalized for treatment of the depression. Prior to beginning treatment with Dr. Morris, the patient had been tried on a course of electro-shock therapy with no noticeable results.

7. The patient had a long history of hospitalizations, mostly in La Crosse, before Dr. Morris became her primary physician.

a. From May 14 to May 20, 1965, she was hospitalized at St. Francis Hospital in La Crosse, for treatment of low back pain.

b. From September 13 to October 3, 1965, she was hospitalized at Lutheran Hospital

in La Crosse, for removal of a spinal disk.

c. From October 11 to October 16, 1965, she was hospitalized at Lutheran Hospital for treatment of low back and neck pain.

d. From March 21 to March 25, 1966, she was hospitalized at Lutheran Hospital for treatment of a ruptured disk, secondary to an automobile accident in December, 1965.

e. From May 15 to June 9, 1967, she was hospitalized at Lutheran Hospital for treatment of the same ruptured disk, including a partial hemilaminectomy and removal of the ruptured intervertebral disk.

f. From April 29 to May 3, 1968, she was hospitalized at Lutheran Hospital for treatment of depression.

g. From November 13 to December 7, 1969, she was hospitalized at St. Francis Hospital for treatment of severe hysterical neurosis and reactive depressive reaction.

h. From November 16 to 17, 1970, she was hospitalized at Lutheran Hospital for oral surgery.

i. On November 24, 1970, she had x-rays taken of her lower back, at St. Francis Hospital in La Crosse. The prosecution attached the radiologist's report to the oral surgery record from Lutheran Hospital, and it is unclear if there was a hospitalization for back pain on this date.

j. From June 1 to June 6, 1971, she was hospitalized at St. Francis for cellulitis of the face secondary to dental infection, low back pain, and arthritis of the sacro-iliac joint.

k. From January 14 to January 27, 1971, she was hospitalized at St. Francis for gastritis and back pain, and a myelogram was done which showed scar tissue.

l. From October 17 to October 24, 1971, she was hospitalized at St. Francis for gastritis and low back pain.

m. In September, 1971, she was evaluated at Mayo Clinic in Rochester. The summary states that she complained of pain in the back and left leg of some six years' duration, and that there was an organic cause for the complaint but that there was a significant emotional aspect. The evaluation concluded that the medications she was taking were appropriate.

n. From January 28 to February 18, 1972, she was hospitalized at St. Francis with an admitting diagnosis of intractable left sciatic pain, with some probable degree of arachnoiditis, and a severe depressive reaction.

o. From March 8 to April 14, 1972, she was hospitalized at St. Francis for implantation of chronic brain stimulation electrodes to treat intractable left sciatic pain due to arachnoiditis, with severe depressive reaction.

p. From May 1 to May 6, 1972, she was hospitalized at St. Francis for treatment of severe burns to her left hand, and intractable pain from chronic lumbar disk syndrome.

q. From May 10 to May 17, 1972, she was hospitalized at St. Francis, with a working diagnosis of intractable pain, and a final diagnosis of chronic lumbar disk syndrome. During this hospitalization, she was operated upon, with a bilateral facet denervation on three lumbar levels.

r. From July 21 to August 27, 1972, she was hospitalized at St. Francis and treated for intractable pain at multiple sites. During this hospitalization, she underwent operations for the removal of the brain stimulating electrode implant equipment, excision of a mass from her left calf, implantation of a perineal nerve stimulator, and bilateral upper thoracic facet rhizotomy.

s. From September 12 to September 23, 1972, she was hospitalized at St. Francis for treatment of intractable chronic lumbar pain, secondary to multiple procedures in the back following disk surgery and degenerative conditions. During this hospitalization, she underwent a rhizotomy of the nerve of Luschka at L-4 L-5, L-5 S-1 bilaterally, and lower lumbar facet denervation by percutaneous dorsal column stimulator.

t. From January 3 to January 7, 1973, she was hospitalized at St. Francis for treatment of intractable pain from chronic lumbar disk syndrome. During this hospitalization, she underwent a repeat facet rhizotomy at L3-4, L4-5 and L5-S1 bilaterally, and dorsal column stimulation.

u. From January 17 to February 26, 1973, she was hospitalized at St. Francis for treatment of chronic lumbar disk syndrome, with thoracic laminectomy and insertion of dorsal column stimulator electrodes. While she was recovering from that, she suffered a myocardial infarction.

v. From June 15 to June 18, 1973, she was hospitalized at St. Francis for treatment of complaint of chest pain from a fall at home.

w. From August 15 to August 29, 1973, she was hospitalized at Lutheran Hospital for cardiac catheterization to treat a diagnosis of complete occlusion of the left anterior descending artery, brought on by arteriosclerotic cardiovascular disease. During the catheterization, she had an episode of severe coronary ischemia, and was sent to intensive care. Over the course of the ensuing week, the physician responsible for the catheterization decided that she had not had an actual myocardial infarction.

x. From late October to mid-November, 1973, she was seen at St. Francis, if not admitted, at least twice for complaints for which the working diagnoses were gall bladder disease and gastric ulcer.

y. In late November, 1973, she had coronary bypass surgery performed in Milwaukee at St. Luke's Hospital.

z. From December 19 to December 23, 1973, she was hospitalized at St. Francis for observation to rule out a repeat myocardial infarction.

8. The patient was, and continues to be, a particularly difficult pain management case for whom the medical goal was, and continues to be, to salvage as much of her potential enjoyment of life as possible.

B. 1974 - 1987

9. Dr. Morris took over the management of the patient's chronic pain, and became her primary physician, in mid-1974. Over the course of the next thirteen years, Dr. Morris made frequent referrals to other physicians, none of whom would accept the patient for long-term pain management.

10. The patient's condition noticeably, progressively, and constantly improved while she was under the care of Dr. Morris. Her ability to function in a normal fashion, to carry out the responsibilities and to enjoy the benefits of life, was substantially enhanced by the course of pain treatment managed by Dr. Morris.

11. During the time the patient was under Dr. Morris' care, she experienced additional well-documented painful physical and deep seated emotional difficulties, including a dental infection requiring surgical intervention; a broken hip; a few falls related to her difficulty in walking because of severe lower back pain, which exacerbated the back pain; a dysfunctional marriage related to her spouse's use of alcohol; some physical and mental abuse within the marriage; depression secondary to the physical and marital difficulties; and sleep disorders which adversely affected her ability to cope with the pain generated from both the physical and emotional difficulties.

12. At various times for varying periods from June 1974, through July 1987, Dr. Morris prescribed and administered Tylenol #4 with Codeine, Seconal, Nembutal, Placidyl, Parest, Quualude, and Phenergan with Codeine for the patient.

a. Tylenol #4 is a narcotic analgesic containing codeine phosphate, a Schedule III controlled substance as defined in § 161.01(4) and § 161.18(5)(b), Stats., with moderate abuse and dependency potential.

b. Seconal is a depressant containing Secobarbital, a Schedule II Controlled Substance as defined in § 161.01(4) and § 161.16(7)(c), Stats., with high abuse and severe dependency potential.

c. Nembutal is a depressant containing Pentobarbital, a Schedule II Controlled Substance as defined in § 161.01(4) and § 161.16(7)(b), Stats., with high abuse and severe dependency potential.

d. Placidyl is a depressant containing Ethchloruynol, a Schedule IV Controlled Substance as defined in § 161.01(4) and § 161.20(2)(b) and (d) with low abuse and limited dependency potential.

e. Phenergan with Codeine is a narcotic analgesic containing codeine phosphate, a Schedule V Controlled Substance as defined in § 161.01(4) and § 161.22(2)(a) with low abuse and limited dependency potential.

f. Parest and Quualude are depressants containing Methaqualone, and at the times relevant to this proceeding, were Schedule II Controlled Substances as defined in § 161.01(4) and § 161.16(b), Stats., with high abuse and severe dependency potential.

13. With some minor variations, between February 1975 and July 1987, Dr. Morris prescribed Tylenol #4 to the patient in a manner which would permit a fairly constant rate of consumption of 25-30 tablets each day. Dr. Morris regularly treated the patient with Tylenol #4 and Placidyl from August 28, 1978 to January 18, 1979; with Tylenol #4 and Seconal from January 1979, through the end of 1981; and with Tylenol #4 and Nembutal from October 15, 1981, through July 1987.

14. Dr. Morris first prescribed Seconal to the patient on March 16, 1976. Between March, 1976, and January, 1979, Dr. Morris prescribed Seconal in varying amounts at intervals ranging from approximately 15 days to approximately 8 months. Beginning in January 1979, Dr. Morris prescribed Seconal to the patient in a manner which would permit a fairly constant rate of consumption of 3 to 4 tablets of Seconal, 100 mg. each, each day, with some minor variations, through the end of 1981, when he ceased prescribing Seconal to the patient.

15. Dr. Morris first prescribed Nembutal to the patient on January 19, 1979. From January 19 to March 2, 1979, he prescribed a total of 27 tablets of Nembutal, 100 mg. each. On January 28, 1980, a year later, there was a two month trial of Nembutal, and beginning in October, 1981, Dr. Morris began to prescribe Nembutal, 100 mg. on a regular basis continuing through July 1987. With some variation, Dr. Morris prescribed a supply of 4 tablets of Nembutal, 100 mg. each day. Dr. Morris did not prescribe Seconal at the same time he prescribed Nembutal. While there is a brief period in early 1980 and late 1981 where the record shows Nembutal and Seconal being prescribed in close temporal proximity, it is clear that the two drugs were not supplied simultaneously. If the patient was getting Nembutal, she was not getting Seconal, and vice versa.

16. Dr. Morris prescribed Placidyl 750 to the patient for the first time on June 16, 1978, again on July 24, 1978, and began prescribing it regularly on August 28, 1978. The last prescription for Placidyl 750 for the patient was January 18, 1979. Over the course of the five-month course of Placidyl, during which time Dr. Morris did not prescribe Seconal or Nembutal, the patient received a prescription for Placidyl every 3 to 5 days, in varying

amounts. The amount prescribed and the period between prescriptions varied, so that the patient might have a supply of Placidyl to allow a rate of consumption as low as 1 tablet every two days, or as high as 9 tablets in one day. On average, the supply would support a rate of about 4 tablets per day.

17. Dr. Morris prescribed Phenergan with Codeine, 4 ounces or 120 cc. at a time, to the patient on several occasions from March 28, 1985 through July 1987. Dr. Morris never repeated the prescription more frequently than once every three days, and there are a number of 3, 4, and 6 month gaps between prescriptions. Over the twenty-six month period, there were a total of twenty-three prescriptions for 4 ounces or 120 cc. of Phenergan with Codeine.

18. Dr. Morris prescribed Parest to the patient between June 1974, and August 1978 at a rate of 6 to 7 tablets of Parest 400 per day. Dr. Morris prescribed one tablet of Quaalude to the patient on each of two days during a 14 day hospital stay in January 1971, but there is no evidence that he repeated the prescription thereafter.

19. Throughout the period June 1974 through July 1987, Dr. Morris saw the patient approximately once each week, and spoke to her on the telephone at least as often. Dr. Morris was familiar with all of the records of the patient's hospitalizations at St. Francis Hospital, and followed the patient closely.

20. Dr. Morris and the patient jointly agreed that the patient would not consume any medications from any other physician, and that the patient would not have more than several days' supply of medication at any time. Dr. Morris and the patient jointly agreed with Fred Von Fischer, a pharmacist at Holmen Drugs in Holmen, Wisconsin, that the patient would personally appear at Holmen Drugs to have prescriptions filled, and that she would not use other pharmacies.

21. The purposes of the agreements between Dr. Morris, the patient, and the pharmacist were to control the patient's medications to obtain optimal pain relief with minimal adverse effects, and to ensure that there was a single, unified approach to the patient's medications, and to ensurethat the patient was under consistent observation to minimize the chance of adverse consequences of the medications.

22. Over the years, Mr. Von Fischer became familiar with the patient, frequently observed her to be in significant pain, and never observed her to be intoxicated on the medications. Mr. Von Fischer recognized that the doses of the medications the patient was receiving were high, but did not believe the doses to be inappropriately high for this patient.

23. Dr. Morris relied upon Mr. Von Fischer as another source of information about the patient's condition, and consulted directly with the pharmacist frequently over the course of the years.

24. The patient was hospitalized or visited a hospital emergency room nineteen times during the thirteen years that Dr. Morris was her primary physician.

25. On December 21, 1974, the patient was seen at the Emergency Room of St. Francis hospital after the car she was driving left the road at about 8:00 a.m. The patient denied losing consciousness. She suffered a bloody nose and headache and stated she was dizzy. She was treated and released.

26. The next time the patient was seen at a hospital was Saturday, June 7, 1975, when she was treated at St. Francis for a broken finger resulting from a fall down the basement stairs sometime before 12:30 p.m. There is no indication in the record that the patient was anything other than sober.

27. The patient was hospitalized at St. Francis Hospital from July 1 to July 9, 1975, for gastroenteritis. The patient's condition was apparently consistent with gastroenteritis with no other complicating factor.

28. The patient was next hospitalized at St. Francis for one day on July 31, 1975, for treatment of an apparent reaction to Sparine in combination with Parest. When the patient presented at the hospital, she was confused, restless, and exhibiting muscle twitching.

29. The patient did not appear at a hospital again until December 11, 1975, for treatment of minor injuries to her left leg and foot from a fall. While she was at the hospital, she told a nurse she was considering a lawsuit because of the fall. There was no apparent connection between her medications and the fall.

30. From January 9 to January 14, 1976, the patient was hospitalized at St. Francis for treatment of gastroenteritis, acute dehydration, and chronic pain syndrome with depressive reaction. During this hospitalization, Dr. Morris requested a psychiatric consult. In his report, the psychiatrist states that he has known the patient for about four years at the point of this consult, and that "generally it appears that the patient has adjusted better during these last three years." The psychiatric consult report includes this evaluation:

On mental status examination the patient presents as an alert, cooperative 46-year-old female. She is able to understand and express herself quite well and demonstrates above average intelligence. She tends to use excessively defenses of denial, projection and rationalization although there are no indications to suggest a blatant thought process disorder. Her affect shows a combination of anger and slight evidences of anxiety and depression.

[The patient] appears to be extremely resistant to any kind of therapy at this time as she has in the past. She is very rigid in her defenses and seems to be unyielding. She is not interested in any other points of view. She seems to like the therapist as long as the therapist agrees with her and then promptly fires the therapist as soon as there seems to be some disagreement. She continues to play the game of "yes but" whenever alternatives and suggestions are arrived at making it almost impossible to really suggest any kind of changes in her life style. One gets the impression that [the patient] would not be happy if she did not have the maladjustment and the misery to contend with.

All in all this is not a very positive picture of [the patient] but the positive side of it is that presumably she has been doing better without using medications so blatantly excessively as she did years gone by, possibly this is the best adjustment to expect from [the patient.]

31. On Sunday, June 20, 1976, the patient presented at the St. Francis Hospital Emergency Room for treatment of a 1-inch laceration of her left thumb, sustained from a fillet knife. There is no indication of any connection between her medications and this accident with the knife.

32. The patient's next hospitalization was over one year later, from July 20 to July 27, 1977, for treatment of gastritis and chronic back pain. The patient presented herself at the hospital after considerable vomiting at home which failed to respond to any home-care remedy.

a. Dr. Morris sought consultation by another physician, Dr. Carlisle, and a psychologist. Dr. Carlisle's evaluation on July 22, 1977 reads:

HISTORY: This is a 47 year old lady being evaluated by me for chronic back and left knee pain. She has a long and complex history which is available in her prior records and will not be repeated here. Essentially she has almost constant low back pain and left knee pain with frequent

episodes of severe pain. This limits her activities and interferes with her sleep. She has had exhausted (sic) forms of therapy including 16 spinal operations, including multiple dorsal column stimulators as well as a perineal nerve stimulator on the left. She has also had psychiatric evaluations and multiple medications. She presently is on Tylenol #3 which seems to give her considerable relief. Her symptoms may be aggravated by a distressful home situation which is of many years duration.

DIAGNOSIS: Intractable pain, low back and left knee.

RECOMMENDATIONS: My only suggestion is that she be evaluated by Doctor Burnett, our clinical psychologist, and that she should try working with him primarily in the areas of hypnosis to see if she can get some pain relief through these methods. Otherwise, all other forms of treatment have been completely exhausted. It appears to me that she may be a good candidate for this autogenic type of therapy."

b. The patient agreed to work with Dr. Burnett in accordance with Dr. Carlisle's recommendations, to attempt non-medicinal pain control.

c. On two occasions during this hospitalization, the patient was observed to be unsteady on her feet and slurring her speech several hours following the administration of Parest for sleep.

i. According to the medication records and nursing notes, on July 21 at 9:00 p.m., the patient was settled for sleep. At 11:00 p.m., she had the Parest prescribed if needed for sleep. At 11:30 p.m., she was up to the bathroom; the nurse did not note anything further at that time. At 1:00 a.m. on July 22, the patient was up to the bathroom, and the nurse noted that she appeared unsteady and her speech was slurred. The nurse put the side rails up, and encouraged the patient to request assistance in getting out of bed. At 1:50 a.m., the patient was asleep. At 3:00 a.m., she was up to the bathroom. At 3:30 a.m., she told the nurse she was having pain in the left knee, and was given pain pills. At 4:15 a.m., she appeared to be sleeping.

ii. At 11:00 p.m. on July 23, the patient requested a sleeping pill, and was given a Parest. At 2:50 a.m. on July 24, the nurse noted that the patient had been awake most of the night, and gave her the two tablets of Tylenol #4 prescribed for when the patient requested pain medication. The nurse noted that the patient's speech was very

slurred and that she was unsteady on her feet. At 5:00 a.m., the nurse noted that the patient was asleep, but had been awake until 5:00 a.m.

33. The patient was next hospitalized from May 29 to June 11, 1978, at St. Francis Hospital. The chief complaint was pain in the back, hip, and leg. Dr. Morris called in Dr. J. Kwako for a consultation and assistance. Dr. Kwako noted that the patient was very depressed, in addition to being in pain, and began treatment with a TNS unit and training in biofeedback pain control. Dr. Morris noted that the patient had been working with Dr. Burnett on the "very important social factors" of the patient's condition, including difficulty in her marriage. Dr. Morris further noted that the patient has at times used excessive quantities of Tylenol #4 in an attempt to relieve her pain, and had used Parest heavily at times for sleep at night. Dr. Morris noted further that the patient was in severe pain on admission, and that treatment in the hospital resulted only in "some improvement." During this stay, Dr. Burnett saw her at least once, working on hypnosis skills for pain control. Dr. Kwako noted that the patient "is a very difficult person to work with" and expressed some reservations about the potential for progress without an intensive program in which the patient was not particularly interested.

34. On June 15, 1978, the patient was taken to Lutheran Hospital in La Crosse at the instigation of her husband, who called the police alleging that the patient had taken an overdose of medication. The patient stated that she and her husband had been having an argument, and physical examination revealed multiple linear abrasions to her arms and neck, consistent with her statement that her husband was frequently physically abusive during arguments. The patient did not wish to be in the hospital at all, but was given syrup of ipecac. The patient vomited a large amount, but no pills. During her stay, there were no signs of drug intoxication. Dr. Morris was apparently not contacted or informed of this incident.

35. The patient was hospitalized at St. Francis Hospital from July 2 to July 5, 1978. She was brought to the hospital by the police, who had been called to check on the patient because she was sleeping in her car. The admitting physician suspected over sedation; the patient entered the hospital unwillingly, but in preference to an alcohol recovery center to which she would have been taken had she refused hospitalization. The patient states that she had had an argument with her husband, who had become violent, and she had left home for a motel nearby. After taking a room, she drove to the rear of the motel, on the Mississippi River, to sit in her carand watch the river. The admission continued for treatment of low back pain with trigger point injections and oral analgesics. The nursing notes reflect continued therapy with Dr. Burnett.

36. From September 19 to September 25, 1978, the patient was hospitalized at St. Francis. The working diagnosis by Dr. Morris was gastritis due to over sedation and dehydration, and chronic back pain syndrome. The admitting history notes that the patient, a very thin woman of 49, had been eating no more than one meal a day for the previous week, and that her use of Benadryl in addition to Placidyl appeared to give her a strongly unpleasant reaction, with disorientation and physical weakness. The discharge summary, also by Dr. Morris, notes that the patient was probably using excessive medication at home. The nursing notes indicate that the patient ate little, but did increase liquid intake, and further record the patient's statement that she wanted to be thin because her husband disliked overweight women.

37. On December 7, 1978, the patient was brought to Lutheran Hospital by the police at her husband's instigation. He alleged that she had been drinking brandy in combination with her medications, and when the police arrived there was indeed a glass of brown liquid in front of the patient and an open bottle of liquor on the table. There is no mention of where the husband was when the police arrived. At the hospital, her speech was noted as slurred, but she was otherwise in good condition. She was admitted to the psychiatric unit, where the psychiatrist noted she was extremely angry and had slurred speech. The psychiatrist records that he talked with her, and she stated her desire to continue therapy with Dr. Burnett. An alcohol screen was negative. The patient was discharged the same day after the slurred speech cleared up. Dr. Morris was apparently not contacted or informed of this incident.

38. The next hospitalization was almost a year later, from November 10 to November 29, 1979, at St. Francis, for intractable pain and acute pain syndrome. The admitting physician was Dr. E.J. Carlisle, who described the patient's condition as severe distress with apparent agonizing pain, anxiety, and inability to cope. The admission's goal was to assist the patient in regaining control of her overall situation. During this hospitalization, the patient was seen by Dr. Annis, a surgeon, at the request of Dr. Carlisle. Dr. Annis reported on an examination of the patient, during which her speech became slurred after he denied the patient's request for surgical intervention for her back and leg pain. Throughout the nursing notes for this hospitalization, there are frequent notations indicating that the nurses believed the patient to be in significant pain.

39. Four months later, the patient was hospitalized at St. Francis Hospital for treatment of a broken left hip. The admitting diagnosis included intractable pain syndrome. The physiciansattending were Drs. Carlisle, Cady, and Morris. Dr. Carlisle performed the surgery, inserting a Harris nail. The patient complained of pain, and requested IM medication on several occasions. At one point, she told the nurse that the injection on the previous night was the

best relief for pain she had had in some time; the injection to which she referred was one-quarter of the dose of Dilaudid she had earlier in the hospitalization, diluted to the same volume. Dr. Carlisle then discontinued all Dilaudid, and ordered Benedryl injections for pain as needed. The patient complained of pain, and stated that she would leave if she couldn't have anything but Benedryl for pain. The patient did leave against medical advice, because of the withdrawal of analgesics.

40. Fourteen months later, the patient was hospitalized at St. Francis Hospital for treatment of a herniated disk, by Drs. Morris and Hruska, from May 3 to May 7, 1981. The patient had a myelogram, and a consultation by Dr. Hruska. Dr. Hruska stated that he believed surgical intervention was the only possibility for relief of the patient's pain. Dr. Hruska and Dr. Annis also recommended that the patient be seen by a pain specialist in Minneapolis, a recommendation to which Dr. Morris agreed and the patient apparently did as well. During this hospitalization in 1981, the patient was frequently noted to be in significant pain. The record contains a number of entries describing what appear to be deliberate shows of pain by the patient to emphasize her subjective complaints of pain. The nursing notes contain regular assessments that the patient was actually in significant pain.

41. There is no record in this proceeding of any hospitalization of the patient between 1981 and 1985.

42. From April 25 to May 3, 1985, the patient was hospitalized at St. Mary's Hospital in Milwaukee for evaluation of a transient ischemic attack; during this hospitalization, a carotid endarterectomy was performed. There are no nursing notes from this hospitalization in the record of this proceeding; the discharge summary notes that the patient was discharged on a variety of medications, including Nembutal 100 mg. four times at night for sleep and Tylenol #4 as needed.

43. One year later, the patient was hospitalized at Lutheran Hospital in La Crosse, overnight April 18-19, 1986. The patient was admitted through the emergency room, with an admitting diagnosis of unstable angina. The discharge summary includes a description of past medical history with emphasis on the 1978 admission to Lutheran instigated by the patient's husband calling the police as a result of a domestic dispute. The discharge summary notes that the patient was agitated, and notes that the physicians, being aware of the 1978 episode, believed her to be suffering withdrawal symptoms. The patient left against medical advice, with thepatient citing drug interactions and a violation of her contract with her physician if she stayed as the reason for leaving. Dr. Morris was not provided with a copy of the record of this hospitalization by Lutheran Hospital.

44. The final hospitalization of the patient during the period of time Dr. Morris was her primary physician took place November 14 to 26, 1986, at Lutheran Hospital in La Crosse. Dr. Morris was not provided a copy of the records of this hospitalization by Lutheran Hospital. The patient was admitted with complaints of angina, and another coronary artery bypass ensued. The discharge summary notes a diagnosis of codeine and barbiturate addiction. The nurses regularly noted the patient's complaints of back pain and apparently believed the complaints to be valid.

45. On three occasions during 1986-1987, a physician concluded that the patient was addicted to or psychologically dependent on the medications prescribed by Dr. Morris.

a. On November 25, 1986, on the basis of one contact with the patient, Dr. A. Erik Gunderson, M.D., informed Dr. Morris that the patient was suffering from chronic drug addiction

b. On December 3, 1986, on the basis of one contact with the patient, J. Robert Grove, M.D., informed Dr. Morris that the patient was psychologically dependent on the analgesic and barbiturate medications Dr. Morris was prescribing.

c. On June 7, 1987, on the basis of one contact with the patient, Michael Meythaler, M.D., informed Dr. Morris that the patient was addicted to Tylenol #4 and recommended a detoxification program for the patient.

C. 1987 - Present

46. In July 1987, Dr. Morris withdrew from the treatment of the patient, who entered and remains under the care of Dr. Meythaler.

47. Dr. Meythaler has a specialty in the treatment of chronic pain. There were no physicians in the La Crosse area with that specialty until Dr. Meythaler arrived in late 1986. Before moving to La Crosse, Dr. Meythaler was a member of a pain clinic in Tucson, Arizona.

48. On the basis of his long term care and treatment of the patient, Dr. Meythaler has concluded that the patient was not addicted to the medications Dr. Morris was prescribing for her.

49. Dr. Meythaler describes the patient here as a very unusual patient, stating that he has seen one or two others who may be equivalent, but he had less contact with the other patients than with this patient. This patient has an extremely high tolerance for medicines in general, a tolerance which Dr. Meythaler called "amazing" and which he believes is partially genetic and partially acquired.

50. Dr. Meythaler, in conjunction with the University of Wisconsin Pain Clinic, has shifted the patient from the large doses of Tylenol #4 to methadone, with the intent of avoiding the acetaminophen content of Tylenol #4 and providing a more even distribution of pain control through a longer-acting medication.

51. In the course of the patient's treatment prior to Dr. Meythaler accepting her as his patient, the patient had already been through every conceivable treatment modality for chronic pain, either before or during Dr. Morris treatment of the patient. The difference between Dr. Morris treatment plan for this patient and Dr. Meythaler's treatment plan for this patient is choice of the narcotic for the chronic opioid therapy, and a reduction in the sleeping medications for the patient. The patient does not sleep as well under Dr. Meythaler's treatment plan as she did under Dr. Morris care, and to this extent Dr. Meythaler's care is less beneficial for the patient than Dr. Morris's care.

52. Chronic opioid therapy is a legitimate medical practice for the control of chronic pain. It is a practice that is the subject of debate in the medical community, and it can appear to be the illicit supply of narcotics to addicts. Chronic opioid therapy is widely accepted by the medical community for the treatment of cancer pain, but somewhat less widely accepted for the treatment of pain of non-cancerous origin because of concern that the patient might become addicted to the drug.

53. Cancer pain and non-cancer pain can be equivalent.

54. The need for a high dose of narcotic analgesic is not necessarily a sign of addiction in a patient with pain.

55. The patient here has not demonstrated drug seeking behavior, has consistently been honest with her physicians about her use of medications even when it has put her in a bad light, and has good reason to be concerned about and fearful of withdrawal of or changes in her medications.

56. Dr. Morris' care of this patient was above the standard of minimally competent practice of medicine, and resulted in the patient becoming more functional and her pain coming under some reasonable level of control.

57. Dr. Morris' prescriptions of controlled substances to this patient were all supported by diagnosed, existing medical conditions.

58. The prescriptions issued by Dr. Morris for controlled substances for this patient were appropriate to the treatment of the patient's medical condition.

59. The prescriptions issued by Dr. Morris for controlled substances for this patient did not cause nor inappropriately exacerbate or complicate the patient's medical condition.

60. The prescriptions issued by Dr. Morris for controlled substances for this patient were reasonable, competent responses to this patient's condition and this patient's reaction to the medications prescribed, and did not create an unnecessary or unacceptable risk of physical or psychological dependence.

61. Dr. Morris adequately monitored his prescription and the patient's use of medications to avoid the risk of inappropriate or excessive prescribing.

CONCLUSIONS OF LAW

1. The Medical Examining Board has jurisdiction in this matter pursuant to § 448.02(3), Stats.

2. Dr. Morris' prescription practices in the care and treatment of this patient were entirely within the course of the legitimate practice of medicine, and do not constitute a violation of § 448.02(3), Stats., or § MED 10.02(2)(p), Wis. Admin. Code.

3. Dr. Morris' conduct and practice in the care and treatment of this patient was above minimal standards of acceptable medical practice, and protected the health, welfare and safety of this patient, and does not constitute a violation of § 448.02(3), Stats., or § MED 10.02(2)(h), Wis. Admin. Code.

ORDER

Now, therefore, the complaint against Dr. David Morris, respondent, is DISMISSED.

OPINION

There is no doubt that Dr. Morris prescribed relatively massive doses of drugs to this patient over an extended period of time. There is no doubt that the amount of drugs prescribed over the period of time involved here would generally be excessive. On the assumption that the patient here had a normal reaction to this quantity and duration of drugs, there was good justification for investigating this case.

What the testimony established in this case is, first, that the patient here does not fit the norm. She is exceptional. Her reaction to medication is far off the normal scale, to the point that a "normal" dose of a medication is not likely to have any effect on her. The state's witnesses clearly believe that the patient's tolerance for drugs is a result of years of excessive use of drugs, and a sign of her addiction. The state's witnesses are convinced that the patient is an addict, and that Dr. Morris is responsible, if not for making her so, for allowing her to continue so. Neither of the state's witnesses actually examined the patient, and neither of them have had any opportunity to know her as a patient. Both of the state's witnesses clearly use their experience and education as the basis for their opinions, but it is clear that this patient is far outside anything either of them have had any opportunity to study. The state's experts were observers looking at the objectively massive doses of drugs over a long period of time, and presuming normal reactions from the patient to the drugs, they concluded that Dr. Morris was not practicing as he should.

The flaw in the state's case is basic. The state used the imaginary normal patient as the reference point for judging Dr. Morris' care of this real patient, and the two are not comparable. Dr. Morris was charged with treating this patient, and only this patient, in a manner which was below the standard of minimally competent practice. Dr. Morris' treatment of this patient is the focus of the case, and the state cannot prove that his care of this patient was less than minimally competent by showing that the same treatment would have been less than minimally competent treatment of a patient with normal characteristics. The question is, did Dr. Morris do wrong by this patient? It does not make any difference whether the treatment would have been appropriate for anybody else if it was competent treatment for this patient. The answer is clear that Dr. Morris did right by this patient, even though it probably would have been the wrong treatment for just about any other patient.

There is no evidence to support the charge that Dr. Morris prescribed medications when not indicated by any diagnosed or then-existing medical condition. The records are replete with diagnoses and documentation of medical conditions, by physicians other than Dr. Morris and by many different nurses, supporting the use of the medications prescribed.

The charge that the medications caused or contributed to the patient's condition apparently has two axes. The first is that because of over-medication the patient was more likely to harm herself by accident, being intoxicated. The second is that her use of medications prescribed by Dr. Morris made treatment of her other conditions, notably coronary artery disease, more difficult. Both depend to some extent on accepting the premise that the patient was addicted to the medications; if she were, then her use of the medications would be an unnecessary

difficulty in the care of her coronary artery disease and other ailments, and it would be inappropriate because it increased her risk of accident in general. On the other hand, if she is not an addict, and the use of the medications is supported by diagnosed medical condition, then it is merely an incident of this patient's condition which complicates the treatment of other conditions. It would not be appropriate to refuse medications to a person simply because the medications will make treatment of other conditions somewhat more complicated.

There is no substantial evidence that the patient was consistently intoxicated on the drugs prescribed by Dr. Morris, or that the patient was more prone to accident because of the drugs than she would have been without them. It is true that the patient did at times demonstrate some signs of intoxication while on the drugs; it is not true that evidence consistently supports the proposition that the drugs caused the signs of intoxication. On the contrary, it is evident that the drugs consumed are not the only factor which determined whether the patient would exhibit symptoms Dr. Sorkin, one of the state's expert witnesses, identified as intoxication. On consistent doses of the same medications, the patient would sometimes be noted to show signs of intoxication, and sometimes not, even within the space of several hours or the same day. It is also quite clear that the patient was not normally intoxicated during the periods she was not in the hospital under nursing observation. What results is a conclusion that the patient may have been intoxicated on a number of occasions over a thirteen year period, but that the instances of possible intoxication were rare, and the frequency decreased as time went on. It is not reasonable to conclude that the instances of intoxication were sufficient to require that the patient's medications be withdrawn or substantially changed, given the clear benefit the patient received from the course of treatment and the absence of any alternative to severe unremitting pain

The charge that Dr. Morris created an unnecessary and unacceptable risk of psychological and physical dependence is again dependent on the premise that this is a patient who reacts in a normal fashion to medication. "Unnecessary" is a word which has no meaning without reference to some standard of need. The evidence is clear and very convincing that the patient needed large doses of medication; Dr. Meythaler testified that the patient has an amazing tolerance for drugs, and that the tolerance is only partially acquired. This patient has a genetic tolerance for drugs. She is certainly dependent on them; without them, she is in severe to agonizing pain. Dr. Morris did not create that dependence, and it is clear that he did not. This patient has, by all accounts, tried substantially everything known for the relief of pain, and for the aid of sleep. The only thing that consistently works is drug therapy. The patient's dependence on the drugs is neither unnecessary nor unacceptable because there was no alternative but pain and sleep deprivation.

It would have been unnecessary and unacceptable to condemn the patient to unremitting severe to agonizing pain, and create a situation where death would be a relief.

Finally, the charge that Dr. Morris failed to monitor and record his prescription practice with this patient is without foundation. It is true that he wrote a letter which stated that the patient had been taking up to a quantity of drugs which was less than the maximum intake the records showed had been prescribed, but it is also true that the letter accurately stated the general course. It is uncontroverted that Dr. Morris and the pharmacist who dispensed the drugs, and there was only one, were in frequent communication about the patient, the quantity and frequency of the prescriptions, and her condition when she appeared in person as required by an agreement between Dr. Morris, the pharmacist, and the patient, to fill the prescriptions. It is a highly unusual practice to follow the prescription of drugs so very closely.

The testimony and my comparison of the medical and hospital records with the testimony convinces me that Dr. Morris provided care to this patient at a standard substantially higher than minimal competence during the thirteen year period referenced in the complaint. There is absolutely no basis for the allegation that Dr. Morris administered, dispensed, prescribed, supplied or obtained controlled substances for this patient other than in the course of legitimate practice of medicine. The allegations of the second count of the complaint are evidently based upon a notably biased reading of the medical and hospital records of this patient, starting from the presumption that no patient could have a legitimate need for the medications of the character and quantity Dr. Morris prescribed for this patient over the duration of time the physician-patient relationship existed. The testimony and the records convince me that this patient did have a legitimate need for the medications prescribed; that over the thirteen year period cited in the complaint the patient had several isolated incidents of intoxication because of the medications; that there was no reasonable alternative to the course of medication overseen by Dr. Morris; that the patient received good care and her condition significantly improved as a result of Dr. Morris' care. The standard by which medical practice is judged is not perfection, but the level of competent reasoned care which is provided by other physicians in the same field. Shier v. Freedman, 58 Wis.2d 269 (1973), Zintek v. Perchik, 163 Wis.2d 439 (Ct. App. 1991).

Part of the problem of this case is determining the standard to be used to decide whether a physician is prescribing excessive quantities of controlled substances. The state's evidence in this case is that Dr. Morris prescribed more than the recommended dose of various drugs for this patient, and the state argues that by doing so he left the bounds of the legitimate practice of medicine and began to practice in a less than minimally competent fashion.

Implicitly, the state bases its case at least as much on the contents of the Physicians' Desk Reference as on the patient's condition, and the state's expert witnesses use the Physicians' Desk Reference as a measure of how far afield Dr. Morris wandered from appropriate practice.

The state's reliance on the Physicians' Desk Reference is misplaced. The recommended dose reflected in the Physicians' Desk Reference is nothing more than the manufacturer's statement to its potential customers of what it believes a particular drug will do at a particular level. The Physicians' Desk Reference is not a definitive statement of appropriate or legal practice of medicine, nor is it universally applicable to all patients.

It seems to me that the only legitimate standard against which to measure a physician's prescribing practice is the condition of the patient for whom the medications are prescribed. Absent unreasonable adverse effects on a patient, the physician's judgment of the appropriate medication really has to be respected. There is an obvious harm in using a heavily edited compilation of drug manufacturers' statements about their products as the standard of practice of medicine to control a physician's treatment of a patient. Consequently, I reject the state's theory that prescribing more than the Physicians' Desk Reference recommended dose is persuasive evidence of assisting illicit drug diversion, and I reject the notion that there is a necessary correlation between exceeding the Physicians' Desk Reference recommended dose of a medication and the less than competent practice of medicine.

The testimony of Dr. Sheila Sorkin, one of the state's experts in this case, is entitled to little weight. Her testimony consists mainly of her opinion that one incident after another is suggestive of the patient's drug intoxication. The incidents she cites are indeed in the record; however, the same record often includes the documentation necessary to rebut her conclusions, and it appears that the only thing she was looking for was support for the proposition that the patient was an addict. She apparently made no assessment of the patient's condition beyond that which would support the allegations of the complaint. The state's case was significantly weaker because of Dr. Sorkin's apparent premise that there really was nothing much the matter with this patient before Dr. Morris started treating her, and Dr. Sorkin's conviction that she is the best person to decide that the patient was an addict.

Although Dr. Sorkin points to numerous incidents as instances of drug intoxication, it is often doubtful that drugs were the operative factor in the symptoms she ascribes to drugs. The patient did not consistently react to constant doses of the medications with symptoms of intoxication, even within the span of a single day during any particular hospital stay. One example of the quality of Dr. Sorkin's testimony comes early in her testimony. On the first

hospitalization of this patient by Dr. Morris, prior to the period during which the complaint alleges his care was incompetent, Dr. Sorkin notes that the patient was slurring her speech and walking with a staggered gait. To Dr. Sorkin, this suggests drug induced intoxication. However, the hospitalization was for cellulitis of the face due to a dental infection, and low back pain radiating into the legs. The nursing notes are replete with the patient's complaints of pain. Dr. Sorkin does not mention anything but the drugs, the doses of which were fairly constant, while the staggered gait and slurred speech were isolated incidents. One need not have significant familiarity with painful legs or dentition to suppose that it hurt to walk and talk, with some noticeable effect on the quality of motion and speech. It would appear that if a person is going to lay staggered gait and slurred speech on an excess of medication, then, so long as the medication remains the same, so should the staggered gait and the slurred speech. Dr. Sorkin's signs of drug intoxication were passing, but the drugs were constant. It is only reasonable to conclude that some other factor was also involved, and the patient's clearly documented physical problems seem like good candidates for another factor.

Secondly, her reliance on the Physician's Desk Reference as a valid reference for the medication needs of this patient is misplaced. The records consistently show that this patient is extremely tolerant of medications, and did not react to them in the manner to be expected if the Physician's Desk Reference were a valid reference for her. Both of the state's experts point to this tolerance as a sign of drug addiction, but in order to accept the diagnosis of drug addiction it is necessary to ignore the deposition of her current treating physician, Dr. Meythaler. Dr. Meythaler once believed the patient to be a drug addict, but having more experience with her now, he no longer believes that she was addicted to any of the medications she was receiving from Dr. Morris.

Thirdly, neither Dr. Sorkin nor Dr. Jeffrey Patterson, the state's other expert, had the opportunity to develop any first-hand impression of this patient, and it is very clear that this patient is far outside the normal range of medical experience. On a review of the records, the state's witnesses must rely on their experiences with other patients, or as patients themselves, for drawing conclusions. Even a short-term personal knowledge of this patient will not necessarily produce an accurate conclusion because of the weight which people tend to give to past experience in interpreting new data.

I am particularly reluctant to credit Dr. Sorkin's testimony because of her apparent prejudice that long term use of controlled substances is conclusive proof of either drug abuse by the patient, malpractice by the physician, or both. Her testimony of her review of the records

of this patient must surely have noted every incident of slurred speech, staggering gait, lethargy, poor balance, confusion and anger that anyone ever noted about this patient between 1965 and 1987. To her, each of them suggested drug intoxication or confirmed her opinion that the patient was an addict. My conclusion that her testimony is the product of prejudice comes from my review of the records of the incidents she noted. In many cases the symptoms which suggest drug intoxication to Dr. Sorkin come and go independently of changes in medication doses. In many cases the behavior which suggests drug intoxication to Dr. Sorkin is at least equally plausibly explained as a symptom of pain or other real physical or emotional disability. It is not uncommon for a person with a painful back or leg to walk with a staggering gait, especially after prolonged bed rest, or for a person who is depressed to be lethargic. And, it is also demonstrably true from these records that the patient's emotional condition had a notable effect on her physical condition, to the point that a hospital psychiatric consult notes that a stressful conversation resulted in the patient having slurred speech.

There are several instances where the records do show the patient was intoxicated from excessive doses of medication. The records also show that Dr. Morris took the patient off the medication which was responsible for most of the instances. There are other scattered instances where it is reasonable to conclude that the patient was intoxicated on prescribed medications; it is not reasonable to conclude that Dr. Morris should have stripped the patient of the medications because of the scattered instances, or that he was practicing below the standard of minimal competence for a family practice physician on the basis of those instances.

Dr. Sorkin did a very thorough review of this patient's records, and demonstrated an impressive familiarity with them. The value of that familiarity is substantially diminished by her apparent failure to consider that there might be some factor other than drugs causing or contributing to the patient's behavior; her resistance to the idea that a competent physician might reasonably disagree with her; and her insistence that she is in a better position to know whether this patient is and was an addict than the chronic pain specialist who is and has been treating her since 1987. Dr. Sorkin is still rather new to the field of addiction medicine, and she has no base of knowledge on which to support an opinion about the treatment of chronic pain patients.

Jeffrey Patterson, D.O., is offered as the state's expert on the treatment of chronic pain. His testimony is entitled to substantially greater weight than Dr. Sorkin's because he has a fund of relevant knowledge and experience on which to base his opinion, and because his opinion about the care of this particular patient apparently takes into account her physical, emotional, and social situation. I am not willing to adopt his opinion for two reasons.

First, it is not clear that his opinion is based upon the standard of practice for a family physician between 1974 and 1987; at points, his testimony is couched in terms of "this day and age" and I doubt that he consistently adjusted his analysis of the records he reviewed to account for differences in medical practice relating to chronic pain treatment by family practice physicians between the relevant period and 1992. Nor does the record of this proceeding reflect at what point in his career Dr. Patterson would have developed sufficient familiarity with the relevant practice to be able to testify accurately today about the state of practice then, other than that it was sometime after 1976.

Second, the basis for Dr. Patterson's opinion is not as persuasive as the basis for the opinion of the Respondent's expert, David Dahl, M.D. Dr. Dahl is a neurologist who became licensed to practice in 1968. By 1974 he was developing a concentration in the treatment of chronic pain. From 1980 to 1987 he was director of the Mt. Sinai Medical Center (Milwaukee) Chronic Pain Management Program. He has been deeply involved in the case management of people whose pain treatment was beyond the ability of their regular physicians. His experience in this regard is substantially closer in time to the relevant period than is Dr. Patterson's apparent concentration, which is evident from Dr. Dahl's ability to distinguish clearly between practice at the time Dr. Morris is accused of violating standards and practice now.

Dr. Dahl's patients at the time he was running the chronic pain clinic included some who were apparently closely comparable to the patient Dr. Morris was treating. Dr. Patterson did not show familiarity with a similar patient profile. In this case, I believe that Dr. Dahl is more likely to be able to form a valid opinion of the quality and character of the care Dr. Morris provided to this patient than Dr. Patterson can.

The thrust of Dr. Dahl's testimony is that there is a small group of chronic pain patients for whom the best possible result is salvage rather than cure. Dr. Dahl testified that in the chronic pain center he ran, approximately one per cent of the patients fell into the "salvage" category, and that for that one per cent, the center focused on improving the patients' ability to function while controlling their pain with a regime of chronic narcotic medication. He testified that he did not object to the care Dr. Morris provided to this patient, that it appeared to him that Dr. Morris had conducted himself appropriately in treating this patient, that Dr. Morris had closely monitored the patient and her condition, and indicated that it is not incompetent care to treat an exceptional patient in an exceptional manner.

The patient testified in this case. Her testimony was clear, credible, and persuasive. She testified that she was much better off under the care of Dr. Morris than she had been before Dr. Morris began treatment of her chronic pain, and that over the period of time he was treating her,

her condition improved. Her subjective view is important, because it tells what she was experiencing and because it squares with the observations of her son, and the observations of the pharmacist who supplied the medications, both of whom testified. She was clear that part of her motive was to assist Dr. Morris to avoid unwarranted discipline for helping her. The patient clearly feels a debt to Dr. Morris, and credits him with saving her life. While the state apparently harbors some doubt, the patient obviously understands what this proceeding is and there is no evidence that she is anything other than the intelligent, competent person described in the various psychiatric and psychological consults in the record of this proceeding.

In this case, it is superficial to argue that a physician who would engage in long term high dose narcotic medication, and combine it with long term sedative medication, must be incompetent. The therapy is clearly exceptional, but so is the patient. The state focused on the therapy, but basically ignored the patient. The course of therapy Dr. Morris chose for this chronic pain patient is substantially similar to the therapy chosen by the patient's current chronic pain specialist, whose judgment was basically seconded by the University of Wisconsin Pain Clinic. The reason for choosing this type of therapy is that it alleviates a large part of the patient's pain and allows her to function in a manner close to normal. Considering the patient, her condition, and the alternatives available to her and Dr. Morris, I have no question that the course of therapy chosen was a reasonable, competent professional medical choice.

Dated this 14th day of August, 1992.

James E. Polewski

James E. Polewski
Administrative Law Judge

NOTICE OF APPEAL INFORMATION

(Notice of Rights for Rehearing or 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 decisi n. (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 court through a petition for judicial review.

2. Judicial Review.

Any person aggrieved by this decision has a right to petition f r 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 disposition 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 December, 22, 1992.