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STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

IN THE MATTER OF
DISCIPLINARY PROCEEDINGS AGAINST

LS9107033 MED

BRUCE GORDON, M.D.,

Respondent

FINAL DECISION AND ORDER

The parties to this proceeding for purposes of s. 227.53, Stats., are:

Bruce Gordon, M.D.
501 Copper Street
Hurley, WI 54534

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 during March, 1992. The Division of Enforcement was represented by Judith Mills Ohm. The Respondent, Bruce Gordon, M.D., appeared in person, represented by attorneys Curtis Swanson and Joy O'Grosky of the law firm Axley Brynelson, 2 E. Mifflin Street, Madison, Wisconsin 53701.

The administrative law judge filed his Proposed Decision on March 19, 1993. Attorney for Complainant filed her Objections to the Proposed Decision on April 26, 1993. Respondent's response to the objections was filed on May 25, 1993. Oral arguments on the objections were heard by the board on October 20, 1993, and the board considered the matter on that date.

Based upon the entire record and file in this matter, the Medical Examining Board makes the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Bruce Gordon, M.D., is the Respondent in this proceeding. He was born August 18, 1948, and is a physician licensed to practice medicine and surgery in the state of Wisconsin pursuant to license #19987, granted July 15, 1976.

2. Respondent specializes in internal medicine and practices in Hurley, Wisconsin.

3. Dilaudid is a narcotic analgesic containing hydromorphone, and is a Schedule II controlled substance as defined in ss. 161.01(4) and 161.16(2)(a)8, Wis. Stats., with high potential for abuse and potential for severe psychological or physical dependence. Dilaudid is a central nervous system depressant.

4. On May 14, 1981, Patient 1, a 39 year old black male with a history of heavy smoking and alcohol use, first presented at Respondent's office. Patient 1 has speech which is difficult to understand, and has a tested Full Scale IQ of 59. The office note indicates that Patient 1 had rhinitis, chronic low back pain, was on Dilaudid and was going to Chicago Pain Clinic. Respondent prescribed Dilaudid and Dimetapp.

5. On August 6, 1981, and November 6, 1981, Patient 1 presented at Respondent's office and was seen by Chris Haserodt, Respondent's physician's assistant. Mr Haserodt noted that Patient 1 had an upper respiratory infection and chronic low back pain. Mr. Haserodt refilled the prescription for Dilaudid and also prescribed Phenergan expectorant on both dates. Respondent reviewed and approved the medical treatment provided to Patient 1 by Mr. Haserodt.

6. On December 17, 1981, Patient 1 presented at Respondent's office. The office note indicates that the patient "wants #40 Dilaudid." Respondent refilled the Dilaudid prescription, 2 mg. #40. Respondent's office note also indicated "contacted Apoth [Apothecary Pharmacy] re. abuse."

7. Respondent treated Patient 1 in his office and wrote prescriptions or approved prescriptions for Patient 1 for Dilaudid on the following dates:

Date	Strength/Amount (Dilaudid)
1/14/82	2 mg. #40
1/28/82; 3/30/82	2 mg. #60

8. At the office visit on March 30, 1982, Patient 1 informed Dr. Gordon that he had been on a Social Security disability because of back pain since 1972. Dr. Gordon continued to write prescriptions for Dilaudid for Patient 1, and did so in the following amounts on the following dates:

4/28/82	2 mg. #60
6/24/82	4 mg. ?

9. On or about July 8, 1982, Dr. Gordon received medical records on Patient 1 from Dr. See, a Minnesota neurologist who had been treating Patient 1 for some time. The records document physical examinations showing back pain, and indicate a history of back pain, with some hospitalizations and an attempt at a myelogram, which the patient could not tolerate, and a history of medication with Dilaudid for pain control.

10. Dr. Gordon continued to prescribe Dilaudid to Patient 1, and did so in the following amounts:

7/29/82	4 mg. ?

11. On July 30, 1982, Dr. Gordon placed a note in his office records to the effect that Patient 1 had been taking Dilaudid since 1971, and that Patient 1 could be addicted to Dilaudid. He continued to prescribe Dilaudid to Patient 1, and did so in the following amounts:

9/13/82	4 mg. #75
11/8/82; 1/11/83	4 mg. #60

12. On February 15, 1983, Dr. Gordon's notes include the notation "beaten up in Duluth ? drug dealer." Dr. Gordon states that the note means Patient 1 was beaten by a person Patient 1 believed to be a drug dealer, not that Dr. Gordon suspected Patient 1 of being a drug dealer. At this office visit, Patient 1 delivered to Dr. Gordon the medical report of Dr. George M. Cowan, a psychiatrist and neurologist in Minnesota, prepared for a Social Security disability proceeding involving Patient 1. That report contained a synopsis of a detailed physical examination, and a history including 1 or 2 tablets of Dilaudid 4 mg. per day since 1971. The report concluded with a diagnostic impression of chronic low back pain syndrome, peripheral neuropathy, possibly secondary to alcohol, addiction to alcohol, and dependence on Dilaudid. Dr. Gordon continued to prescribe Dilaudid to patient 1, in the following amounts.

2/15/83	4 mg. #60

13. In early 1983, Dr. Gordon contacted the Iron County, Wisconsin, Sheriff's Department and told a detective that he had been prescribing Dilaudid for Patient 1 and two other African-American men from out of the area, and he asked if the Sheriff's Department would help him in determining if the men were legitimate patients or taking advantage of him. Dr. Gordon continued prescribing Dilaudid:

3/1/83	4 mg. #30

14. On February 28, 1983, an Administrative Law Judge for the U.S. Department of Health and Human Services issued a decision approving Patient 1's claim for Supplemental Security Income, following the Social Security Administration's decision that Patient 1 was not disabled, and Patient 1's appeal of that determination. The decision included a determination that Patient 1 was completely disabled from gainful employment because of chronic low back pain syndrome, chronic myofacial injury of the neck, cirrhosis of the liver, chronic alcohol abuse, and mental retardation with a Full-Scale IQ of 59. Dr. Gordon continued to prescribe Dilaudid:

5/6/83; 6/22/83; 7/22/83	4 mg. #60
9/15/83	4 mg. #75
11/22/83	4 mg. #60

15. In late 1983 or early 1984, Dr. Gordon was contacted by a detective of the Iron County, Wisconsin Sheriff's Department and informed that the Sheriff's Department was unable to pursue any investigation about the three patients to whom Dr. Gordon was prescribing Dilaudid, but that the information they had received from him would be shared with other law enforcement agencies. Dr. Gordon continued to prescribe Dilaudid:

1/12/84; 3/8/84;	
3/20/84; 8/3/84	4 mg. #60
8/17/84	4 mg. #25

16. On October 23, 1984, Dr. Gordon included the notation " ? under investigation by Clark County Sheriff for drug sales (phone call Clark County)." He continued to prescribe Dilaudid to the patient, in the following amounts.

10/23/84; 12/18/84; 2/12/85	4 mg. #60

17. On February 26, 1985, Dr. Gordon noted that Patient 1 reported that the police in Kansas City had taken all of his medications from him. He continued to prescribe Dilaudid, in the following amounts:

2/26/85	4 mg. #30
4/11/85	4 mg. #60

18. In May 1985, Dr. Gordon was informed by an officer of the Superior Police Department that the Superior Police Department was investigating Patient 1 and two other patients on suspicion of possible resale of Dilaudid. In June 1985, the same officer called Dr. Gordon to inform him that the police could not prove anything in regard to suspicions that Patient 1 was selling or abusing Dilaudid. Dr. Gordon informed the police that he would continue to treat Patient 1 as he had unless there were some evidence that Patient 1 was a drug abuser or drug dealer. He continued to prescribe Dilaudid in the following amounts:

6/6/85	4 mg. #60
8/1/85; 10/24/85; 1/6/86; 3/31/86; 9/10/86; 11/26/86; 2/11/87; 5/6/87	4 mg. #90
7/17/87	4 mg. #100 q. 4h. prn

19. On August 5, 1987, Patient 1 brought to Dr. Gordon a copy of a discharge summary from the Miller-Dwan Medical Center in Duluth, for an admission from June 17 to June 18, 1986, for the purpose of a lumbar myelogram and CT scan to assess the etiology of back and lower extremity discomfort. Findings were a lateral recess compression at the L4,5 level secondary to degenerative joint disease and a mild bulging of the L4,5 annulus. The neurosurgeon, Dr. Richard Freeman, recommended conservative treatment and discharged Patient 1 with a limited supply of Dilaudid. Dr. Gordon continued to prescribe Dilaudid:

11/20/87	4 mg. ? prn
3/9/88; 6/8/88; 8/31/88; 2/21/89; 6/2/89	4 mg. #90 [some are noted "q. 4h. prn" and some are noted "prn."]
7/7/89	4 mg. ? prn
9/5/89; 12/5/89; 3/6/90; 6/5/90; 9/10/90; 12/17/90	4 mg. q. 4h. prn
1/3/91	4 mg. #90 prn
2/26/91	4 mg. #120
5/21/91	4 mg. #90 q. 4h. prn
9/9/91	4 mg. #90 0-2/day

20. Dr. Gordon's prescriptions of Dilaudid to Patient 1 were adequately supported by patient history and examination.

21. Dr. Gordon's prescriptions of Dilaudid to Patient 1 were reasonable in amount, interval, and duration based on patient history and repeated examination and degree of supervision of the medication exercised by Dr. Gordon.

22. Dr. Gordon was well justified in not subjecting Patient 1 to the painful effects of repeating failed experiments with alternative therapies for pain control.

23. Dr. Gordon's prescription practice with regard to Dilaudid and Patient 1 demonstrated due regard for the possibility of drug abuse and diversion, and did not expose either the patient or the public to unreasonable or unacceptable risk of harm.

AS TO COUNTS II AND III

24. Actifed-C has antitussive, antihistaminic and nasal decongestant effects, contains codeine, and is a Schedule V controlled substance as defined in ss. 161.01(4) and 161.22(2)(a), Stats., with potential for abuse and physical or psychological dependence.

25. Robitussin-DAC has antitussive, expectorant and nasal decongestant effects, contains codeine, and is a Schedule V controlled substance as defined in ss. 161.01(4) and 161.22(2)(a), Stats., with potential for abuse and physical or psychological dependence.

26. Tussend is an antitussive and decongestant, contains hydrocodone, which is a narcotic analgesic, and is a Schedule III controlled substance, as defined in secs. 161.01(4) and 161.18(5)(d), Stats., with potential for abuse and physical or psychological dependence.

27. Tussionex is an antitussive, contains hydrocodone, which is a narcotic analgesic, and is a Schedule III controlled substance, as defined in secs. 161.01(4) and 161.18(5)(d), Stats., with potential for abuse and physical or psychological dependence.

28. Tranxene is a benzodiazepine, contains chlorazepate and is a Schedule IV controlled substance, as defined in secs. 161.01(4) and 161.20(2)(cp), Stats., with potential for abuse and physical or psychological dependence.

29. Librium contains chlordiazepoxide and is a Schedule IV controlled substance, as defined in secs. 161.01(4) and 161.20(2)(cm), Stats., with potential for abuse and physical or psychological dependence.

30. Xanax is benzodiazepine and contains alprazolam and is a Schedule IV controlled substance as defined in secs. 161.01(4) and 161.20(2)(a), Stats., with potential for abuse and physical or psychological dependence.

31. Dilaudid, Actifed with codeine, Robitussin-DAC, Tussend, Tussionex, Tranxene, Librium and Xanax are all central nervous system depressants.

32. Dr. Gordon wrote or approved prescriptions for Patient 1 for Actifed with codeine or Robitussin-DAC on the following dates: 12/17/81; 1/14/82; 9/10/82; 1/11/83; 2/15/83; 5/6/83; 6/22/83; 9/15/83; 11/22/83; 1/12/84; 3/8/84; 10/23/84; 2/26/85; 1/6/86; 2/21/89; 12/5/89; 12/17/90 and 2/26/91.

33. Dr. Gordon wrote or approved prescriptions for Patient 1 for Tussend or Tussionex on the following dates: 12/18/84; 2/12/85; 4/11/85; 6/6/85; 8/1/85; 3/31/86; 11/26/86; 2/11/87; 5/6/87; 6/8/88; 8/31/88 and 5/1/89.

34. Dr. Gordon's records for Patient 1 demonstrate that Patient 1 was prone to bronchitis, and upper respiratory infections. Dr. Gordon's notes of office visits by Patient 1 for the dates of the prescriptions of the narcotic antitussive/decongestant/expectorant medications almost always contain clear indications of examinations and history supporting the prescriptions for the medications on those dates.

35. Dr. Gordon wrote or approved prescriptions for Patient 1 for Tranxene on 3/30/82, 3/20/84, 8/3/84, 8/17/84 and 10/23/84. He wrote or approved prescriptions for Patient 1 for Librium on 5/6/83, 6/22/83 and 1/12/84. He wrote or approved prescriptions for Patient 1 for Xanax on 4/11/85, 6/6/85, 8/1/85, 10/24/85, 1/6/86, 3/31/86, 11/26/86, 12/5/89, 3/6/90, 6/5/90, 5/21/91 and 9/9/91.

36. Dr. Gordon was aware that Patient 1 used alcohol, and had noted alcohol on Patient 1's breath at office visits prior to July, 1982. On or about July 8, 1982, Dr. Gordon received medical records relating to Patient 1 from a neurologist in Minnesota; those records contained evidence of a history of alcoholism and a hospitalization in 1978 for alcoholic peripheral neuritis. Dr. Gordon's own records contain Dr. Gordon's diagnosis of Patient 1's alcoholism, and notes of Patient 1's statements to Dr. Gordon after 1983 that he was no longer drinking alcohol on a regular basis. On five occasions from late 1984 to January, 1986, Dr. Gordon's notes include mention of the odor of alcohol on Patient 1's breath during office calls. Dr. Gordon's records also contain notes that Patient 1 stopped all use of alcohol in February 1985, and notes of office visits from that time forward include notes of the Patient's continuing sobriety.

37. There was no adverse reaction by Patient 1 to the Librium, Tranxene, or Xanax prescribed by Dr. Gordon. The Librium, Tranxene and Xanax did not contribute to or exacerbate Patient 1's use of alcohol either alone or in combination with any of the other medications Dr. Gordon prescribed for Patient 1. The Librium, Tranxene, and Xanax enabled Patient 1 to completely stop the use of alcohol, and replaced alcohol as an antianxiety agent for Patient 1 on intermittent occasions of stress.

38. Codeine cough syrups are readily available without a prescription on consumer request at pharmacies in quantities equal to and frequencies greater than those prescribed for Patient 1 by Dr. Gordon. Codeine cough syrups are more effective than non-codeine cough syrups.

39. During the course of his treatment of Patient 1, Dr. Gordon prescribed, and Patient 1 used, a lumbar sacral corset. Patient 1 saw a chiropractor, who informed him that degenerative disk disease is not amenable to chiropractic treatment. Dr. Gordon discussed with Patient 1 the improbability that surgery would be effective in relieving his back pain. Over the course of his treatment with Dr. Gordon, Patient 1 adjusted his intake of Dilaudid but never developed any signs of tolerance to the medication. Patient 1, in accordance with Dr. Gordon's discussions with him, used the minimum amount of Dilaudid necessary to obtain pain relief, sometimes using half of one tablet per day, sometimes two tablets. Patient 1's consumption of the medication was at all times consistent with a person using the medication carefully for pain relief.

40. Dr. Gordon's treatment of Patient 1 with Dilaudid and benzodiazepines and codeine cough syrup provided Patient 1 with significant long term benefits; over the course of his treatment with Dr. Gordon, Patient 1 has substantially improved his personal care habits, has become completely sober from alcohol, has improved his ability to function despite a notably low IQ, and has developed and maintained a long term relationship with a primary care physician.

41. During the course of his treatment with Dr. Gordon, Patient 1 saw Dr. Gordon, Dr. Gordon's physician assistant, or Dr. Gordon's associate regularly, approximately every two to three months. The interval between visits to the clinic varies, but the overall course of the physician patient relationship was clearly established in fairly frequent visits.

42. Dr. Gordon's prescriptions of Dilaudid, Actifed with codeine, Robitussin-DAC, Tussend, Tussionex, Tranxene, Librium and Xanax to Patient 1 were well within legitimate professional practice based on patient history and examination, and demonstrated efficacy of the treatment provided for identified conditions.

43. Dr. Gordon was well justified in prescribing medications known to be effective for treatment of identified conditions in conservative amounts rather than subjecting Patient 1 to trials of medications which were known to be less effective or ineffective treatments of the identified conditions, and in treating the conditions of the presenting patient rather than treating the patient's condition without regard to the patient's economic, social, and personal circumstances.

44. Dr. Gordon acted appropriately in his prescribing practices with regard to Patient 1 when he continued to prescribe medications clearly indicated for the treatment of identified conditions despite having some concern that the patient was misleading him, and appropriately weighed the patient's interests in medical treatment more heavily than society's interests in preventing persons who are vaguely suspected of drug abuse from gaining access to controlled substances.

45. Dr. Gordon's prescribing practices with regard to Patient 1 did not expose either Patient 1 or the public to any unreasonable or unacceptable risk of harm.

AS TO COUNT IV

46. On November 8, 1982, Patient 1 presented at Dr. Gordon's office and reported chest pain when walking uphill for 2 blocks, accompanied by some shortness of breath. Dr. Gordon took a history, which indicated no family history of heart attack or stroke, and did a physical examination. Dr. Gordon noted a faint systolic ejection murmur, louder when the patient was sitting up, fainter when the patient was supine, with no gallop. Dr. Gordon assessed the patient's complaints on the visit to be angina and low back pain. The treatment plan was a trial of nitroglycerine, and consideration of a stress test.

47. On January 11, 1983, Patient 1 stated his symptoms as a tightness in his chest, rather than pain, when walking uphill, and some shortness of breath on level ground, and coughing up yellow sputum. Dr. Gordon assessed the situation as either bronchitis or angina, but considered the possibility of angina to be reduced substantially from the previous visit with the changed description of the discomfort, the productive cough, and no indication that the nitroglycerine had any effect. Dr. Gordon prescribed Amoxicillin for bronchitis, and continued to consider the possibility of a stress test.

48. On February 15, 1983, Patient 1 presented at Dr. Gordon's office again for treatment of low back pain, and made no complaint of continued chest pain.

49. Patient 1 returned to Dr. Gordon's office on May 6, 1983, complaining of low back pain and bronchitis. His productive cough was not accompanied by any pain.

50. On June 22, 1983, Patient 1 again returned to Dr. Gordon's office, complaining of back pain, and reported that he had been seen at a hospital 10 days previous for pneumonia, accompanied by a cough producing yellow sputum. The notes of the visit indicate that the patient's cough is improving, and that there is no problem with angina.

51. On March 20, 1984, Patient 1 reported to Dr. Gordon that 4 or 5 times per week he was having chest pains on walking uphill. The discomfort went away with less than 5 minutes rest, and there was no discomfort related to the exertion of climbing stairs or walking on level surfaces. Patient 1 reported at this visit that he had an uncle who had a heart attack when the uncle was less than 60 years old. Dr. Gordon did a physical examination, including a neck vascular examination showing no carotid bruits, and an examination of Patient 1's chest, showing his lungs to be clear and finding no murmur or gallop on listening to his heart. There was no edema, and good radial pulses. Dr. Gordon concluded that there was no obvious evidence of vascular disease, and decided to repeat a trial of nitroglycerine, with instructions to the patient to test if the nitroglycerine relieved the chest discomfort, and to call in before the next scheduled visit if anything happened.

52. On May 8, 1984, Patient 1 reported to Dr. Gordon that he had had a spell of tightness in his chest, which had been diagnosed as emphysema at St. Mary's Hospital Emergency Room in Duluth. Patient 1 continued a heavy smoking habit, which was regularly noted as an aggravating factor in his respiratory discomforts. Dr. Gordon examined the patient, and noted no wheezing or ronchi, no heart murmur or gallop, and no edema. Dr. Gordon assessed the symptoms as indicative of either coronary artery disease or chronic obstructive lung disease. Dr. Gordon dispensed a trial supply of Theo-Dur to address the possibility of emphysema or chronic obstructive lung disease. Dr. Gordon considered the likelihood that the patient was describing shortness of breath when he said "tightness in the chest," and also believed that coronary disease was less likely than pulmonary problems, given that the patient had recently visited a hospital emergency room and had been sent away with the understanding that his complaint of chest discomfort was not cardiac in origin.

53. By August 1984, Dr. Gordon was confident that the patient's chest symptoms were related to his chronic smoking, chronic obstructive lung disease, and that the patient's course made the probability of increasing angina, or unstable angina, very unlikely.

54. On October 24, 1985, Patient 1 reported that he had visited a hospital emergency room with a complaint of an aching chest, and had followed up with a stress test at a clinic in Superior. He described a treadmill stress test to Dr. Gordon, and reported that he was told that he did not have any heart disease and that his pain was probably from his back.

55. Dr. Gordon's treatment of Patient 1's complaint of chest pain was adequately supported by his clinical evaluation of Patient 1, and did not expose Patient 1 to an unreasonable or unacceptable risk of cardiac arrest or death.

AS TO COUNT V

Count V of the Amended Complaint was dismissed on motion of the Complainant, Division of Enforcement.

AS TO COUNTS VI AND VII

56. Patient 2 was a 54 year old black male who first came to Dr. Gordon on September 10, 1981. He told Dr. Gordon that he had had radical neck surgery for cancer, followed by radiation therapy earlier in 1981, and that he was using Dilaudid, 2 mg., one or two tablets per day for pain. The patient had a left radical neck scar and bilateral parotid enlargement, left greater than right. Dr. Gordon diagnosed acute pharyngitis, and prescribed antibiotics to treat the infection, and refilled a prescription for Dilaudid that had previously been filled at a pharmacy in Nebraska in June, 1981. Dr. Gordon noted the possibility that Patient 2 was abusing Dilaudid.

57. Patient 2 returned to Dr. Gordon on November 24, 1981, and stated that someone had stolen his Dilaudid. Dr. Gordon noted that at the time Patient 2 appeared in his office, Patient 2 was in no apparent distress, that it had been at least six months since the radical neck surgery had been done, and noted again the possibility that Patient 2 was abusing Dilaudid. Patient 2 stated that he had had an operation in Omaha to relieve hemorrhoids two or three weeks earlier, and that he was planning to return to Omaha in the second week of December. Dr. Gordon prescribed Dilaudid 2mg. #30 to Patient 2.

58. Patient 2 returned to Dr. Gordon's office on February 15, 1982, complaining of a sore throat. Dr. Gordon noted the Patient was hoarse and examined his throat, and diagnosed pharyngitis. The patient informed Dr. Gordon on this visit that he had been diagnosed with malignant neoplasm of the larynx. Dr. Gordon prescribed a Benedryl gargle and Dilaudid 4mg. #40 for continuing sporadic pain from the neck condition.

59. Patient 2 returned to Dr. Gordon's office on April 7, 1982, complaining of constipation and chronic indigestion. Dr. Gordon examined the patient, who was still hoarse, and noted that the left tonsilar area was still presenting some signs of a mild infection. Patient 2 told Dr. Gordon that he had been laid off from job as a truck driver, and was receiving unemployment compensation. The patient told Dr. Gordon that he was scheduled for a redirect laryngoscopy on May 5, 1982, in Omaha. Dr. Gordon ran a throat culture, which was negative, and refilled the Benedryl gargle from the previous visit, and prescribed Dilaudid 4mg. #60. Dr. Gordon discussed the cautions applicable to Dilaudid with the Patient on this visit.

60. At the April 7, 1982, visit, or shortly thereafter, Dr. Gordon received a letter from David G. Smith, M.D., who stated that Patient 2 was receiving radiation therapy for cancer of the larynx. The letter was dated November 5, 1979.

61. Patient 2 returned to Dr. Gordon's office on June 4, 1982, complaining of back pain from a recent lifting injury, a cough, nasal congestion, post-nasal discharge, a rash, and continuing sporadic pain from his throat and neck. Dr. Gordon examined Patient 2, and diagnosed a low back strain, for which he prescribed Norgesic Forte, Novahistine for the cough and congestion, Lotrimin lotion for the rash, and Dilaudid 4 mg. #50 for the throat and neck pain.

62. Dr. Gordon prescribed Dilaudid to Patient 2 on the following additional dates and amounts:

Dates	Strength/Amount
7/29/82	4mg. #60
8/26/82	4mg. #50
10/7/82; 12/17/82	4mg. #60

63. In early 1983, Dr. Gordon contacted the Iron County, Wisconsin, Sheriff's Department and told a detective that he had been prescribing Dilaudid for Patient 2 and two other African-American men from out of the area, and he asked if the Sheriff's Department would help him in determining if the men were legitimate patients or taking advantage of him. Dr. Gordon continued to treat Patient 2 with Dilaudid:

2/15/83; 4/26/83; 6/17/83; 8/18/83; 11/18/83; 1/17/84	4mg. #60

64. In late 1983 or early 1984, Dr. Gordon was contacted by a detective of the Iron County, Wisconsin Sheriff's Department and informed that the Sheriff's Department was unable to pursue any investigation about the three patients to whom Dr. Gordon was prescribing Dilaudid, but that the information they had received from him would be shared with other law enforcement agencies. In the absence of information that Patient 2 was misusing the medication, Dr. Gordon continued to prescribe Dilaudid:

2/24/84	4mg. #30
4/20/84; 6/20/84; 9/13/84; 11/8/84; 1/3/85; 3/8/85; 5/3/85	4mg. #60

65. In May 1985, Dr. Gordon was informed by an officer of the Superior Police Department that the Superior Police Department was investigating Patient 2 and two other patients on suspicion of possible resale of Dilaudid. In June 1985, the same officer called Dr. Gordon to inform him that the police could not prove anything in regard to suspicions that Patient 2 was selling or abusing Dilaudid. Dr. Gordon informed the police that he would continue to treat Patient 2 as he had unless there were some evidence that Patient 2 was a drug abuser or drug dealer. He prescribed Dilaudid to Patient 2 one last time on June 28, 1985, 4 mg. #60.

66. At each office visit during which Dr. Gordon prescribed Dilaudid for Patient 2, Dr. Gordon actually examined Patient 2. Dr. Gordon had been presented with actual physical evidence that Patient 2 had undergone both radiation treatment and surgical treatment for cancer in his neck, and Patient 2 continued to complain of sporadic pain as a result of that treatment and current cancer of the larynx. Dr. Gordon performed at least one examination during which he observed that a portion of Patient 2's larynx had been removed.

67. Dr. Gordon did not provide any medical care or treatment to Patient 2 after June, 1985.

68. Dr. Gordon prescribed Dilaudid for Patient 2 for almost four years without performing adequate physical evaluations and without obtaining adequate medical records to confirm a legitimate medical condition which would justify prescribing Dilaudid to Patient 2 on a regular basis over that period of time.

AS TO COUNT VIII

69. At Patient 2's first office visit with Dr. Gordon on September 10, 1981, his blood pressure was recorded as 170/90. On November 24, 1981, the second office visit, Patient 2's blood pressure was recorded as 188/100. On February 15, 1982, the third office visit, Patient 2's blood pressure was recorded as 190/100.

70. On April 7, 1982, Patient 2's fourth visit to Dr. Gordon's office, Patient 2's blood pressure was taken, but not recorded even though his blood pressure was elevated on the first three office visits.

71. On June 4, 1982, Patient 2's blood pressure was recorded as 192/96.

72. On July 29, 1982, Patient 2's blood pressure was recorded as 206/104. Dr. Gordon elicited a history from the patient that was positive for high blood pressure in his family, with both parents and one sister having diagnosed high blood pressure. Both parents had died of heart problems. Dr. Gordon started Patient 2 on Moduretic, a diuretic, for the treatment of the high blood pressure at this visit.

73. Dr. Gordon prescribed Moduretic, 5/50 1 tablet each day, to Patient 2 on August 26, October 7, and December 17, 1982, and on February 15, 1983. Patient 2 became non-compliant with the Moduretic for approximately three weeks, and Dr. Gordon resumed the treatment, one tablet per day, on April 26, 1983, and continued it on June 17, 1983. Dr. Gordon increased the dose to two tablets per day on August 18, 1983, and continued at that level on November 18, 1983.

74. On August 18, 1983 and November 18, 1983, Dr. Gordon added Corgard, 40 mg. each day, to the Moduretic treatment. Corgard is indicated for the management of hypertension.

75. On January 17, 1984, Dr. Gordon discontinued the Corgard and the Moduretic, and instituted Minizide, 1 mg., three times each day. Dr. Gordon continued this prescription on February 24 and April 20, 1984.

76. On June 20, 1984, Patient 2 reported swelling in both legs every other day, without any pain, and without any symptoms of dizziness or dyspnea on exertion. Dr. Gordon examined Patient 2 and noted no unusual lung or heart sounds, but did note 2+ edema in the lower extremities. Dr. Gordon assessed a need for better blood pressure control, and prescribed Lasix 40 mg. in addition to the Minizide prescription, which he continued. Lasix is a potent diuretic which, if given in excessive amounts, can lead to profound diuresis with water and electrolyte depletion.

77. Dr. Gordon saw Patient 2 again on September 13, 1984, and noted that the patient had 2+ edema of the feet. Dr. Gordon increased the Minizide to 2 mg. three times a day, and continued the Lasix at 40 mg. each day.

78. Dr. Gordon continued this course of treatment, Minizide 2 mg. three times a day, Lasix 40 mg. each day, on November 8, 1984, January 3, March 8, and May 3, 1985.

79. On examination January 3, 1985, Dr. Gordon assessed Patient 2 as having increased edema again, but no signs of congestive heart failure.

80. On June 28, 1985, Dr. Gordon discontinued the Lasix and started Bumex, 2 mg. each day, and continued the Minizide. Bumex is a potent diuretic which, if given in excessive amounts, can lead to a profound diuresis with water and electrolyte depletion.

81. Patient 2's blood pressure remained elevated from August 26, 1982 through June 28, 1985.

82. Dr. Gordon did not order any tests to monitor Patient 2's electrolytes and kidney function until June 28, 1985.

83. There is substantial variance in the practice of competent physicians in treating hypertension. Some physicians will investigate whether there has been end organ damage from existing hypertension before beginning to treat the hypertension, while others will treat the hypertension before investigating to determine whether there has already been damage done, and others will not investigate whether there has been end organ damage. In cases where the patient's blood pressure is only mildly elevated, it is unlikely that there has been end organ damage. Nonetheless, baseline evaluation of renal status and electrolytes is minimally necessary in treating a patient with hypertension.

AS TO COUNT IX

84. Patient 3, a 45-year old black male, first presented at Dr. Gordon's office on August 4, 1982, and was seen by Chris Haserodt, Dr. Gordon's physician's assistant. Patient 3 reported that he had been laryngectomized three years earlier, as treatment for cancer, and had a tracheostomy. Patient 3 stated that within the next several weeks he would be seeing a physician with whom he had previously established a physician-patient relationship for a reevaluation of possible metastases. On examination, Patient 3 had a cough with mucous production. Mr. Haserodt noted the

patient's appearance as "no distress" and prescribed Amoxicillin 250 t.i.d. and Dilaudid 2 mg. #60, two tablets every 8 hours as needed for pain. The prescription was approved by Dr. Gordon.

85. On August 13, 1982, Patient 3 returned to Dr. Gordon's office, and was seen by Dr. Gordon. Patient 3 stated that he was going to Canada, was planning to go to Dallas, Texas in October, and was using 2 to 4 Dilaudid each day. Dr. Gordon's assessment was that Patient 3 had malignant neoplasm of the larynx, and he prescribed Dilaudid 4 mg. #60.

86. Patient 3 returned to Dr. Gordon's office on August 27, 1982, with complaints of an ear ache, obstructed nasal passages, and sinus pain. Dr. Gordon prescribed Ampicillin 250, an oral decongestant, and Dilaudid #60, with and noted an assessment of cancer of the larynx.

87. Patient 3 returned to Dr. Gordon's office on October 6, 1982, complaining of a purulent discharge from the tracheostomy, and a cough producing clumps of mucous. Dr. Gordon noted Patient 3's appearance as "no distress" and prescribed Keflex, and refilled the Dilaudid, 4 mg. #60. Dr. Gordon also noted a plan to obtain chest x-rays if Patient 3's condition had not improved in seven to ten days.

88. On October 27, 1982, Patient 3 returned to Dr. Gordon's office, and complained of depression, reporting that he was separated from his wife and children. He told Dr. Gordon that he was drinking every day. Dr. Gordon diagnosed depression, and prescribed Desyrel, an antidepressant medication, and refilled the Dilaudid, 4 mg. #60.

89. On November 29, 1982, Patient 3 returned to Dr. Gordon's office, and Dr. Gordon continued his diagnosis of depression. Dr. Gordon discontinued the Desyrel, and prescribed Pamelor, an antidepressant, and Dilaudid, 4 mg. #60 for pain associated with cancer of the larynx.

90. Dr. Gordon's patient records for Patient 3 include either the Patient's report that he was drinking, or the objective assessment that the patient had alcohol on his breath, on eight occasions between March 1, 1983, and March 10, 1986.

91. Dr. Gordon prescribed Pamelor, 75 mg. to Patient 3 on January 4, 1983; June 1, 1983; July 15, 1983; August 12, 1983, and November 10, 1983.

92. Dr. Gordon saw Patient 3 on office visits, and prescribed Dilaudid 4 mg. #60 to Patient 3 on the following occasions: January 4, 1983; February 4, 1983; March 1, 1983;

April 12, 1983; June 1, 1983; July 15, 1983; August 12, 1983; October 7, 1983; November 10, 1983; December 22, 1983; February 3, 1984; March 2, 1984 (#30); May 7, 1984; June 25, 1984; August 20, 1984; October 22, 1984; December 17, 1984; February 28, 1985 and May 20, 1985.

93. On June 1, 1983, Dr. Gordon looked for needle tracks in Patient 3's extremities, but found none.

94. In late 1983, Dr. Gordon received a telephone call from Detective Richard Miller of the Duluth, Minnesota Police Department. Det. Miller was following up on an inquiry from a pharmacist in Superior, Wisconsin, who had been filling Dilaudid prescriptions written by Dr. Gordon for one of Dr. Gordon's patients. On the basis of Dr. Gordon's oral description of Patient 3, Det. Miller advised Dr. Gordon that he believed that Patient 3 was using an alias, and had previously been involved in a prescription scam. Det. Miller told Dr. Gordon that he would investigate, and contact him with the results of the investigation. Det. Miller later received photographs of several people from at least the Iron County, Wisconsin, Sheriff, and then dropped the investigation and did not contact Dr. Gordon. There is no evidence that Patient 3 is the person Det. Miller had in mind when he heard Dr. Gordon's description over the telephone, or that Patient 3 had previously been involved in any prescription violations.

95. On February 3, 1984, Dr. Gordon noted that Patient 3 had hypertrophic mucosa, and his records indicate that he questioned whether Patient 3 was using cocaine.

96. On or about October 22, 1984, Clark County law enforcement officials spoke with Dr. Gordon, informing him that Clark County officials believed that Patient 3 was using an alias in his dealings with Dr. Gordon, and that they suspected Patient 3 was engaging in illegal traffic of narcotics. Dr. Gordon asked what, if anything, he could do to assist with the investigation. As a result of that conversation, Dr. Gordon agreed to keep Patient 3 in the regular cycle, and informed Clark County of when he expected to see Patient 3 return.

97. On February 28, 1985, Patient 3 reported to Dr. Gordon that he had used "uppers" several months earlier, and that he had used intravenous drugs at some point in the past.

98. In May, 1985, Officer David St. John of the Superior Police Department notified Dr. Gordon that the Superior Police were investigating Patient 3 and two other patients for possible resale of Dilaudid.

99. On or about June 21, 1985, Officer St. John called Dr. Gordon and told him that Patient 3 had been using an alias when he presented at Dr. Gordon's office, and that Patient 3 had been arrested in Minneapolis on suspicion of resale of Dilaudid. Dr. Gordon told Officer St. John that Patient 3 would not get any more Dilaudid from him.

100. On March 10, 1986, Patient 3 presented at Dr. Gordon's office, reporting that he had a bad cold, low back pain, and left leg pain. Dr. Gordon noted on his chart that Patient 3 had alcohol on his breath, and that Patient 3 claimed he was not dealing drugs. Dr. Gordon assessed Patient 3's condition as depression and narcotic abuse, wrote the note "NO NARCOTIC MEDS AT ANY TIME" in Patient 3's chart, and prescribed Desyrel for the depression. Patient 3 never returned to Dr. Gordon's office.

101. Dr. Gordon prescribed Dilaudid to Patient 3 for three years without conducting physical evaluations sufficient to identify or confirm a medical condition which would justify regularly prescribing Dilaudid to Patient 3 for that period of time.

AS TO COUNT X

102. Dr. Gordon's records of Patient 3 note that Patient 3 was depressed on October 27, 1982, March 1, 1983, and include a diagnosis of depression on June 1, 1983. On July 15, 1983, Dr. Gordon listed Patient 3's chief complaint to be depression, and included the note that Patient 3 had reported that he had had a brain scan and that Patient 3 reported he had unusual thoughts. Patient 3 refused a referral to a psychiatric hospital.

103. Dr. Gordon noted that Patient 3 was depressed, or included a diagnosis of depression, in Patient 3's records on August 12, 1983, October 7, 1983, November 10, 1983, June 25, 1984, August 20, 1984, October 22, 1984, December 17, 1984, February 20, 1985 and May 20, 1985.

104. On Thursday, February 28, 1985, Patient 3 reported to Dr. Gordon that he "hears voices all night" and that he was "being told to kill people in his family." Dr. Gordon's assessment note was to question whether this was early psychosis, and Patient 3 agreed to return to Dr. Gordon's office on the following Monday. Patient 3 did not keep that appointment, and Dr. Gordon next saw Patient 3 when he returned to Dr. Gordon's office on May 20, 1985.

105. There is no reason to believe that Patient 3 was ever inclined to follow the instructions to harm his family he said he was hearing at night, and no evidence that he ever acted in any inappropriate fashion due to mental disease or defect.

106. The law in the state of Wisconsin in 1985 set a strict standard for emergency detention of people who are suspected to be mentally ill, and required evidence of recent overt action demonstrating that the person who was the subject of the emergency detention petition was likely to be an immediate danger to himself or others. A petition for emergency detention which was based on the expression of unusual thoughts, without corresponding action, was legally insufficient to permit the involuntary restraint of the person expressing the thoughts.

107. There is no substantial evidence that it is inappropriate to prescribe consistently stable doses of Dilaudid for pain control contemporaneously with medication for treatment of depression, or that the patient's abstinence from alcohol use is a prerequisite for medical treatment of depression or pain.

108. Dr. Gordon took reasonable action in setting an early return visit for Patient 3 when Patient 3 told him of hearing voices instructing him to kill members of his family, without indication that Patient 3 was inclined to follow the instructions.

AS TO COUNT XI

109. Dr. Gordon examined Patient 3 on August 13, 1982, and recorded Patient 3's blood pressure on that date as 140/90. Patient 3's next recorded blood pressure reading was 140/110 on January 4, 1983. Patient 3 was also seen by Dr. Gordon on August 27, October 6, October 27, and November 29, 1982.

110. Dr. Gordon examined Patient 3 on November 10, 1983, and recorded Patient 3's blood pressure on that date as 118/90. On December 22, 1983, Patient 3's blood pressure was recorded as 128/86. Patient 3 was also seen by Dr. Gordon on February 4, March 1, April 12, June 1, July 15, August 12, and October 7, 1983.

111. It was the practice in Dr. Gordon's office for a nurse or assistant to take the blood pressure of each patient on each visit, and to note the reading on a slip of paper separate from the patient file. There is no reason to believe that the care of Patient 3 deviated from that practice, and insufficient evidence to support the conclusion that Patient 3's blood pressure was not checked even though the reading was not recorded in the file.

112. On February 3, 1984, Patient 3's blood pressure was recorded as 116/90. Dr. Gordon prescribed Hygroton, 25 mg. Hygroton is a diuretic/antihypertensive.

113. On March 2, 1984, Patient 3's blood pressure was recorded as 120/86, Dr. Gordon continued the Hygroton, 25 mg.

114. On May 7, 1984, Patient 3 was again examined by Dr. Gordon, who continued the prescription for Hygroton. Dr. Gordon did not record Patient 3's blood pressure on that date.

115. On June 25, 1984, Patient 3 reported that he had visited Texas, had angina, and saw a physician who did not provide any medications but told him his heart was skipping beats. Dr. Gordon examined Patient 3 and noted no heart murmur or gallops, but an occasional irregular beat. Dr. Gordon did not obtain any records from the Texas physician, and elected to monitor Patient 3's condition rather than order tests at that time. Dr. Gordon continued the Hygroton and recorded Patient 3's blood pressure as 104/86.

116. Patient 3 continued to receive prescriptions for Hygroton at visits to Dr. Gordon approximately every two months through the end of May, 1985. Patient 3's blood pressure was recorded August 20, 1984 as 120/90; October 22, 1984, as 132/80; December 17, 1984, as 134/80; February 28, 1985, as 126/98, and May 20, 1985, as 142/84.

117. There is insufficient evidence to conclude that Patient 3's blood pressure was not consistently measured on his visits to Dr. Gordon's office, even though the measurements were not consistently recorded in the permanent file.

118. There is insufficient evidence to conclude that Dr. Gordon did not know Patient 3's blood pressure on May 7, 1984, when he continued the prescription for Hygroton as a result of the office visit on that date.

119. Dr. Gordon initiated treatment of Patient 3's hypertensive treatment without monitoring the patient's electrolytes and kidney function.

120. There is substantial variance in the practice of competent physicians treating hypertension. However, baseline evaluation of renal status and electrolytes is minimally necessary in treating a patient with hypertension.

CONCLUSIONS OF LAW

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

2. Dr. Gordon's conduct in prescribing Dilaudid to Patient 1 constituted the prescription of controlled substances in the course of legitimate professional practice, and did not violate s. MED 10.02(2)(p), Wis. Admin. Code or s. 448.02(3), Stats.

3. Dr. Gordon's conduct in prescribing Dilaudid in combination with Actifed with Codeine, Robitussin-DAC, Tussend, Tussionex, Tranxene, Librium and Xanax to Patient 1 constituted the prescription of controlled substances in the course of legitimate professional practice, and did not violate s. MED 10.02(2)(p), Wis. Admin. Code or s. 448.02(3), Stats.

4. Dr. Gordon's conduct in prescribing controlled substances to Patient 1 did not constitute any danger to the health, welfare or safety of either Patient 1 or the public, and did not violate s. MED 10.02(2)(h), Wis. Admin. Code, or s. 448.02(3), Stats.

5. Dr. Gordon's conduct in assessing Patient 1's history of chest pain and discomfort was at or above the standard of minimally competent physicians and did not constitute a danger to the health, welfare or safety of either Patient 1 or the public, and did not violated s. MED 10.02(2)(h), Wis. Admin. Code, or s. 448.02(3), Stats.

6. Dr. Gordon's conduct in prescribing Dilaudid to Patient 2 constituted prescribing controlled substances in the course of legitimate professional practice, and did not violate s. MED 10.02(2)(p), Wis. Admin. Code, or s. 448.02(3), Stats.

7. Dr. Gordon's conduct in prescribing Dilaudid to Patient 2 constituted a danger to the health, welfare or safety of Patient or public, in violation of sec. MED 10.02(2)(h), Code.

8. Dr. Gordon's treatment of Patient 2's hypertension constituted a danger to the health, safety or welfare of Patient 2, in violation of sec. MED 10.02(2)(h), Code.

9. Dr. Gordon's conduct in prescribing Dilaudid to Patient 3 constituted a danger to the health, safety or welfare of patient or public, in violation of sec. MED 10.02(2)(h), Code.

10. Dr. Gordon's treatment of Patient 3's hypertension constituted a danger to the health, welfare or safety of Patient 3 in violation of sec. MED 10.02(2)(h), Code.

ORDER

NOW THEREFORE, IT IS ORDERED that Bruce Gordon, M.D., be, and hereby is, reprimanded.

IT IS FURTHER ORDERED that within 60 days of the date hereof, Dr. Gordon shall participate in an assessment of his knowledge and skills in the practice of internal medicine to be conducted by the University of Wisconsin School of Medicine, Continuing Education Program. The assessment shall be coordinated by Dr. Thomas Meyer, Director of the Continuing Education Program. Dr. Gordon shall within 12 months of the date hereof, participate in and successfully complete any education program recommended pursuant to the assessment. At the conclusion of the program, if any, Dr. Meyer shall submit a report to the Medical Examining Board evaluating respondent's participation and performance in the program and indicating successful completion of the program if accomplished.

IT IS FURTHER ORDERED that Dr. Gordon shall within 12 months of the date hereof, satisfactorily complete the 45 hour program in prescribing controlled substances offered by the University of Medicine and Dentistry of New Jersey, including the clinical portion. In the alternative, Dr. Gordon shall satisfactorily complete the 25 hour program entitled Clinical and Ethical Issues in Prescribing Abusive Drugs, offered by the University of South Florida School of Medicine, Tampa Florida. Dr. Gordon shall release to the board all records of attendance and evaluation of performance for the program selected.

IT IS FURTHER ORDERED that all expenses incurred by Dr. Gordon in complying with this Order shall be borne by him.

EXPLANATION OF VARIANCE

The board has accepted the ALJ's suggested Findings of Fact for Counts I through V pertaining to Patient 1. The board has not accepted in their entirety the recommended findings pertaining to Patients 2 and 3. While the board does not find that Dr. Gordon's prescribing practice for these two patients was other than in the course of legitimate medical practice, it does find that his practice in that regard tended to constitute a danger to the health, welfare or safety of patient or public. Further, the board finds that Dr. Gordon's treatment of these two patients' hypertensive conditions also tended to constitute a danger to the health, welfare or safety of those patients. The specific variances from the Proposed Decision and the bases therefore are as follows:

1. **Paragraph 68 of the Proposed Decision found as follows:**

68. Dr. Gordon prescribed small amounts of Dilaudid to Patient 2, and required regular contact and monitoring of Patient 2's condition by means of the process he set for refilling the prescription. The prescriptions were consistent in dose and frequency, and were insufficient in amount or frequency to pose any unreasonable or unacceptable risk to either Patient 2 or the public.

The board instead finds as follows:

68. Dr. Gordon prescribed Dilaudid for Patient 2 for almost four years without performing adequate physical evaluations and without obtaining adequate medical records to confirm a legitimate medical condition which would justify prescribing Dilaudid to Patient 2 on a regular basis over that period of time.

The record is clear that Dr. Gordon either did not request or, if requested, did not receive prior medical records of Patient 2 other than a letter and consent form received on April 7, 1982, from the patient's previous treating physician certifying that Patient 2 was receiving radiation therapy for cancer of the larynx as of the time of the letter, which was dated October 18, 1979. The board accepts the expert testimony of Dr. Leon Radant that the mere presence of a scar and the presence of radiation changes on skin, without recourse to supporting medical records and in the absence of adequate medical evaluation, do not establish a basis for or justify prescribing Demerol for this patient on a repeated and prolonged basis. The board also agrees with Dr. Radant's testimony that Dr. Gordon's evaluation fell below minimum standards by failing to establish any basis for a clinical determination that the patient was experiencing chronic neuropathic pain (Tr., pp. 298-303).

2. **The Proposed Decision states as follows at Findings of Fact 82 and 83:**

82. Dr. Gordon did not order any tests to monitor Patient 2's electrolytes and kidney function until June 28, 1985. Patient 2's level of compliance with the medication plan for the treatment of his hypertension was not notably high during most of the course of Dr. Gordon's treatment of him, making test analysis premised on compliance with medication plans unreliable.

83. There is substantial variance in the practice of competent physicians in treating hypertension. Some physicians will investigate whether there has been end organ damage from existing hypertension before beginning to treat the hypertension, while others will treat the hypertension before investigating to

determine whether there has already been damage done, and others will not investigate whether there has been end organ damage. In cases where the patient's blood pressure is only mildly elevated, it is unlikely that there has been end organ damage.

Paragraphs 82 and 83 of this Final Decision and Order instead read:

> 82. Dr. Gordon did not order any tests to monitor Patient 2's electrolytes and kidney function until June 28, 1985.
>
> 83. There is substantial variance in the practice of competent physicians in treating hypertension. Some physicians will investigate whether there has been end organ damage from existing hypertension before beginning to treat the hypertension, while others will treat the hypertension before investigating to determine whether there has already been damage done, and others will not investigate whether there has been end organ damage. In cases where the patient's blood pressure is only mildly elevated, it is unlikely that there has been end organ damage. Nonetheless, baseline evaluation of renal status and electrolytes is minimally necessary in treating a patient with hypertension.

Dr. Radant testified that in his opinion the minimum standard of care in treating a patient presenting with hypertension would require an analysis of the patient's urine, electrolytes and electrocardiogram. When asked to explain the basis for that opinion, Dr. Radant responded:

> Well, basically one does these things to determine . . . whether there's an underlying etiology for the elevated blood pressure. Is this an individual who experiences underlying renal compromise or adrenal disorders that might be contributing to this particular problem. Further one wants to have a base line data -- database especially with electrolyte status if the consideration is one of using diuretics to treat this problem (Tr., pp. 313-314).

The board agrees.

3. **Proposed Decision Finding of Fact 84 states:**

> 84. Dr. Gordon prescribed low levels of diuretics for Patient 2, and the low dosages of the medications make it extremely unlikely that any electrolyte imbalance would occur even if Patient 2 had been particularly conscientious about not missing a dose.

It may be noted that even respondent's expert witness, Dr. Charles Steidinger, agreed that a patient's electrolyte levels should be checked periodically, and no less frequently than every six months when a diuretic is prescribed to determine whether the patient is suffering from electrolyte imbalance. In this case, Dr. Gordon did not monitor Patient 2's electrolytes until approximately three years following initiation of treatment for high blood pressure. The board agrees that Dr. Gordon's treatment thus fell below minimum standards, and this medically inaccurate finding has therefore been struck.

4. **Paragraph 85 of the Proposed Decision is as follows:**

> 85. Dr. Gordon's course of treatment of Patient 2's mild hypertension was based on adequate clinical evaluation of Patient 2 with consistent monitoring of the Patient on return visits at frequent intervals, and posed no unreasonable or unacceptable risk to Patient 2.

Consistent with the modification made to paragraph 83, this paragraph has also been struck.

5. **Paragraph 103 of the Proposed Decision reads as follows:**

> 103. Dr. Gordon's prescriptions of Dilaudid were based on clinical evaluation of Patient 3, which was repeated at frequent intervals, and which was adequate to support the prescription of the stable doses of Dilaudid prescribed to Patient 3.

Instead, the board finds as follows at paragraph 101:

> Dr. Gordon prescribed Dilaudid to Patient 3 for three years without obtaining an adequate medical history of Patient 3 sufficient to identify or confirm a medical condition justifying prescribing Dilaudid for that period of time.

Patient 3 had undergone a laryngectomy three years prior to prior to presenting at Dr. Gordon's office. There was general agreement that it would not be usual for the patient to continue to suffer serious chronic pain after such a period of time. Nonetheless, Dr. Gordon initiated a course of treatment for pain without having obtained the medical records which would have provided a basis for determining whether such treatment was indicated, instead relying on the patient's subjective report of his pain. The board agrees with Dr. Radant that minimum standards of care required that Dr. Gordon contact prior treating physicians to receive information necessary to establish whether ongoing treatment Dilaudid was indicated, especially in circumstances where questions were raised whether this patient may have been abusing the substance.

6. **Paragraph 104, as proposed, states:**

> 104. The Dilaudid prescribed was insufficient to pose any unreasonable risk of harm to Patient 3 or the public.

This paragraph has been struck. Absent clear justification for prescribing Dilaudid for this patient over a period of three years, given that this patient was an admitted abuser of alcohol and other drugs, and in light of an ongoing dialogue between Dr. Gordon and area law enforcement authorities pertaining to possible illegal drug activities by Patient 3, the board finds it impossible to conclude that this treatment regimen was "insufficient to pose any unreasonable risk of harm to Patient 3 or the public."

7. **The ALJ's finding at paragraph 110 states:**

> 110. There is no substantial evidence that it is inappropriate to prescribe consistently stable doses of Dilaudid for pain control contemporaneously with medication for treatment of depression, or that the patient's abstinence from alcohol use is a prerequisite for medical treatment of depression or pain.

As a general proposition, the cited statement is probably correct. Accordingly, the suggested corollary found at paragraph 12, standing alone, is not clearly erroneous. That paragraph reads:

> Dr. Gordon's conduct in prescribing Dilaudid for a patient he was treating for depression, knowing that the patient used alcohol, and knowing that the patient had reported unusual thoughts, did not constitute a danger to either the patient or the public.

However, having already found that Dr. Gordon's prescription of Dilaudid for Patient 3 in the total circumstances presented fell below minimum standards, this finding may not stand, and has therefore been struck.

8. **Findings of Fact 122 and 124 read as follows:**

> 122. There is sufficient evidence to conclude that Dr. Gordon performed an adequate evaluation of Patient 3's condition as borderline hypertensive before instituting treatment with small amounts of Hygroton.
>
> 124. There is substantial variance in the practice of competent physicians treating hypertension, and it is not unusual for a competent physician to treat mild hypertension with small doses of diuretic/antihypertensives without monitoring the patient's electrolytes or kidney function.

For the reasons set forth at section 2, above, the board has modified these findings at paragraphs 119 and 120 to read as follows:

> 119. Dr. Gordon initiated treatment of Patient 3's hypertensive treatment without monitoring the patient's electrolytes and kidney function.
>
> 120. There is substantial variance in the practice of competent physicians treating hypertension. However, baseline evaluation renal status and electrolytes is minimally necessary in treating a patient with hypertension.

9. Consistent with the foregoing modifications to the Findings of Fact, the board has made the following modifications to the Conclusions of Law:

a) The ALJ's Conclusion of Law at paragraph 7 finds that Dr. Gordon's conduct in prescribing Dilaudid to Patient 2 did not constitute a violation of sec. Med 10.02(2)(h), Code. The board instead finds that it did (See Finding of Fact 68).

b) The Proposed Decision concluded that Dr. Gordon's treatment of Patient 2 for hypertension did not violate sec. Med 10.02(2)(h), Code. The board finds that it did (see Findings of Fact 82 and 83).

c) The board has replaced the ALJ's conclusions at paragraphs 9 and 10 with the single conclusion that Dr. Gordon's prescribing of Dilaudid for Patient 3 violated sec. Med 10.02(2)(h), Code (see Finding of Fact 101).

d) The Conclusion of the ALJ that Dr. Gordon's handling of Patient 3's hypertension did not violate sec. Med 10.02(2)(h), Code, has been modified by the board to conclude that it did (see Findings of Fact 119 and 120).

10. Based upon the forgoing findings of violation, the board has ordered discipline as follows:

It is well settled that the purposes for discipline are to protect the public, to deter other licensees from engaging in similar misconduct, and to promote the rehabilitation of the licensee. *State v. Aldrich,* 71 Wis. 2d 206 (1976). Punishment of the licensee is not an appropriate consideration. *State v. McIntyre,* 41 Wis. 2d 481 (1961). There has never been any suggestion in this case that Dr. Gordon's treatment of any of these patients was other than properly motivated. The consideration of public protection therefore militates for nothing more than a reprimand as an expression of the board's disapproval, along with limitations on the license to address any possible problems with Dr. Gordon's practice skills. In requiring that Dr. Gordon successfully participate

in one of the two nationally recognized courses on prescribing abusable substances, the board addresses the one area of Dr. Gordon's practice where need for remediation has been fully demonstrated. In ordering that he submit to an assessment of his practice skills in the area of his specialty, any further need for remedial education will be determined. If such remedial education is found to be required, the board orders that it be undertaken and successfully completed.

Dated this 18th day of November, 1993.

STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

by _____
Clark O. Olsen, M.D.
Secretary

WRA:BDLS2:3864

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 c mmences 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 court 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 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 November 19, 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 dismiss the proceeding for review solely because of a failure to serve a copy of the petition upon a party or the party's 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.

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST BRUCE GORDON, M.D., RESPONDENT.	: : : :: :	NOTICE OF FILING PROPOSED DECISION LS9107033MED

TO: Curtis Swanson, Attorney
Joy O'Grosky, Attorney
2 East Mifflin St.
Madison, WI 53701
Certified P 992 818 934

Judith Mills Ohm, Attorney
Department of Regulation and Licensing
Division of Enforcement
P.O. Box 8935
Madison, WI 53708

PLEASE TAKE NOTICE that a Proposed Decision in the above-captioned matter has been filed with the Medical Examining Board by the Administrative Law Judge, James E. Polewski. A copy of the Proposed Decision is attached hereto.

If you have objections to the Proposed Decision, you may file your objections in writing, briefly stating the reasons, authorities, and supporting arguments for each objection. Your objections and argument must be received at the office of the Medical Examining Board, Department of Regulation and Licensing, Room 176, 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708, on or before April 26, 1993. You must also provide a copy of your objections and argument to all other parties by the same date.

You may also file a written response to any objections to the Proposed Decision. Your response must be received at the office of the Medical Examining Board no later than seven (7) days after receipt of the objections. You must also provide a copy of your response to all other parties by the same date.

The attached Proposed Decision is the Administrative Law Judge's recommendation in this case and the Order included in the Proposed Decision is not binding upon you. After reviewing the Proposed Decision, together with any objections and arguments filed, the Medical Examining Board will issue a binding Final Decision and Order.

Dated at Madison, Wisconsin this 19th day of March, 1993.

James E. Polewski
James E. Polewski
Administrative Law Judge

STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

IN THE MATTER OF
DISCIPLINARY PROCEEDINGS AGAINST

PROPOSED DECISION
LS9107033 MED

BRUCE GORDON, M.D.,

RESPONDENT.

The parties to this proceeding for purposes of s. 227.53, Stats., are:

Bruce Gordon, M.D.
501 Copper Street
Hurley WI 54534

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 during March, 1992. The Division of Enforcement was represented by Judith Mills Ohm. The Respondent, Bruce Gordon, M.D., appeared in person, represented by attorneys Curtis Swanson and Joy O'Grosky of the law firm Axley Brynelson, 2 E. Mifflin Street, Madison, Wisconsin 53701.

Upon the entire record and file 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.

FINDINGS OF FACT

1. Bruce Gordon, M.D., is the Respondent in this proceeding. He was born August 18, 1948, and is a physician licensed to practice medicine and surgery in the state of Wisconsin pursuant to license #19987, granted July 15, 1976.

2. Respondent specializes in internal medicine and practices in Hurley, Wisconsin.

3. Dilaudid is a narcotic analgesic containing hydromorphone, and is a Schedule II controlled substance as defined in ss. 161.01(4) and 161.16(2)(a)8, Wis. Stats., with high potential for abuse and potential for severe psychological or physical dependence. Dilaudid is a central nervous system depressant.

4. On May 14, 1981, Patient 1, a 39 year old black male with a history of heavy smoking and alcohol use, first presented at Respondent's office. Patient 1 has speech which is difficult to understand, and has a tested Full Scale IQ of 59. The office note indicates that Patient 1 had rhinitis, chronic low back pain, was on Dilaudid and was going to Chicago Pain Clinic. Respondent prescribed Dilaudid and Dimetapp.

5. On August 6, 1981, and November 6, 1981, Patient 1 presented at Respondent's office and was seen by Chris Haserodt, Respondent's physician's assistant. Mr Haserodt noted that Patient 1 had an upper respiratory infection and chronic low back pain. Mr. Haserodt refilled the prescription for Dilaudid and also prescribed Phenergan expectorant on both dates. Respondent reviewed and approved the medical treatment provided to Patient 1 by Mr. Haserodt.

6. On December 17, 1981, Patient 1 presented at Respondent's office. The office note indicates that the patient "wants #40 Dilaudid." Respondent refilled the Dilaudid prescription, 2 mg. #40. Respondent's office note also indicated "contacted Apoth [Apothecary Pharmacy] re. abuse."

7. Respondent treated Patient 1 in his office and wrote prescriptions or approved prescriptions for Patient 1 for Dilaudid on the following dates:

Date	Strength/Amount (Dilaudid)
1/14/82	2 mg. #40
1/28/82; 3/30/82	2 mg. #60

8. At the office visit on March 30, 1982, Patient 1 informed Dr. Gordon that he had been on a Social Security disability because of back pain since 1972. Dr. Gordon continued to write prescriptions for Dilaudid for Patient 1, and did so in the following amounts on the following dates:

4/28/82	2 mg. #60
6/24/82	4 mg. ?

9. On or about July 8, 1982, Dr. Gordon received medical records on Patient 1 from Dr. See, a Minnesota neurologist who had been treating Patient 1 for some time. The records document physical examinations showing back pain, and indicate a history of back pain, with some hospitalizations and an attempt at a myelogram, which the patient could not tolerate, and a history of medication with Dilaudid for pain control.

10. Dr. Gordon continued to prescribe Dilaudid to Patient 1, and did so in the following amounts:

7/29/82	4 mg. ?

11. On July 30, 1982, Dr. Gordon placed a note in his office records to the effect that Patient 1 had been taking Dilaudid since 1971, and that Patient 1 could be addicted to Dilaudid. He continued to prescribe Dilaudid to Patient 1, and did so in the following amounts:

9/13/82	4 mg. #75
11/8/82; 1/11/83	4 mg. #60

12. On February 15, 1983, Dr. Gordon's notes include the notation "beaten up in Duluth ? drug dealer." Dr. Gordon states that the note means Patient 1 was beaten by a person Patient 1 believed to be a drug dealer, not that Dr. Gordon suspected Patient 1 of being a drug dealer. At this office visit, Patient 1 delivered to Dr. Gordon the medical report of Dr. George M. Cowan, a psychiatrist and neurologist in Minnesota, prepared for a Social Security disability proceeding involving Patient 1. That report contained a synopsis of a detailed physical examination, and a history including 1 or 2 tablets of Dilaudid 4 mg. per day since 1971. The report concluded with a diagnostic impression of chronic low back pain syndrome, peripheral neuropathy, possibly secondary to alcohol, addiction to alcohol, and dependence on Dilaudid. Dr. Gordon continued to prescribe Dilaudid to patient 1, in the following amounts.

2/15/83	4 mg. #60

13. In early 1983, Dr. Gordon contacted the Iron County, Wisconsin, Sheriff's Department and told a detective that he had been prescribing Dilaudid for Patient 1 and two other African-American men from out of the area, and he asked if the Sheriff's Department would help him in determining if the men were legitimate patients or taking advantage of him. Dr. Gordon continued prescribing Dilaudid:

3/1/83	4 mg. #30

14. On February 28, 1983, an Administrative Law Judge for the U.S. Department of Health and Human Services issued a decision approving Patient 1's claim for Supplemental Security Income, following the Social Security Administration's decision that Patient 1 was not disabled, and Patient 1's appeal of that determination. The decision included a determination that Patient 1 was completely disabled from gainful employment because of chronic low back pain syndrome, chronic myofacial injury of the neck, cirrhosis of the liver, chronic alcohol abuse, and mental retardation with a Full-Scale IQ of 59. Dr. Gordon continued to prescribe Dilaudid:

5/6/83; 6/22/83; 7/22/83	4 mg. #60
9/15/83	4 mg. #75
11/22/83	4 mg. #60

15. In late 1983 or early 1984, Dr. Gordon was contacted by a detective of the Iron County, Wisconsin Sheriff's Department and informed that the Sheriff's Department was unable to pursue any investigation about the three patients to whom Dr. Gordon was prescribing Dilaudid, but that the information they had received from him would be shared with other law enforcement agencies. Dr. Gordon continued to prescribe Dilaudid:

1/12/84; 3/8/84;	
3/20/84; 8/3/84	4 mg. #60
8/17/84	4 mg. #25

16. On October 23, 1984, Dr. Gordon included the notation " ? under investigation by Clark County Sheriff for drug sales (phone call Clark County)." He continued to prescribe Dilaudid to the patient, in the following amounts.

10/23/84; 12/18/84; 2/12/85	4 mg. #60

17. On February 26, 1985, Dr. Gordon noted that Patient 1 reported that the police in Kansas City had taken all of his medications from him. He continued to prescribe Dilaudid, in the following amounts:

2/26/85	4 mg. #30
4/11/85	4 mg. #60

18. In May 1985, Dr. Gordon was informed by an officer of the Superior Police Department that the Superior Police Department was investigating Patient 1 and two other patients on suspicion of possible resale of Dilaudid. In June 1985, the same officer called Dr. Gordon to inform him that the police could not prove anything in regard to suspicions that Patient 1 was selling or abusing Dilaudid. Dr. Gordon informed the police that he would continue to treat Patient 1 as he had unless there were some evidence that Patient 1 was a drug abuser or drug dealer. He continued to prescribe Dilaudid in the following amounts:

6/6/85	4 mg. #60
8/1/85; 10/24/85; 1/6/86; 3/31/86; 9/10/86; 11/26/86; 2/11/87; 5/6/87	4 mg. #90
7/17/87	4 mg. #100 q. 4h. prn

19. On August 5, 1987, Patient 1 brought to Dr. Gordon a copy of a discharge summary from the Miller-Dwan Medical Center in Duluth, for an admission from June 17 to June 18, 1986, for the purpose of a lumbar myelogram and CT scan to assess the etiology of back and lower extremity discomfort. Findings were a lateral recess compression at the L4,5 level secondary to degenerative joint disease and a mild bulging of the L4,5 annulus. The neurosurgeon, Dr. Richard Freeman, recommended conservative treatment and discharged Patient 1 with a limited supply of Dilaudid. Dr. Gordon continued to prescribe Dilaudid:

11/20/87	4 mg. ? prn
3/9/88; 6/8/88; 8/31/88; 2/21/89; 6/2/89	4 mg. #90 [some are noted "q. 4h. prn" and some are noted "prn."]
7/7/89	4 mg. ? prn
9/5/89; 12/5/89; 3/6/90; 6/5/90; 9/10/90; 12/17/90	4 mg. q. 4h. prn
1/3/91	4 mg. #90 prn
2/26/91	4 mg. #120
5/21/91	4 mg. #90 q. 4h. prn
9/9/91	4 mg. #90 0-2/day

20. Dr. Gordon's prescriptions of Dilaudid to Patient 1 were adequately supported by patient history and examination.

21. Dr. Gordon's prescriptions of Dilaudid to Patient 1 were reasonable in amount, interval, and duration based on patient history and repeated examination and degree of supervision of the medication exercised by Dr. Gordon.

22. Dr. Gordon was well justified in not subjecting Patient 1 to the painful effects of repeating failed experiments with alternative therapies for pain control.

23. Dr. Gordon's prescription practice with regard to Dilaudid and Patient 1 demonstrated due regard for the possibility of drug abuse and diversion, and did not expose either the patient or the public to unreasonable or unacceptable risk of harm.

AS TO COUNTS II AND III

24. Actifed-C has antitussive, antihistaminic and nasal decongestant effects, contains codeine, and is a Schedule V controlled substance as defined in ss. 161.01(4) and 161.22(2)(a), Stats., with potential for abuse and physical or psychological dependence.

25. Robitussin-DAC has antitussive, expectorant and nasal decongestant effects, contains codeine, and is a Schedule V controlled substance as defined in ss. 161.01(4) and 161.22(2)(a), Stats., with potential for abuse and physical or psychological dependence.

26. Tussend is an antitussive and decongestant, contains hydrocodone, which is a narcotic analgesic, and is a Schedule III controlled substance, as defined in secs. 161.01(4) and 161.18(5)(d), Stats., with potential for abuse and physical or psychological dependence.

27. Tussionex is an antitussive, contains hydrocodone, which is a narcotic analgesic, and is a Schedule III controlled substance, as defined in secs. 161.01(4) and 161.18(5)(d), Stats., with potential for abuse and physical or psychological dependence.

28. Tranxene is a benzodiazepine, contains chlorazepate and is a Schedule IV controlled substance, as defined in secs. 161.01(4) and 161.20(2)(cp), Stats., with potential for abuse and physical or psychological dependence.

29. Librium contains chlordiazepoxide and is a Schedule IV controlled substance, as defined in secs. 161.01(4) and 161.20(2)(cm), Stats., with potential for abuse and physical or psychological dependence.

30. Xanax is benzodiazepine and contains alprazolam and is a Schedule IV controlled substance as defined in secs. 161.01(4) and 161.20(2)(a), Stats., with potential for abuse and physical or psychological dependence.

31. Dilaudid, Actifed with codeine, Robitussin-DAC, Tussend, Tussionex, Tranxene, Librium and Xanax are all central nervous system depressants.

32. Dr. Gordon wrote or approved prescriptions for Patient 1 for Actifed with codeine or Robitussin-DAC on the following dates: 12/17/81; 1/14/82; 9/10/82; 1/11/83; 2/15/83; 5/6/83; 6/22/83; 9/15/83; 11/22/83; 1/12/84; 3/8/84; 10/23/84; 2/26/85; 1/6/86; 2/21/89; 12/5/89; 12/17/90 and 2/26/91.

33. Dr. Gordon wrote or approved prescriptions for Patient 1 for Tussend or Tussionex on the following dates: 12/18/84; 2/12/85; 4/11/85; 6/6/85; 8/1/85; 3/31/86; 11/26/86; 2/11/87; 5/6/87; 6/8/88; 8/31/88 and 5/1/89.

34. Dr. Gordon's records for Patient 1 demonstrate that Patient 1 was prone to bronchitis, and upper respiratory infections. Dr. Gordon's notes of office visits by Patient 1 for the dates of the prescriptions of the narcotic antitussive/decongestant/expectorant medications almost always contain clear indications of examinations and history supporting the prescriptions for the medications on those dates.

35. Dr. Gordon wrote or approved prescriptions for Patient 1 for Tranxene on 3/30/82, 3/20/84, 8/3/84, 8/17/84 and 10/23/84. He wrote or approved prescriptions for Patient 1 for Librium on 5/6/83, 6/22/83 and 1/12/84. He wrote or approved prescriptions for Patient 1 for Xanax on 4/11/85, 6/6/85, 8/1/85, 10/24/85, 1/6/86, 3/31/86, 11/26/86, 12/5/89, 3/6/90, 6/5/90, 5/21/91 and 9/9/91.

36. Dr. Gordon was aware that Patient 1 used alcohol, and had noted alcohol on Patient 1's breath at office visits prior to July, 1982. On or about July 8, 1982, Dr. Gordon received medical records relating to Patient 1 from a neurologist in Minnesota; those records contained evidence of a history of alcoholism and a hospitalization in 1978 for alcoholic peripheral neuritis. Dr. Gordon's own records contain Dr. Gordon's diagnosis of Patient 1's alcoholism, and notes of Patient 1's statements to Dr. Gordon after 1983 that he was no longer drinking alcohol on a regular basis. On five occasions from late 1984 to January, 1986, Dr. Gordon's notes include mention of the odor of alcohol on Patient 1's breath during office calls. Dr. Gordon's records also contain notes that Patient 1 stopped all use of alcohol in February 1985, and notes of office visits from that time forward include notes of the Patient's continuing sobriety.

37. There was no adverse reaction by Patient 1 to the Librium, Tranxene, or Xanax prescribed by Dr. Gordon. The Librium, Tranxene and Xanax did not contribute to or exacerbate Patient 1's use of alcohol either alone or in combination with any of the other medications Dr. Gordon prescribed for Patient 1. The Librium, Tranxene, and Xanax enabled Patient 1 to completely stop the use of alcohol, and replaced alcohol as an antianxiety agent for Patient 1 on intermittent occasions of stress.

38. Codeine cough syrups are readily available without a prescription on consumer request at pharmacies in quantities equal to and frequencies greater than those prescribed for Patient 1 by Dr. Gordon. Codeine cough syrups are more effective than non-codeine cough syrups.

39. During the course of his treatment of Patient 1, Dr. Gordon prescribed, and Patient 1 used, a lumbar sacral corset. Patient 1 saw a chiropractor, who informed him that degenerative disk disease is not amenable to chiropractic treatment. Dr. Gordon discussed with Patient 1 the improbability that surgery would be effective in relieving his back pain. Over the course of his treatment with Dr. Gordon, Patient 1 adjusted his intake of Dilaudid but never developed any signs of tolerance to the medication. Patient 1, in accordance with Dr. Gordon's discussions with him, used the minimum amount of Dilaudid necessary to obtain pain relief, sometimes using half of one tablet per day, sometimes two tablets. Patient 1's consumption of the medication was at all times consistent with a person using the medication carefully for pain relief.

40. Dr. Gordon's treatment of Patient 1 with Dilaudid and benzodiazepines and codeine cough syrup provided Patient 1 with significant long term benefits; over the course of his treatment with Dr. Gordon, Patient 1 has substantially improved his personal care habits, has become completely sober from alcohol, has improved his ability to function despite a notably low IQ, and has developed and maintained a long term relationship with a primary care physician.

41. During the course of his treatment with Dr. Gordon, Patient 1 saw Dr. Gordon, Dr. Gordon's physician assistant, or Dr. Gordon's associate regularly, approximately every two to three months. The interval between visits to the clinic varies, but the overall course of the physician patient relationship was clearly established in fairly frequent visits.

42. Dr. Gordon's prescriptions of Dilaudid, Actifed with codeine, Robitussin-DAC, Tussend, Tussionex, Tranxene, Librium and Xanax to Patient 1 were well within legitimate professional practice based on patient history and examination, and demonstrated efficacy of the treatment provided for identified conditions.

43. Dr. Gordon was well justified in prescribing medications known to be effective for treatment of identified conditions in conservative amounts rather than subjecting Patient 1 to trials of medications which were known to be less effective or ineffective treatments of the identified conditions, and in treating the conditions of the presenting patient rather than treating the patient's condition without regard to the patient's economic, social, and personal circumstances.

44. Dr. Gordon acted appropriately in his prescribing practices with regard to Patient 1 when he continued to prescribe medications clearly indicated for the treatment of identified conditions despite having some concern that the patient was misleading him, and appropriately weighed the patient's interests in medical treatment more heavily than society's interests in preventing persons who are vaguely suspected of drug abuse from gaining access to controlled substances.

45. Dr. Gordon's prescribing practices with regard to Patient 1 did not expose either Patient 1 or the public to any unreasonable or unacceptable risk of harm.

AS TO COUNT IV

46. On November 8, 1982, Patient 1 presented at Dr. Gordon's office and reported chest pain when walking uphill for 2 blocks, accompanied by some shortness of breath. Dr. Gordon took a history, which indicated no family history of heart attack or stroke, and did a physical examination. Dr. Gordon noted a faint systolic ejection murmur, louder when the patient was sitting up, fainter when the patient was supine, with no gallop. Dr. Gordon assessed the patient's complaints on the visit to be angina and low back pain. The treatment plan was a trial of nitroglycerine, and consideration of a stress test.

47. On January 11, 1983, Patient 1 stated his symptoms as a tightness in his chest, rather than pain, when walking uphill, and some shortness of breath on level ground, and coughing up yellow sputum. Dr. Gordon assessed the situation as either bronchitis or angina, but considered the possibility of angina to be reduced substantially from the previous visit with the changed description of the discomfort, the productive cough, and no indication that the nitroglycerine had any effect. Dr. Gordon prescribed Amoxicillin for bronchitis, and continued to consider the possibility of a stress test.

48. On February 15, 1983, Patient 1 presented at Dr. Gordon's office again for treatment of low back pain, and made no complaint of continued chest pain.

49. Patient 1 returned to Dr. Gordon's office on May 6, 1983, complaining of low back pain and bronchitis. His productive cough was not accompanied by any pain.

50. On June 22, 1983, Patient 1 again returned to Dr. Gordon's office, complaining of back pain, and reported that he had been seen at a hospital 10 days previous for pneumonia, accompanied by a cough producing yellow sputum. The notes of the visit indicate that the patient's cough is improving, and that there is no problem with angina.

51. On March 20, 1984, Patient 1 reported to Dr. Gordon that 4 or 5 times per week he was having chest pains on walking uphill. The discomfort went away with less than 5 minutes rest, and there was no discomfort related to the exertion of climbing stairs or walking on level surfaces. Patient 1 reported at this visit that he had an uncle who had a heart attack when the uncle was less than 60 years old. Dr. Gordon did a physical examination, including a neck vascular examination showing no carotid bruits, and an examination of Patient 1's chest, showing his lungs to be clear and finding no murmur or gallop on listening to his heart. There was no edema, and good radial pulses. Dr. Gordon concluded that there was no obvious evidence of vascular disease, and decided to repeat a trial of nitroglycerine, with instructions to the patient to test if the nitroglycerine relieved the chest discomfort, and to call in before the next scheduled visit if anything happened.

52. On May 8, 1984, Patient 1 reported to Dr. Gordon that he had had a spell of tightness in his chest, which had been diagnosed as emphysema at St. Mary's Hospital Emergency Room in Duluth. Patient 1 continued a heavy smoking habit, which was regularly noted as an aggravating factor in his respiratory discomforts. Dr. Gordon examined the patient, and noted no wheezing or ronchi, no heart murmur or gallop, and no edema. Dr. Gordon assessed the symptoms as indicative of either coronary artery disease or chronic obstructive lung disease. Dr. Gordon dispensed a trial supply of Theo-Dur to address the possibility of emphysema or chronic obstructive lung disease. Dr. Gordon considered the likelihood that the patient was describing shortness of breath when he said "tightness in the chest," and also believed that coronary disease was less likely than pulmonary problems, given that the patient had recently visited a hospital emergency room and had been sent away with the understanding that his complaint of chest discomfort was not cardiac in origin.

53. By August 1984, Dr. Gordon was confident that the patient's chest symptoms were related to his chronic smoking, chronic obstructive lung disease, and that the patient's course made the probability of increasing angina, or unstable angina, very unlikely.

54. On October 24, 1985, Patient 1 reported that he had visited a hospital emergency room with a complaint of an aching chest, and had followed up with a stress test at a clinic in Superior. He described a treadmill stress test to Dr. Gordon, and reported that he was told that he did not have any heart disease and that his pain was probably from his back.

55. Dr. Gordon's treatment of Patient 1's complaint of chest pain was adequately supported by his clinical evaluation of Patient 1, and did not expose Patient 1 to an unreasonable or unacceptable risk of cardiac arrest or death.

AS TO COUNT V

Count V of the Amended Complaint was dismissed on motion of the Complainant, Division of Enforcement.

AS TO COUNTS VI AND VII

56. Patient 2 was a 54 year old black male who first came to Dr. Gordon on September 10, 1981. He told Dr. Gordon that he had had radical neck surgery for cancer, followed by radiation therapy earlier in 1981, and that he was using Dilaudid, 2 mg., one or two tablets per day for pain. The patient had a left radical neck scar and bilateral parotid enlargement, left greater than right. Dr. Gordon diagnosed acute pharyngitis, and prescribed antibiotics to treat the infection, and refilled a prescription for Dilaudid that had previously been filled at a pharmacy in Nebraska in June, 1981. Dr. Gordon noted the possibility that Patient 2 was abusing Dilaudid.

57. Patient 2 returned to Dr. Gordon on November 24, 1981, and stated that someone had stolen his Dilaudid. Dr. Gordon noted that at the time Patient 2 appeared in his office, Patient 2 was in no apparent distress, that it had been at least six months since the radical neck surgery had been done, and noted again the possibility that Patient 2 was abusing Dilaudid. Patient 2 stated that he had had an operation in Omaha to relieve hemorrhoids two or three weeks earlier, and that he was planning to return to Omaha in the second week of December. Dr. Gordon prescribed Dilaudid 2mg. #30 to Patient 2.

58. Patient 2 returned to Dr. Gordon's office on February 15, 1982, complaining of a sore throat. Dr. Gordon noted the Patient was hoarse and examined his throat, and diagnosed pharyngitis. The patient informed Dr. Gordon on this visit that he had been diagnosed with malignant neoplasm of the larynx. Dr. Gordon prescribed a Benedryl gargle and Dilaudid 4mg. #40 for continuing sporadic pain from the neck condition.

59. Patient 2 returned to Dr. Gordon's office on April 7, 1982, complaining of constipation and chronic indigestion. Dr. Gordon examined the patient, who was still hoarse, and noted that the left tonsilar area was still presenting some signs of a mild infection. Patient 2 told Dr. Gordon that he had been laid off from job as a truck driver, and was receiving unemployment compensation. The patient told Dr. Gordon that he was scheduled for a redirect laryngoscopy on May 5, 1982, in Omaha. Dr. Gordon ran a throat culture, which was negative, and refilled the Benedryl gargle from the previous visit, and prescribed Dilaudid 4mg. #60. Dr. Gordon discussed the cautions applicable to Dilaudid with the Patient on this visit.

60. At the April 7, 1982, visit, or shortly thereafter, Dr. Gordon received a letter from David G. Smith, M.D., who stated that Patient 2 was receiving radiation therapy for cancer of the larynx. The letter was dated November 5, 1979.

61. Patient 2 returned to Dr. Gordon's office on June 4, 1982, complaining of back pain from a recent lifting injury, a cough, nasal congestion, post-nasal discharge, a rash, and continuing sporadic pain from his throat and neck. Dr. Gordon examined Patient 2, and diagnosed a low back strain, for which he prescribed Norgesic Forte, Novahistine for the cough and congestion, Lotrimin lotion for the rash, and Dilaudid 4 mg. #50 for the throat and neck pain.

62. Dr. Gordon prescribed Dilaudid to Patient 2 on the following additional dates and amounts:

Dates	Strength/Amount
7/29/82	4mg. #60
8/26/82	4mg. $50
10/7/82; 12/17/82	4mg. #60

63. In early 1983, Dr. Gordon contacted the Iron County, Wisconsin, Sheriff's Department and told a detective that he had been prescribing Dilaudid for Patient 2 and two other African-American men from out of the area, and he asked if the Sheriff's Department would help him in determining if the men were legitimate patients or taking advantage of him. Dr. Gordon continued to treat Patient 2 with Dilaudid:

2/15/83; 4/26/83; 6/17/83; 8/18/83; 11/18/83; 1/17/84	4mg. #60

64. In late 1983 or early 1984, Dr. Gordon was contacted by a detective of the Iron County, Wisconsin Sheriff's Department and informed that the Sheriff's Department was unable to pursue any investigation about the three patients to whom Dr. Gordon was prescribing Dilaudid, but that the information they had received from him would be shared with other law enforcement agencies. In the absence of information that Patient 2 was misusing the medication, Dr. Gordon continued to prescribe Dilaudid:

2/24/84	4mg. #30
4/20/84; 6/20/84; 9/13/84; 11/8/84; 1/3/85; 3/8/85; 5/3/85	4mg. #60

65. In May 1985, Dr. Gordon was informed by an officer of the Superior Police Department that the Superior Police Department was investigating Patient 2 and two other patients on suspicion of possible resale of Dilaudid. In June 1985, the same officer called Dr. Gordon to inform him that the police could not prove anything in regard to suspicions that Patient 2 was selling or abusing Dilaudid. Dr. Gordon informed the police that he would continue to treat Patient 2 as he had unless there were some evidence that Patient 2 was a drug abuser or drug dealer. He prescribed Dilaudid to Patient 2 one last time on June 28, 1985, 4 mg. #60.

66. At each office visit during which Dr. Gordon prescribed Dilaudid for Patient 2, Dr. Gordon actually examined Patient 2. Dr. Gordon had been presented with actual physical evidence that Patient 2 had undergone both radiation treatment and surgical treatment for cancer in his neck, and Patient 2 continued to complain of sporadic pain as a result of that treatment and current cancer of the larynx. Dr. Gordon performed at least one examination during which he observed that a portion of Patient 2's larynx had been removed.

67. Dr. Gordon did not provide any medical care or treatment to Patient 2 after June, 1985.

68. Dr. Gordon prescribed small amounts of Dilaudid to Patient 2, and required regular contact and monitoring of Patient 2's condition by means of the process he set for refilling the prescription. The prescriptions were consistent in dose and frequency, and were insufficient in amount or frequency to pose any unreasonable or unacceptable risk to either Patient 2 or the public.

AS TO COUNT VIII

69. At Patient 2's first office visit with Dr. Gordon on September 10, 1981, his blood pressure was recorded as 170/90. On November 24, 1981, the second office visit, Patient 2's blood pressure was recorded as 188/100. On February 15, 1982. the third office visit, Patient 2's blood pressure was recorded as 190/100.

70. On April 7, 1982, Patient 2's fourth visit to Dr. Gordon's office, Patient 2's blood pressure was taken, but not recorded even though his blood pressure was elevated on the first three office visits.

71. On June 4, 1982, Patient 2's blood pressure was recorded as 192/96.

72. On July 29, 1982, Patient 2's blood pressure was recorded as 206/104. Dr. Gordon elicited a history from the patient that was positive for high blood pressure in his family, with both parents and one sister having diagnosed high blood pressure. Both parents had died of heart problems. Dr. Gordon started Patient 2 on Moduretic, a diuretic, for the treatment of the high blood pressure at this visit.

73. Dr. Gordon prescribed Moduretic, 5/50 1 tablet each day, to Patient 2 on August 26, October 7, and December 17, 1982, and on February 15, 1983. Patient 2 became non-compliant with the Moduretic for approximately three weeks, and Dr. Gordon resumed the treatment, one tablet per day, on April 26, 1983, and continued it on June 17, 1983. Dr. Gordon increased the dose to two tablets per day on August 18, 1983, and continued at that level on November 18, 1983.

74. On August 18, 1983 and November 18, 1983, Dr. Gordon added Corgard, 40 mg. each day, to the Moduretic treatment. Corgard is indicated for the management of hypertension.

75. On January 17, 1984, Dr. Gordon discontinued the Corgard and the Moduretic, and instituted Minizide, 1 mg., three times each day. Dr. Gordon continued this prescription on February 24 and April 20, 1984.

76. On June 20, 1984, Patient 2 reported swelling in both legs every other day, without any pain, and without any symptoms of dizziness or dyspnea on exertion. Dr. Gordon examined Patient 2 and noted no unusual lung or heart sounds, but did note 2+ edema in the lower extremities. Dr. Gordon assessed a need for better blood pressure control, and prescribed Lasix 40 mg. in addition to the Minizide prescription, which he continued. Lasix is a potent diuretic which, if given in excessive amounts, can lead to profound diuresis with water and electrolyte depletion.

77. Dr. Gordon saw Patient 2 again on September 13, 1984, and noted that the patient had 2+ edema of the feet. Dr. Gordon increased the Minizide to 2 mg. three times a day, and continued the Lasix at 40 mg. each day.

78. Dr. Gordon continued this course of treatment, Minizide 2 mg. three times a day, Lasix 40 mg. each day, on November 8, 1984, January 3, March 8, and May 3, 1985.

79. On examination January 3, 1985, Dr. Gordon assessed Patient 2 as having increased edema again, but no signs of congestive heart failure.

80. On June 28, 1985, Dr. Gordon discontinued the Lasix and started Bumex, 2 mg. each day, and continued the Minizide. Bumex is a potent diuretic which, if given in excessive amounts, can lead to a profound diuresis with water and electrolyte depletion.

81. Patient 2's blood pressure remained elevated from August 26, 1982 through June 28, 1985.

82. Dr. Gordon did not order any tests to monitor Patient 2's electrolytes and kidney function until June 28, 1985. Patient 2's level of compliance with the medication plan for the treatment of his hypertension was not notably high during most of the course of Dr. Gordon's treatment of him, making test analysis premised on compliance with medication plans unreliable.

83. There is substantial variance in the practice of competent physicians in treating hypertension. Some physicians will investigate whether there has been end organ damage from existing hypertension before beginning to treat the hypertension, while others will treat the hypertension before investigating to determine whether there has already been damage done, and others will not investigate whether there has been end organ damage. In cases where the patient's blood pressure is only mildly elevated, it is unlikely that there has been end organ damage.

84. Dr. Gordon prescribed low levels of diuretics for Patient 2, and the low dosages of the medications make it extremely unlikely that any electrolyte imbalance would occur even if Patient 2 had been particularly conscientious about not missing a dose.

85. Dr. Gordon's course of treatment of Patient 2's mild hypertension was based on adequate clinical evaluation of Patient 2 with consistent monitoring of the Patient on return visits at frequent intervals, and posed no unreasonable or unacceptable risk to Patient 2.

AS TO COUNT IX

86. Patient 3, a 45-year old black male, first presented at Dr. Gordon's office on August 4, 1982, and was seen by Chris Haserodt, Dr. Gordon's physician's assistant. Patient 3 reported that he had been laryngectomized three years earlier, as treatment for cancer, and had a tracheostomy. Patient 3 stated that within the next several weeks he would be seeing a physician with whom he had previously established a physician-patient relationship for a reevaluation of possible metastases. On examination, Patient 3 had a cough with mucous production. Mr. Haserodt noted the patient's appearance as "no distress" and prescribed Amoxicillin 250 t.i.d. and Dilaudid 2 mg. #60, two tablets every 8 hours as needed for pain. The prescription was approved by Dr. Gordon.

87. On August 13, 1982, Patient 3 returned to Dr. Gordon's office, and was seen by Dr. Gordon. Patient 3 stated that he was going to Canada, was planning to go to Dallas, Texas in October, and was using 2 to 4 Dilaudid each day. Dr. Gordon's assessment was that Patient 3 had malignant neoplasm of the larynx, and he prescribed Dilaudid 4 mg. #60.

88. Patient 3 returned to Dr. Gordon's office on August 27, 1982, with complaints of an ear ache, obstructed nasal passages, and sinus pain. Dr. Gordon prescribed Ampicillin 250, an oral decongestant, and Dilaudid #60, with and noted an assessment of cancer of the larynx.

89. Patient 3 returned to Dr. Gordon's office on October 6, 1982, complaining of a purulent discharge from the tracheostomy, and a cough producing clumps of mucous. Dr. Gordon noted Patient 3's appearance as "no distress" and prescribed Keflex, and refilled the Dilaudid, 4 mg. #60. Dr. Gordon also noted a plan to obtain chest x-rays if Patient 3's condition had not improved in seven to ten days.

90. On October 27, 1982, Patient 3 returned to Dr. Gordon's office, and complained of depression, reporting that he was separated from his wife and children. He told Dr. Gordon that he was drinking every day. Dr. Gordon diagnosed depression, and prescribed Desyrel, an antidepressant medication, and refilled the Dilaudid, 4 mg. #60.

91. On November 29, 1982, Patient 3 returned to Dr. Gordon's office, and Dr. Gordon continued his diagnosis of depression. Dr. Gordon discontinued the Desyrel, and prescribed Pamelor, an antidepressant, and Dilaudid, 4 mg. #60 for pain associated with cancer of the larynx.

92. Dr. Gordon's patient records for Patient 3 include either the Patient's report that he was drinking, or the objective assessment that the patient had alcohol on his breath, on eight occasions between March 1, 1983, and March 10, 1986.

93. Dr. Gordon prescribed Pamelor, 75 mg. to Patient 3 on January 4, 1983; June 1, 1983; July 15, 1983; August 12, 1983, and November 10, 1983.

94. Dr. Gordon saw Patient 3 on office visits, and prescribed Dilaudid 4 mg. #60 to Patient 3 on the following occasions: January 4, 1983; February 4, 1983; March 1, 1983; April 12, 1983; June 1, 1983; July 15, 1983; August 12, 1983; October 7, 1983; November 10, 1983; December 22, 1983; February 3, 1984; March 2, 1984 (#30); May 7, 1984; June 25, 1984; August 20, 1984; October 22, 1984; December 17, 1984; February 28, 1985 and May 20, 1985.

95. On June 1, 1983, Dr. Gordon looked for needle tracks in Patient 3's extremities, but found none.

96. In late 1983, Dr. Gordon received a telephone call from Detective Richard Miller of the Duluth, Minnesota Police Department. Det. Miller was following up on an inquiry from a pharmacist in Superior, Wisconsin, who had been filling Dilaudid prescriptions written by Dr. Gordon for one of Dr. Gordon's patients. On the basis of Dr. Gordon's oral description of Patient 3, Det. Miller advised Dr. Gordon that he believed that Patient 3 was using an alias, and had previously been involved in a prescription scam. Det. Miller told Dr. Gordon that he would investigate, and contact him with the results of the investigation. Det. Miller later received photographs of several people from at least the Iron County, Wisconsin, Sheriff, and then dropped the investigation and did not contact Dr. Gordon. There is no evidence that Patient 3 is the person Det. Miller had in mind when he heard Dr. Gordon's description over the telephone, or that Patient 3 had previously been involved in any prescription violations.

97. On February 3, 1984, Dr. Gordon noted that Patient 3 had hypertrophic mucosa, and his records indicate that he questioned whether Patient 3 was using cocaine.

98. On or about October 22, 1984, Clark County law enforcement officials spoke with Dr. Gordon, informing him that Clark County officials believed that Patient 3 was using an alias in his dealings with Dr. Gordon, and that they suspected Patient 3 was engaging in illegal traffic of narcotics. Dr. Gordon asked what, if anything, he could do to assist with the investigation. As a result of that conversation, Dr. Gordon agreed to keep Patient 3 in the regular cycle, and informed Clark County of when he expected to see Patient 3 return.

99. On February 28, 1985, Patient 3 reported to Dr. Gordon that he had used "uppers" several months earlier, and that he had used intravenous drugs at some point in the past.

100. In May, 1985, Officer David St. John of the Superior Police Department notified Dr. Gordon that the Superior Police were investigating Patient 3 and two other patients for possible resale of Dilaudid.

101. On or about June 21, 1985, Officer St. John called Dr. Gordon and told him that Patient 3 had been using an alias when he presented at Dr. Gordon's office, and that Patient 3 had been arrested in Minneapolis on suspicion of resale of Dilaudid. Dr. Gordon told Officer St. John that Patient 3 would not get any more Dilaudid from him.

102. On March 10, 1986, Patient 3 presented at Dr. Gordon's office, reporting that he had a bad cold, low back pain, and left leg pain. Dr. Gordon noted on his chart that Patient 3 had alcohol on his breath, and that Patient 3 claimed he was not dealing drugs. Dr. Gordon assessed Patient 3's condition as depression and narcotic abuse, wrote the note "NO NARCOTIC MEDS AT ANY TIME" in Patient 3's chart, and prescribed Desyrel for the depression. Patient 3 never returned to Dr. Gordon's office.

103. Dr. Gordon's prescriptions of Dilaudid were based on clinical evaluation of Patient 3, which was repeated at frequent intervals, and which was adequate to support the prescription of the stable doses of Dilaudid prescribed to Patient 3.

104. The Dilaudid prescribed was insufficient to pose any unreasonable risk of harm to Patient 3 or the public.

AS TO COUNT X

105. Dr. Gordon's records of Patient 3 note that Patient 3 was depressed on October 27, 1982, March 1, 1983, and include a diagnosis of depression on June 1, 1983. On July 15, 1983, Dr. Gordon listed Patient 3's chief complaint to be depression, and included the note that Patient 3 had reported that he had had a brain scan and that Patient 3 reported he had unusual thoughts. Patient 3 refused a referral to a psychiatric hospital.

106. Dr. Gordon noted that Patient 3 was depressed, or included a diagnosis of depression, in Patient 3's records on August 12, 1983, October 7, 1983, November 10, 1983, June 25, 1984, August 20, 1984, October 22, 1984, December 17, 1984, February 20, 1985 and May 20, 1985.

107. On Thursday, February 28, 1985, Patient 3 reported to Dr. Gordon that he "hears voices all night" and that he was "being told to kill people in his family." Dr. Gordon's assessment note was to question whether this was early psychosis, and Patient 3 agreed to return to Dr. Gordon's office on the following Monday. Patient 3 did not keep that appointment, and Dr. Gordon next saw Patient 3 when he returned to Dr. Gordon's office on May 20, 1985.

108. There is no reason to believe that Patient 3 was ever inclined to follow the instructions to harm his family he said he was hearing at night, and no evidence that he ever acted in any inappropriate fashion due to mental disease or defect.

109. The law in the state of Wisconsin in 1985 set a strict standard for emergency detention of people who are suspected to be mentally ill, and required evidence of recent overt action demonstrating that the person who was the subject of the emergency detention petition was likely to be an immediate danger to himself or others. A petition for emergency detention which was based on the expression of unusual thoughts, without corresponding action, was legally insufficient to permit the involuntary restraint of the person expressing the thoughts.

110. There is no substantial evidence that it is inappropriate to prescribe consistently stable doses of Dilaudid for pain control contemporaneously with medication for treatment of depression, or that the patient's abstinence from alcohol use is a prerequisite for medical treatment of depression or pain.

111. Dr. Gordon took reasonable action in setting an early return visit for Patient 3 when Patient 3 told him of hearing voices instructing him to kill members of his family, without indication that Patient 3 was inclined to follow the instructions.

112. Dr. Gordon's conduct in prescribing Dilaudid for a patient he was treating for depression, knowing that the patient used alcohol, and knowing that the patient had reported unusual thoughts, did not constitute a danger to either the patient or the public.

AS TO COUNT XI

113. Dr. Gordon examined Patient 3 on August 13, 1982, and recorded Patient 3's blood pressure on that date as 140/90. Patient 3's next recorded blood pressure reading was 140/110 on January 4, 1983. Patient 3 was also seen by Dr. Gordon on August 27, October 6, October 27, and November 29, 1982.

114. Dr. Gordon examined Patient 3 on November 10, 1983, and recorded Patient 3's blood pressure on that date as 118/90. On December 22, 1983, Patient 3's blood pressure was recorded as 128/86. Patient 3 was also seen by Dr. Gordon on February 4, March 1, April 12, June 1, July 15, August 12, and October 7, 1983.

115. It was the practice in Dr. Gordon's office for a nurse or assistant to take the blood pressure of each patient on each visit, and to note the reading on a slip of paper separate from the patient file. There is no reason to believe that the care of Patient 3 deviated from that practice, and insufficient evidence to support the conclusion that Patient 3's blood pressure was not checked even though the reading was not recorded in the file.

116. On February 3, 1984, Patient 3's blood pressure was recorded as 116/90. Dr. Gordon prescribed Hygroton, 25 mg. Hygroton is a diuretic/antihypertensive.

117. On March 2, 1984, Patient 3's blood pressure was recorded as 120/86, Dr. Gordon continued the Hygroton, 25 mg.

118. On May 7, 1984, Patient 3 was again examined by Dr. Gordon, who continued the prescription for Hygroton. Dr. Gordon did not record Patient 3's blood pressure on that date.

119. On June 25, 1984, Patient 3 reported that he had visited Texas, had angina, and saw a physician who did not provide any medications but told him his heart was skipping beats. Dr. Gordon examined Patient 3 and noted no heart murmur or gallops, but an occasional irregular beat. Dr. Gordon did not obtain any records from the Texas physician, and elected to monitor Patient 3's condition rather than order tests at that time. Dr. Gordon continued the Hygroton and recorded Patient 3's blood pressure as 104/86.

120. Patient 3 continued to receive prescriptions for Hygroton at visits to Dr. Gordon approximately every two months through the end of May, 1985. Patient 3's blood pressure was recorded August 20, 1984 as 120/90; October 22, 1984, as 132/80; December 17, 1984, as 134/80; February 28, 1985, as 126/98, and May 20, 1985, as 142/84.

121. There is insufficient evidence to conclude that Patient 3's blood pressure was not consistently measured on his visits to Dr. Gordon's office, even though the measurements were not consistently recorded in the permanent file.

122. There is sufficient evidence to conclude that Dr. Gordon performed an adequate evaluation of Patient 3's condition as borderline hypertensive before instituting treatment with small amounts of Hygroton.

123. There is insufficient evidence to conclude that Dr. Gordon did not know Patient 3's blood pressure on May 7, 1984, when he continued the prescription for Hygroton as a result of the office visit on that date.

124. There is substantial variance in the practice of competent physicians treating hypertension, and it is not unusual for a competent physician to treat mild hypertension with small doses of diuretic/antihypertensives without monitoring the patient's electrolytes or kidney function.

CONCLUSIONS OF LAW

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

2. Dr. Gordon's conduct in prescribing Dilaudid to Patient 1 constituted the prescription of controlled substances in the course of legitimate professional practice, and did not violate s. MED 10.02(2)(p), Wis. Admin. Code or s. 448.02(3), Stats.

3. Dr. Gordon's conduct in prescribing Dilaudid in combination with Actifed with Codeine, Robitussin-DAC, Tussend, Tussionex, Tranxene, Librium and Xanax to Patient 1 constituted the prescription of controlled substances in the course of legitimate professional practice, and did not violate s. MED 10.02(2)(p), Wis. Admin. Code or s. 448.02(3), Stats.

4. Dr. Gordon's conduct in prescribing controlled substances to Patient 1 did not constitute any danger to the health, welfare or safety of either Patient 1 or the public, and did not violate s. MED 10.02(2)(h), Wis. Admin. Code, or s. 448.02(3), Stats.

5. Dr. Gordon's conduct in assessing Patient 1's history of chest pain and discomfort was at or above the standard of minimally competent physicians and did not constitute a danger to the health, welfare or safety of either Patient 1 or the public, and did not violated s. MED 10.02(2)(h), Wis. Admin. Code, or s. 448.02(3), Stats.

6. Dr. Gordon's conduct in prescribing Dilaudid to Patient 2 constituted prescribing controlled substances in the course of legitimate professional practice, and did not violate s. MED 10.02(2)(p), Wis. Admin. Code, or s. 448.02(3), Stats.

7. Dr. Gordon's conduct in prescribing Dilaudid to Patient 2 did not constitute a danger to health, welfare or safety of Patient 2 or the public, and did not violate s. MED 10.02(2)(h), Wis. Admin. Code, or s. 448.02(3), Stats.

8. Dr. Gordon's treatment of Patient 2's hypertension did not constitute a danger to health, safety or welfare of Patient 2 or the public, and did not violate s. MED 10.02(2)(h), Wis. Admin. Code, or s. 448.02(3), Stats.

9. Dr. Gordon's conduct in prescribing Dilaudid to Patient 3 constituted prescribing controlled substances in the course of legitimate professional practice, and did not violate s. MED 10.02(2)(p), Wis. Admin. Code, or s. 448.02(3), Stats.

10. Dr. Gordon's treatment of Patient 3's depression, contemporaneously with prescribing Dilaudid, did not constitute a danger to health, welfare or safety of Patient 3 or the public, and did not violate s. MED 10.02(2)(h), Wis. Admin. Code, or s. 448.02(3), Stats.

11. Dr. Gordon's treatment of Patient 3's hypertension did not constitute a danger to the health, welfare or safety of Patient 3 or the public, and did not violate s. MED 10.02(2)(h), Wis. Admin. Code, or s. 448.02(3), Stats.

ORDER

NOW THEREFORE, IT IS ORDERED that the disciplinary proceedings against Dr. Bruce Gordon be, and hereby are, DISMISSED.

OPINION

COUNT I.

Count I of the Amended Complaint in this matter asserts that Dr. Gordon prescribed Dilaudid to Patient 1 otherwise than in the course of legitimate professional practice in the following respects:

> "Respondent prescribed Dilaudid to Patient 1 in excessive amounts and for excessive periods of time without having performed adequate physical examinations of Patient 1, without obtaining adequate medical histories of Patient 1 and without having identified and confirmed any legitimate medical condition which would justify prescribing Dilaudid to Patient 1"

Respondent prescribed Dilaudid to Patient 1 after Respondent suspected that Patient 1 was a probable drug addict, drug abuser or drug dealer, in the absence of any medical condition which would justify prescribing Dilaudid in spite of the patient history of probable drug addiction, drug abuse or drug dealing.

Respondent prescribed Dilaudid to Patient 1 without attempting any alternative therapies to address Patient 1's complaints of pain."

A.

The phrase "excessive amounts and for excessive periods of time" implies large quantities, a long time, and little need. The evidence is that Dr. Gordon prescribed consistent amounts of Dilaudid which would support a modest consumption rate by Patient 1. The evidence is that Patient 1 treated the medication with the respect it deserved, and consumed larger and smaller amounts of the medication depending on his need for pain relief. The evidence is that Patient 1 was and continues to be a patient who has intermittent episodes of significant pain, and that Dilaudid is an efficient medication for its relief.

The evidence is very clear and undisputed that Patient 1 is a man of limited intelligence and even more limited communication ability, and that it is extremely unlikely that any person would be able to obtain sufficient historically accurate information about his prior treating physicians to obtain records from any significantly distant place or time.

The evidence is very clear that Patient 1 has several patent, obvious causes of potential pain, and that Dr. Gordon has examined him regularly for a period of many years, had elicited oral communication from him over those years, and has developed a strong physician-patient relationship with him. Dr. Gordon is clearly a physician with a notably developed diagnostic skill, and it is clear that the rest of the professional medical community in and around Hurley relies on that skill in their own practices. It is possible that Dr. Gordon was and is wrong about Patient 1, and Patient 1 had and has no continuing need for Dilaudid. However, it is also clear that if Dr. Gordon is wrong, it is not because he has failed in any duty to identify the patient's condition, but only because the condition of the Patient's pain cannot be confirmed by any method which does not rely on the Patient's communication. Dr. Gordon believes the Patient; the State does not. It is the State's burden to prove that Dr. Gordon has failed to practice in a minimally competent fashion by crediting the Patient's reports of the Patient's condition, confirmed, to the extent that is possible, by the physician's evaluation. The State has failed to do that.

B.

The State has decided that Patient 1 probably is a drug abuser, drug addict, or drug dealer. The basis for the conclusion is, apparently, that Dr. Gordon thought there was a possibility that Patient 1 might be a drug abuser, and the fact that Patient 1 had abused alcohol. There is no evidence whatsoever to support a conclusion that it is more likely than not that Patient 1 actually was or is a drug abuser, drug addict, or drug dealer. In fact, the evidence is that the no police agency investigating the suspicion could prove any of that.

Dr. Gordon acted appropriately in considering the possibility that Patient 1 had no legitimate need for the medication he was requesting. Noting the possibility, and taking steps to check on the validity of the suspicion, is a sign of a competent physician. Deciding that the suspicion is not sufficient to override the Patient's reports of the Patient's condition, and the physician's own clinical evaluation of the Patient's condition, and continuing to prescribe Dilaudid is not a sign of reckless disregard for the possibility of drug abuse or diversion, but rather the common experience of physicians who believe their patients and trust their own evaluations despite the risk that they might be wrong. There is insufficient basis to conclude that Dr. Gordon was prescribing the medication to Patient 1 without regard to medical justification. That the State's expert disagrees with Dr. Gordon's judgment is not surprising, considering that the State's expert has little experience with chronic narcotic therapy and a demonstrable bias against the prescription of narcotics in any case. The Respondent's experts, Dr. Shannon, Dr. Talley, and Dr. Steidinger, all have substantially more experience in the use of narcotics and, perhaps not surprisingly, substantially less concern about the ability of physicians to prescribe them safely.

Part of the State's conclusion that Patient 1 is probably a drug abuser is that he is a black male who travels a significant distance to see Dr. Gordon and obtain a prescription for Dilaudid. Part of the basis is that he admittedly used alcohol inappropriately; part of the basis is that Dr. Radant, the State's expert, decided Patient 1 has an addiction prone personality. Dr. Radant does not have credentials sufficient to support that diagnosis of an addiction prone personality in the face of Dr. Shannon's testimony that Patient 1 has none of the signs of a narcotic addict. Dr. Shannon is a recognized national authority on narcotic addiction and abuse, who has made a career out of the study and treatment of narcotic addiction. His testimony in support of the conclusions Dr. Gordon drew about each of the Patients in this case is entitled to far greater weight than the testimony of Dr. Radant.

Patient 1 admittedly used alcohol inappropriately. He did so for the apparent purpose of self-medicating for chronic depression and anxiety. Dr. Talley, Respondent's expert on the medical treatment of depression and anxiety, spoke at some length of the tendency of persons who do not have access to more appropriate medications to use alcohol to treat the symptoms of depression. Dr. Talley pointed out that as Patient 1 obtained appropriate medical treatment for depression and anxiety, his use of alcohol decreased and stopped completely. It is more likely than not that Patient 1 was not abusing alcohol, but inappropriately self-medicating for depression and anxiety.

C.

The evidence is clear that Patient 1 reported that he had been treated at several pain clinics, without relief. The record contains the findings of a determination by an administrative law judge for the U.S. Department of Health and Social Services that Patient 1 is totally disabled by several causes, including chronic back pain. The determination of the federal ALJ was made in a case in which the social security administration, a division of the ALJ's employer, was attempting to cancel Patient 1's disability benefit payments. It is abundantly clear that Dr. Gordon had every reason to know and believe that Patient 1 was a person suffering from chronic intractable pain, who had already been tried on every reasonable alternative therapy to potent narcotics.

Nonetheless, Dr. Gordon did try some alternative therapies, including muscle relaxants and an LS corset. Dr. Shannon's testimony about the medical consequences of socio-economic status indicates that it is highly improbable that Patient 1, a poorly educated, unintelligent, economically disadvantaged middle aged African American male would be willing to spend time and money on treatment of less immediate benefit than the medication he knew was available and effective. As Dr. Shannon points out, people with less money are less likely to spend it in ways that do not obviously meet the need; his career in treating economically and socially disadvantaged populations provides the basis for his observation. That Patient 1 would prefer Dilaudid for pain relief is not surprising, in as much as it is undoubtedly more effective than a back brace and aspirin. Given that the potential for harm because of the use of Dilaudid as prescribed by Dr. Gordon is at best speculative, it is not reasonable to conclude that Dr. Gordon should have prescribed a less effective method of pain control for Patient 1.

The State asserts that Dr. Gordon's conduct in prescribing Dilaudid to Patient 1 subjected Patient 1 to unacceptable risks of drug abuse or dependence, or of exacerbating or perpetuating Patient 1's drug abuse or dependence, and of drug overdose. The possibility of all of this exists; Dr. Gordon clearly recognized it.

However, there is, it seems to me, a substantial difference between a possibility and an unacceptable risk. Any use of narcotics poses a risk; the question is, how big a risk and is the risk justified? The evidence in this case is that the risk was minimal, and well justified. It appears that Patient 1 is dependent, to some degree, on Dilaudid. That is unfortunate, but it is not any blot on Dr. Gordon that Patient 1 depends on Dilaudid for pain relief at times. There is substantial evidence that Patient 1 is functioning at a much higher level at the time of the hearing, because of Dr. Gordon's constant treatment, than he was when he first came to see Dr. Gordon. There is no evidence that Patient 1 is or was an addict or a drug dealer. Dr. Gordon's assessment of the risk of prescribing Dilaudid to Patient 1 would appear to have been correct.

COUNT II.

Count II of the Amended Complaint asserts that Dr. Gordon prescribed Dilaudid, Actifed with Codeine, Robitussin-DAC, Tussend, Tussionex, Tranxene, Librium and Xanax to Patient 1 otherwise than in the course of legitimate professional practice in the following respects:

> Respondent prescribed Dilaudid, Actifed with Codeine, Robitussin-DAC, Tussend, Tussionex, Tranxene, Librium and Xanax to Patient 1 for excessive periods of time.
>
> Respondent prescribed those medications to Patient 1 after he suspected Patient 1 was a probably drug addict, drug abuser, or drug dealer.
>
> Respondent prescribed those medications to Patient 1 without attempting alternative therapies to address Patient 1's complaints.
>
> Respondent prescribed those medications to Patient 1 without exchanging medical records with the other clinic where Patient 1 said he was being treated, to see if Patient 1 was getting controlled substances from the other clinic and to inform the other clinic that he was prescribing the medications for Patient 1.

A.

The testimony in this case includes Dr. Radant's criticism of Dr. Gordon's prescriptions of codeine antitussives, based in large part on Dr. Radant's impression that Dr. Gordon was prescribing codeine cough syrups at almost every office visit. On cross examination of Dr. Radant, Dr. Radant actually counted the number of office visits at which Dr. Gordon had prescribed codeine cough syrups and was compelled to substantially modify his testimony. Dr. Gordon had prescribed codeine cough syrups at several office visits, but it clearly was not a uniform practice. And, as the medical records and the testimony show, there was a good basis for the prescription on each

occasion. Further, the amount and frequency of the prescriptions was substantially less than would be available to Patient 1 on his own authority by signing for it at the pharmacy.

Dr. Talley testified that there was no reason not to prescribe the Tranxene, Librium, and Xanax to Patient 1 contemporaneously with the Dilaudid and the codeine cough syrup if he needed each of the medications. And, from the evidence, it is clear that Patient 1 benefited greatly from the Tranxene, Librium, and Xanax, to the point that he was able to stop using alcohol for relief of anxiety and depression.

B.

The State's allegation that Dr. Gordon suspected Patient 1 was a probable drug abuser, drug addict, or drug dealer is misleading. Dr. Gordon suspected that Patient 1 might possibly be a drug abuser, drug addict or drug dealer; he never believed it was probable that Patient 1 was any of those things. The combination of "suspect" and "probable" leads to the impression that Dr. Gordon thought Patient 1 probably was abusing or diverting drugs; if the evidence supported that impression, it would be appropriate to discipline Dr. Gordon. The evidence, however, is that while Dr. Gordon was concerned about the possibility, he did not ever think it was the probability.

Dr. Steidinger, Dr. Talley, and Dr. Shannon all indicated that it is always appropriate to be concerned about the possibility that the patient who is asking for potent narcotics is using the physician. They all indicated that it is grossly inappropriate for the physician to deprive a patient of pain relief because of the mere suspicion that the patient is using the physician, and the clear import of their testimony is that it is a violation of the physician's duty to permit the police to dictate whether a patient gets narcotics. In this case, the State emphasized the fact that Dr. Gordon received several contacts from law enforcement agencies as an indication that he knew, or should have known, that these Patients were violating the drug control laws. The fact that the police could not prove anything against any of the Patients was apparently not an important factor to the State. It was important to Dr. Gordon, and obviously would be to any patient who depends on narcotics for pain relief.

C.

Alternative therapies to codeine cough syrups are widely regarded as ineffective. Alternative therapies to Librium, Tranxene, and Xanax require either a great deal of time, the ability to significantly alter circumstances of life, or the acceptance of less desirable consequences. It is highly improbable that a person of low socio-economic

background and low intelligence, who is already self-medicating with alcohol, is an appropriate candidate for the less immediately effective therapies. Physicians should undoubtedly attempt the lowest level of medical intervention which will likely bring about the desired therapeutic result. Dr. Gordon cannot be faulted for considering that the alternatives to codeine cough syrups, Librium, Tranxene, and Xanax, or the like, were likely to be ineffective for this patient, in as much as there is a general recognition among the medical community that the alternatives are less effective. Drs. Talley and Steidinger testified in a manner which was both direct and clear in support of the therapy choices here, and even Dr. Radant will admit that codeine cough syrups are useful because they are effective, and tend to be more effective than non-codeine cough syrups.

D.

Dr. Gordon certainly could have, and perhaps even should have, exchanged records with the Duluth Clinic, to make sure that all the physicians treating Patient 1 were aware of each other. On the other hand, the failure to do so is not an indication that Dr. Gordon was prescribing controlled substances otherwise than in the course of legitimate professional practice. Even considering the decision not to exchange records in light of all the other allegations against Dr. Gordon related to Patient 1, there is no substantial reason to believe that Dr. Gordon was prescribing any of the medication to Patient 1 for other than legitimate medical treatment. The prescriptions may not have been the choice of all other physicians, but there is no reason to believe that the treatment choices were less than minimally competent.

The standard for judging whether the physician's conduct is less than minimally competent may include an assessment of the risk of harm to the patient. As the State points out, it is not necessary that harm actually occur, but that the risk of harm be present at an unacceptably high level. "Unacceptable risk" is a phrase which implies the recognition that competent medical treatment may carry with it some degree of risk to the patient; the issue is, how much risk is unacceptable? It seems to me that the State has a particularly difficult argument to make when it alleges that a course of treatment which resulted in significant improvement to the Patient's condition posed an unacceptable high risk of harm which not only did not occur, but was actually seen to become less probable as the treatment continued. In this case, the State argues that Dr. Gordon's use of prescription medication subjected Patient 1 to an unacceptable risk of drug abuse or dependence, or exacerbating the drug abuse or dependence the State insists Patient 1 exhibits. In fact, the record shows that Patient 1 steadily decreased his use of alcohol to the point that he stopped altogether; that over the course of his

treatment with Dr. Gordon, he became notably more functional and appeared to be enjoying life far more. To the extent that there was a risk in the course of treatment, it came at the beginning and the success of the therapy was demonstrated by the increasingly diminished risk. One has to choose between alternatives: either Patient 1's condition improved so dramatically by accident, even though Dr. Gordon was prescribing medications for other than legitimate medical reason, or, Dr. Gordon was pursuing a course of medical treatment in prescribing the medications. Given all of the circumstances here, it is far more likely that Dr. Gordon was practicing effective medicine than that he was writing prescriptions to supply a person he believed to be abusing drugs.

COUNT III.

Count III of the Amended Complaint asserts that Dr. Gordon's conduct in providing medical care and treatment to Patient 1 fell below minimum standards of practice established in the profession in the following respects:

> Respondent prescribed Dilaudid, in combination with other central nervous system depressants, to Patient 1 for at least 10 years, knowing that Patient 1 had abused alcohol, without adequate evaluation of Patient 1's complaints and without trials of alternative therapy.
>
> Respondent prescribed Dilaudid, in combination with other central nervous system depressants, knowing that Patient 1 had abused alcohol and after Respondent suspected that Patient 1 was a probable drug addict, drug abuser or drug dealer, without adequate caution with regard to the combined sedative effect of those drugs.

The complaint asserts that Respondent's conduct created the following unacceptable risks:

> Respondent's prescribing of controlled substances to Patient 1, without adequate evaluation of Patient 1's complaints and without trials of alternative therapy, created the unacceptable risk that Respondent would fail to diagnose and treat Patient 1 for potentially correctable diseases or conditions.
>
> Respondent's prescribing of controlled substances to Patient 1, after he suspected that Patient 1 was a probable drug dealer, created the unacceptable risk that Patient 1 would illegally sell the controlled substances which Respondent prescribed to Patient 1, thereby endangering the health, welfare or safety of the public.

> Respondent's prescribing of controlled substances to Patient 1, without adequate caution, created the unacceptable risk that Patient 1 would suffer an impairment of judgment and slowed reaction times while operating a motor vehicle, thereby endangering the health, welfare or safety of Patient 1 and the public.

A.

It is true that Dr. Gordon prescribed Dilaudid to Patient 1 for at least 10 years, in combination with other medications which have some tendency to be central nervous system depressants, and while knowing that Patient 1 had abused, and was still abusing, alcohol. However, it clearly is not true that Dr. Gordon failed to perform adequate evaluation of Patient 1's complaints, or that he failed to at least consider if not institute some trials of alternatives.

Dr. Radant's testimony appears to be the foundation for the allegation that Dr. Gordon's practice is less than minimally competent. It appears to me that Dr. Radant's opinion of minimally competent medical practice is both very high, which is commendable, and very sheltered, which in this case is not. Dr. Radant is a physician who, if he adheres to the standards he testified to, is extremely cautious in the use of narcotics and prescription medications in general. He clearly has had little or no experience in dealing with people who really do have drug abuse problems, but he is constantly on watch for people who might tend to the problem if left to their own devices. I believe he sees drug abuse where other physicians would clearly see a reason to watch carefully to see if there might be drug abuse. I am convinced that Dr. Radant believes that suspicion of the possibility of drug abuse is the trigger which should compel a minimally competent physician to deny a patient controlled substances unless it is possible to prove the patient is not abusing the medication. The thrust of Dr. Radant's testimony is that it is only with great trepidation that he would believe his patient had need of narcotic analgesic if the cause of the pain were other than obvious trauma, and, if he consented to prescribe narcotics, he would do so at low levels.

The testimony of Drs. Shannon, Talley, and Steidinger shows a far more rational approach to the very real problem of drug abuse. Drs. Shannon and Talley both testify that the great mass of humankind has no interest in drug abuse; Dr. Steidinger testifies that there is always a great risk of diversion when prescribing potent narcotics, but that the physician has to decide whether or not he believes his patient. If the physician trusts his patient, the physician should prescribe the medication which will relieve the pain consistently, effectively, and efficiently. The decision needs to be based on the

information the physician has about the patient in front of him, combined with a realistic appraisal of the physician's experience, education, and training in related areas. Dr. Gordon does not share Dr. Radant's perception of the degree of danger in narcotics, or his perception of the frequency of drug abuse. Dr. Radant testified at length about how Dr. Gordon's Patients were addiction prone personalities, as part of the basis of his opinion that Dr. Gordon's practice was less than competent. Dr. Shannon, an undisputable expert in the field of addiction, had a diametrically opposed perception, as did Dr. Talley, who also deals with patients Dr. Radant would identify as great risks for drug abuse.

Dr. Shannon, whose practice emphasizes the treatment of narcotic addictions, testified that Dr. Radant's perception of the dangers of narcotics as central nervous system depressants is greatly inflated. It is true that opiates have some tendency to depress the central nervous system; however, that tendency is very slight. Drs. Talley and Steidinger had no criticism of the combination of Dilaudid and Librium, Tranxene, and Xanax; Dr. Talley was actively pleased with the persistence with which Dr. Gordon pursued medical treatment of Patient 1's depression and anxiety to wean Patient 1 off of alcohol, which he described as a much more dangerous drug.

In this count of the Amended Complaint, as in most of the others, the State presumes that because Dr. Gordon's notes are sparse that he did little or no examination. The State will argue that Dr. Gordon does not remember what sort of examination he did, in 1983, and that his depositions are inconsistent on what he did or did not do by way of examination and evaluation of his patients. The State will also point out that Dr. Gordon has a motive to testify in such a way as to make himself look good, and that his credibility is very, very low. My difficulty is, nobody would remember specifics of examinations for any length of time, and everybody would naturally testify on the basis of what they generally did, and everybody would have inconsistencies in multiple depositions on the same topic. There is no rule or law which requires physicians to keep SOAP notes. It would be very helpful if physicians would do so, and dictate or type all of their notes, and surely the standard of practice is moving more in the direction of standardized note formats. Surely, Dr. Gordon wishes that he had kept better notes, and presumably is doing a much better job of it now, considering that his notes improved even during his treatment of Patient 1. I do not consider that sparse notes in and of themselves are an indication that a physician failed to do an adequate evaluation of a patient in 1983. It is an indication that the notes are not particularly helpful, and that the physician should have been keeping better notes, but it does not indicate that the physician is anything less than competent. The fact that the notes are poor does not mean that the evaluation was poor, and it is less likely to mean the evaluation was poor than that the physician was busy when the treatment is as successful as Dr. Gordon's treatment of Patient 1 was.

It is the State's burden to prove that it is more likely than not that Dr. Gordon did not do an adequate evaluation of Patient 1's condition while treating him, if the State wishes to have Dr. Gordon disciplined for treating Patient 1 in such a way that he created an unacceptable risk of missing a diagnosis he should have made. The State cannot shift the burden to Dr. Gordon to prove he did what he should have done simply by pointing out that his notes are sparse. In some cases, sparse notes will be part of a set of circumstances which will sustain a conclusion that the physician did not do a minimally competent evaluation. The circumstances in this case do not make it appear more likely than not that Dr. Gordon did an incompetent evaluation, even though Dr. Radant does not agree with the treatment Dr. Gordon provided, because a substantial part of the foundation of Dr. Radant's opinion that the treatment was inappropriate is the fact that the evaluation notes are poor. The State failed to carry its burden of proof. First, if the State is going to claim that the sparse notes are an accurate reflection of the totality of the examination, it is going to need to offer some evidence that supports the claim. When Dr. Gordon testifies that his notes are sparse, but that he did a reasonable examination for the presenting complaint, the State needs something with which to rebut or preempt the defense. That something could be the patient, a nurse, some witness who can testify with reasonable competence and credibility that Dr. Gordon's notes are a complete record of the total examination, or some document to disprove the defense; otherwise, the State has nothing but an assertion based on the presumption that the physician did it wrong. The binding presumption is that the physician did it right, unless and until the State makes it appear more likely that he did it wrong.

In this case, not only did the State never present any substantial evidence to rebut the defense that the examination was competent even though the notes were sparse, but Dr. Gordon presented multiple witnesses from the medical community in which he practices to testify as to his habit and practice in examining, evaluating, assessing, and diagnosing patients. Unless each of those witnesses is greatly inflating his or her actual experience with and opinion of Dr. Gordon, Dr. Gordon is a particularly careful and insightful and accurate diagnostician. On the one hand, the State asserts that his notes demonstrate an inadequate evaluation of his patient; on the other, the patient shows a consistent and notable improvement over the course of frequent visits to Dr. Gordon, and dozens of people who have reason to know his practice testify that he uniformly does a good evaluation. More likely than not, he does.

Dr. Gordon's counsel remarked upon the degree to which the State's case is based upon innuendo without supporting proof. One of the factors which weakens the State's case is its frequently repeated assertion that Dr. Gordon suspected that Patient 1

was probably a drug abuser, drug addict or drug dealer; in Count III, the State alleges that Dr. Gordon suspected that Patient 1 was probably a drug dealer who was selling the Dilaudid Dr. Gordon prescribed, but that he went ahead and prescribed it anyway. The record of this proceeding shows that Dr. Gordon never came to suspect that Patient 1 was probably anything other than a patient seeking medical care; that Dr. Gordon suspected he might be something other than a legitimate patient is true, but it is also a statement with an entirely different implication. Any reasonable physician would suspect that Patient 1 might be something other than a legitimate patient; competent practice really does require the physician to consider the possibility. Consideration of the possibility, and taking steps to investigate, does not equate to belief that the possibility is a probability. In this case, the State's repeated assertion of what Dr. Gordon believed is inconsistent with the information the State knows he had, and the response the State knows he made to the information. Dr. Gordon was repeatedly told by a variety of law enforcement agencies that they were looking into his patients, the ones he requested be investigated, but that they had not found anything definitive. Dr. Gordon repeatedly told the law enforcement agencies that he would keep on prescribing as long as there was nothing more than suspicion that his patients might be something other than legitimate medical cases.

The State alleges the fact that the Duluth Police Department told Dr. Gordon it could not prove anything against Patient 1 as if that were some sort of warning to Dr. Gordon that he should stop prescribing to Patient 1. One cannot help but wonder whether the State intends to imply that a minimally competent physician will defer to the unsupported opinion of a police officer that a patient may be involved in criminal activity, and change his treatment of his patient despite his clinical judgment. That message is clearly implied by the State's case, and I reject it.

COUNT IV.

Count IV of the Amended Complaint asserts that Dr. Gordon's care of Patient 1 fell below the minimum standards of competence established in the profession in the following respects:

> Respondent failed to order any laboratory tests or other tests or procedures, such as an EKG or a stress test, from November 1982 through May 1983, to evaluate Patient 1 for his complaints of chest pain on exertion in November 1982 and January 1983.
>
> Respondent failed to order any laboratory tests or other tests or procedures, such as an EKG or a stress test, in March 1984, to evaluate Patient 1 for his recurring complaints of chest pain on exertion.

> Dr. Gordon's conduct is alleged to have constituted a danger to the health, welfare and safety of the patient or the public because it created the unacceptable risk that Patient 1 could have a serious cardiac problem which would not be identified and treated, thereby creating the unacceptable risk that Patient 1 could suffer a cardiac arrest and death.

A.

The allegations of Count IV appear to be substantially informed by the practice standards of Dr. Radant, not necessarily the standards established in the profession generally. Dr. Steidinger testified to the point directly, saying that there was some basis for concern about a cardiac problem with the Patient complaining of chest pain on exertion, but that the therapeutic trial of nitroglycerine with which Dr. Gordon responded is a common method of primary care practice. Dr. Gordon had reason to question whether this was a complaint of cardiac origin, in as much as this Patient has difficulty communicating clearly and he was treating the Patient for bronchitis or upper respiratory problems which could well explain chest pain on exertion. Dr. Steidinger testified that what the proper therapeutic response is, is a judgment call. By definition, conduct which is determined by a judgment call cannot be below standards of minimum competence.

B.

The incident of March, 1984, of Patient 1 complaining of chest pains when walking uphill, but not upstairs, to which Dr. Gordon responded with another trial of nitroglycerine and specific instructions to call in and report anything unusual, looks even less like incompetent practice than the first. The Patient had been feeling no pain on exertion for months, had been examined for any signs of cardiac problems, with none being found, and the response of a trial of nitroglycerine appears to comply with Dr. Steidinger's understanding of the common practice of medicine. A more aggressive approach is not unreasonable, but the evidence does not support the allegation that it is the only minimally competent approach.

COUNT V.

Count V of the Amended Complaint was dismissed on motion of the State, and the allegations were not tried.

COUNT VI.

Count VI of the Amended Complaint asserts that Dr. Gordon prescribed Dilaudid to Patient 2 otherwise than in the course of legitimate professional practice in the following respects:

> Respondent prescribed Dilaudid to Patient 2 for excessive periods of time without having performed adequate physical evaluations of Patient 2, without obtaining adequate medical records of Patient 2 and without having identified and confirmed any legitimate medical condition which would justify prescribing Dilaudid to Patient 2.
>
> Respondent prescribed Dilaudid to Patient 2 after Respondent suspected that Patient 2 was a probable drug addict, drug abuser or both, in the absence of any medical condition which would justify prescribing Dilaudid in spite of the patient's history of probable drug addiction or drug abuse.
>
> Respondent prescribed Dilaudid to Patient 2 without attempting any alternative therapies to address Patient 2's complaints of pain.
>
> Respondent prescribed Dilaudid to Patient 2 without exchanging medical records with Patient 2's physicians in Omaha, where Patient 2 reported he was being treated at the same time as Respondent was treating Patient 2, as of November 24, 1981, to ascertain whether Patient 2 was receiving any additional controlled substances from his physicians in Omaha and to apprise the physicians in Omaha for the controlled substances that Respondent was prescribing for Patient 2.

The complaint alleges that Dr. Gordon's treatment subjected Patient 2 to unacceptable risks of drug abuse or dependence, or of exacerbating and perpetuating Patient 2's drug abuse and dependence.

A.

As with Patient 1, the State alleges that Dr. Gordon did not perform an adequate evaluation of Patient 2 to support the prescription of Dilaudid to him. This allegation is the opinion of Dr. Radant. Dr. Steidinger, however, is of the opinion that there was adequate justification for the prescriptions, that they were neither excessive in amount or duration, and that they posed no real risk to the Patient or the public.

On the basis of the State's presentation of its case during the hearing, the support for the basic allegation that Dr. Gordon did not do an adequate evaluation of Patient 2 to support the prescription is mainly the relative lack of detail in Dr. Gordon's notes of Patient 2, at least during the early stages of the physician-patient relationship. There is no more evidence in regard to Patient 2 that Dr. Gordon's examinations were as limited as his notes are than there was in regard to Patient 1. For that reason, the State has failed to carry its burden of proving that it is more likely than not that Dr. Gordon did an inadequate evaluation. Nor is it any more clear with regard to Patient 2 than it was with regard to Patient 1 that a physician must be able to prove that a patient is in need of pain relief before the physician may competently prescribe narcotic analgesics if the physician believes the patient when the patient says the patient needs pain relief.

B.

The strong level of suspicion attributed by the State to Dr. Gordon about Patient 2's status as a drug abuser or drug addict is inconsistent with the information the State knew Dr. Gordon had, and the response the State knew Dr. Gordon made to the information. As with Patient 1, mere suspicion, even suspicion that is strong enough to lead a physician to investigate, is not the equivalent of a conclusion that it is more likely than not that a patient is a drug abuser or drug addict. The information available to Dr. Gordon with regard to Patient 2, as with Patient 1, includes the fact that the Patient did not request greater doses or greater frequency or greater amounts of medication, did not lose multiple prescriptions, did not have other people calling in for his prescription for him, did not ask for early prescriptions on a frequent basis, in short, Patient 2 did none of the things which Dr. Shannon and Dr. Talley indicate are standard signs of a drug abuser.

C.

It would have been appropriate to attempt some less potent forms of medication for pain relief for Patient 2, rather than continuing to rely on Dilaudid. The reasons for doing so are that it is possible that less potent medications would provide effective relief through a drug which is more convenient and less expensive for the Patient, and which provides less temptation to illicit use. The reasons are not the health and safety of the Patient, who did not appear to be at any risk from the medication, or abusing it in any way.

D.

It would have been appropriate for Dr. Gordon to exchange medical records with the physicians who were treating Patient 2 in Omaha. Doing so would have provided more information to Dr. Gordon, and would have either made him more comfortable that he was pursuing an appropriate course or raised questions which he needed to resolve. Exchanging records with the other physicians might well have improved the quality of care Patient 2 was receiving from all of his physicians. The allegation of this count of the complaint is that Dr. Gordon was prescribing controlled substances to Patient 2 otherwise than in the course of legitimate professional practice; the fact that the quality of care might have been improved by exchanging records does not lead to the conclusion that Dr. Gordon was not practicing medicine at the time he wrote the prescriptions for Patient 2, nor does it make it more likely that Dr. Gordon was prescribing without a legitimate medical motive.

COUNT VII.

Count VII of the Amended Complaint alleges that Dr. Gordon's treatment of Patient 2 fell below the minimum standards of practice established in the profession in the following respects:

> Respondent prescribed Dilaudid to Patient 2 for approximately four years without adequate evaluation of Patient 2's complaint and without trials of alternative therapy.
>
> Respondent prescribed Dilaudid, after Respondent suspected that Patient 2 was a probable drug addict, drug abuser, or both, without adequate caution with regard to the sedative effects of the drug.

The complaint alleges that Dr. Gordon's course of treatment of Patient 2 created the following unacceptable risks:

> Respondent's prescribing of Dilaudid to Patient 2, without adequate evaluation of Patient 2's complaints and without trials of alternative therapy, created the unacceptable risk that Respondent would fail to diagnose and treat Patient 2 for potentially correctable diseases or conditions.
>
> Respondent's prescribing of Dilaudid to Patient 2, without adequate caution, created the unacceptable risk that Patient 2 would suffer an impairment of judgment and slowed reaction times while operating a motor vehicle, thereby endangering the health, welfare or safety of Patient 2 or the public.

A.

The record indicates that Dr. Gordon prescribed Dilaudid to Patient 2 on numerous occasions, and that the prescriptions were preceded by office visits and examinations, and that Patient 2 provided Dr. Gordon with both objective physical evidence of surgical intervention and documentary evidence of surgical intervention for cancer of the larynx, from which Patient 2 claimed continued pain. Dr. Gordon believed Patient 2 when Patient 2 stated he continued to suffer intermittent pain which was relieved by small doses of Dilaudid.

The State's case is premised on the claim that it is not reasonable to believe that a person who has undergone surgery and radiation therapy on the throat more than several months previously will still have pain from either the surgery or the radiation treatment, or both. The defense is that pain is subjective, and cannot be proved or disproved by a test; that radiation can and does result in changes in the body's structure that may result in long term pain. There is only one person who knows whether the claim of pain is truthful, and that person is the patient. The physician who is in the best position to make the analysis of the patient's veracity is the physician who is treating the patient.

In this case, the record indicates that Dr. Gordon regularly consulted with and examined Patient 2. In order to find that Dr. Gordon performed a less than adequate evaluation of Patient 2's condition, one would have to determine that the only evaluation which was done is the evaluation which is apparent from the details in the physician's notes. Dr. Gordon's notes are poor. That does not convince me that Dr. Gordon's examinations are poor, in as much as there is voluminous testimony from patients and medical professionals familiar with his practice that his examinations are of high quality. It is true that the issue in this proceeding is not whether Dr. Gordon is generally a good physician, but whether he met minimally competent standards of practice with reference to specific patients. The relevant evidence is that which tends to make the existence of any fact which is of consequence to the determination of the action more probable or less probable than it would be without the evidence; on that standard, the fact that Dr. Gordon is shown to hold to a particular standard of examination in substantial areas of his practice makes it more probable that he holds to the same standard in all of it.

Dr. Gordon could undoubtedly have been more aggressive in pursuing alternative therapies. However, it is no more likely than not that it is below the standard of minimally competent practice for a physician to continue a course of therapy which appears to be effective without undesired side effects just because the medication employed has a high value in illegal markets.

B.

Patient 2 may have been abusing Dilaudid. Dr. Gordon suspected that there was a possibility that he was doing so. However, Dr. Gordon believed that he probably was not abusing, addicted to, or dealing Dilaudid, and continued to prescribe Dilaudid to Patient 2. The State's allegation that Dr. Gordon suspected that Patient 2 probably was abusing or addicted to Dilaudid is contradicted by the evidence, and has previously been discussed.

There is adequate evidence that Dr. Gordon cautioned Patient 2 about the effects of the medication, and that the sedative effects of the medication, in the doses prescribed, is very slight.

C.

The risks to Patient 2 from the course of treatment with Dilaudid overseen by Dr. Gordon are minimal. Dr. Gordon was correct in his assessment of the risks involved in operating a motor vehicle while taking Dilaudid in the doses he prescribed; Dr. Shannon's testimony amply supports Dr. Gordon's conclusion, and Dr. Steidinger's opinion that there was no risk to the Patient or the public as a result of Patient 2 driving a motor vehicle from Dr. Gordon's prescriptions of Dilaudid to Patient 2 . Dr. Radant's opinion on the topic appears to be based on substantially less reliable information.

The evidence in this proceeding which relates to Dr. Gordon's ability to accurately evaluate and correctly diagnose his patients' conditions overwhelmingly supports the conclusion that Dr. Gordon takes the time necessary to understand his patient's condition, and that he is better than average at eliciting material information from his patients. In the absence of information which would make it more likely than not that Dr. Gordon did not do with Patient 2 what he apparently does with the rest of his patients, it is difficult to conclude that Patient 2 was put at unacceptable risk of a poor diagnosis because Dr. Gordon did a poor evaluation of his condition.

COUNT VIII.

Count VIII of the Amended Complaint alleges that Dr. Gordon's conduct in treating Patient 2's high blood pressure was below minimum standards of competence in the following respects:

Respondent began treating Patient 2's high blood pressure without assessing whether Patient 2 had already suffered organ damage or other adverse effects from the might blood pressure. A minimally competent assessment for a patient with pedal edema and hypertension would have include3d testing Patient 2's electrolytes and kidney function and taking a chest x-ray and an electrocardiogram.

Respondent prescribed diuretics to Patient 2 from July 29, 1982, until June 28, 1985, without any monitoring of Patient 2's electrolytes and kidney function until June 28, 1985.

Respondent prescribed combination diuretics, an uncommon and hazardous practice, to Patient 2 from June 20, 1984 until June 28, 1985, without any monitoring of Patient 2's electrolytes and kidney function until June 28, 1985.

Respondent failed to perform adequate evaluations to determine the etiology of Patient 2's edema.

The complaint alleges that Dr. Gordon's course of treatment created unacceptable risks for Patient 2:

Respondent's failure to adequately assess whether Patient 2 had suffered any organ damage before beginning treatment for high blood pressure created the unacceptable risk that any organ damage or other adverse effects from the high blood pressure would not be timely diagnosed or treated, and that any underlying disorders contributing to Patient 2's high blood pressure would not be recognized and treated.

Respondent's failure to monitor Patient 2's electrolytes and kidney function created the unacceptable risk the Patient 2 could develop an electrolyte imbalance resulting in circulatory collapse, arrythmia and death.

Respondent's failure to perform adequate evaluations to determine the etiology of Patient 2's edema created the unacceptable risk that Respondent would not recognize and treat Patient 2 for the presence of significant underlying organ system failure.

A.

In this count of the complaint, the State postulates that Dr. Gordon was incompetent in treating high blood pressure because he did not run enough tests and diagnostic procedures. The fact of the matter is, Dr. Gordon started treating Patient 2 for mildly elevated blood pressure after Patient 2 had been a patient for several months and had been seen frequently between September 10, 1981, and July 29, 1982. Dr. Gordon had good reason to know, from clinical evaluation, what condition Patient 2

was in and what diagnostic tests were likely to be of some value in treating Patient 2. It is true that he could have ordered tests to show that Patient 2 had no cardiac problem, but it is also true that he had listened to Patient 2's heart on several occasions and that the likelihood of an electrocardiogram or a chest x-ray revealing something Dr. Gordon would not have known from prior examinations is very low. The level of risk to which Patient 2 is exposed by beginning treatment with Moduretic before checking specifically for end organ damage that was not apparent on any previous examination would appear to be very low, and the benefit to be derived from the procedures would appear to depend mainly on the physician's judgment of the value of having a record of the test.

B.

The standard of practice of medicine in the early 1980's, according to Dr. Steidinger, was such that Dr. Gordon should have checked Patient 2's electrolytes during the course of treatment with diuretics, before the time he actually did check. Dr. Steidinger also testified that if the patient was not compliant with the medication, the test would tell him nothing. Dr. Talley was particularly informative on the difficulties of getting patients, particularly patients from lower socio-economic backgrounds, to be compliant with medication plans for hypertension. There is adequate basis in the record to conclude that Patient 2 was not particularly compliant with the medication plan, to the point that he did not always maintain a supply of the medication. Dr. Gordon was justified in relying on physical examination and consultation with the patient to decide that there was no particular point in running the electrolyte or kidney function tests.

C.

In several of its factual allegations, the State notes that diuretics can, if prescribed in excessive amounts, lead to electrolyte depletion, cardiac arrythmia, and death. Prescribing multiple diuretics at the same time obviously increases the danger of the patient taking excessive amounts. "Excessive" is a word that refers to a standard of how much medication is sufficient, and how much is too much. In this case, Dr. Gordon prescribed low amounts of several diuretics. The patient did not have a notably high compliance rate with the medication plan, and was examined relatively frequently by Dr. Gordon. There is no support for an allegation that the prescribed diuretics were "too much" in this particular instance.

The overwhelming evidence in this case is that there was only a remote possibility that Patient 2 might develop an electrolyte imbalance. It is certainly theoretically possible, and a physician should know that and consider the possibility, but the

physician is not incompetent because he proceeds with a course of treatment that carries some small degree of risk. Here, as in other counts, the State appears to be relying on Dr. Radant's perception of risk. Based on the testimony of Dr. Steidinger, Dr. Talley, and Dr. Gordon, I conclude that Dr. Radant is either notably risk averse or he misunderstood the task he was asked to undertake as the State's expert in reviewing Dr. Gordon's treatment. It seems to me that there is a significant difference between correctly identifying the standard as stated in medical texts for a particular treatment, and applying the concept to a real patient. The focus is much narrower in the text than it will ever be in life, simply because the text has to concern itself with a discrete condition and the physician has to expand the concern to the totality of the patient's relevant circumstances.

COUNT IX.

Count IX of the Amended Complaint alleges that Dr. Gordon prescribed controlled substances to Patient 3 otherwise than in the course of legitimate professional practice, in the following respects:

> Respondent prescribed Dilaudid to Patient 3 for excessive periods of time without having performed adequate physical examinations of Patient 3, without obtaining adequate medical histories of Patient 3 and without having identified and confirmed any legitimate medical condition which would justify prescribing Dilaudid to Patient 3.
>
> Respondent prescribed Dilaudid to Patient 3 after Respondent suspected that Patient 3 was a probable drug addict, drug abuser or drug dealer, in the absence of any medical condition which would justify prescribing Dilaudid in spite of the patient's history of probable drug addiction, drug abuse or drug dealing.
>
> Respondent prescribed Dilaudid to Patient 3 without attempting any alternative therapies to address Patient 3's complaints of pain.
>
> Respondent failed to adequately address Patient 3's use of alcohol, which is a central nervous system depressant, while continuing to prescribe Dilaudid, a central nervous system depressant, to Patient 3 in combination with antidepressant therapy.
>
> Respondent prescribed Dilaudid to Patient 3 without exchanging medical records with the other physicians who Patient 3 claimed were treating him for possible metastases of his cancer of the larynx, to ascertain whether Patient 3 was receiving any additional controlled substances from those physicians and to apprise those physicians of the controlled substances that Respondent was prescribing to Patient 3.

The analysis which applies to these allegations against Dr. Gordon relative to Patient 1 and Patient 2 applies here as well. There is no material difference between the Patients in this regard.

In this count, the State implies that the prescription of a medication with a tendency to be a central nervous system depressant to a person who is known to use, and occasionally abuse, alcohol, is a significant problem. The testimony of the expert witnesses, with the exception of Dr. Radant, is that the CNS effects of Dilaudid in the prescribed amounts is minimal. Certainly, one should be careful with the use of alcohol while taking narcotics, but one should be careful about the use of alcohol at all times. The increase in the risk from the use of either narcotics or alcohol alone is the issue; the testimony in this case, as applied to this Patient, is that the risk is very small, and not unacceptable.

The allegation that implies that it is somehow improper to prescribe antidepressant medications to a person who is also taking some narcotics on occasion for pain relief, and who also continues to use alcohol, seems to be based on a misapprehension that the synergistic effect of Dilaudid, alcohol, and antidepressants creates a significant risk that the patient will lose consciousness, cease breathing, and die. Dr. Shannon's testimony indicates that while such a result is possible, a person would have to make an affirmative effort to obtain it.

COUNT X.

Count X of the Amended Complaint alleges that Dr. Gordon's treatment of Patient 3 fell below the minimum standards established in the profession in the following respects:

> Respondent, while treating Patient 3 for depression and knowing that Patient 3 was using alcohol, continued to prescribe Dilaudid to Patient 3.
>
> When Respondent was informed on July 15, 1983, that Patient 3 "had brain scan" Respondent did not obtain any more information from Patient 3, such as when, where and by whom the brain scan and neurologic evaluation were done, so that Respondent could obtain the medical records regarding the brain scan and neurologic evaluation.
>
> When Patient 3 reported hearing voices and said that he was being told to kill people in his family, in February 1985, Respondent failed to refer Patient 3 for psychiatric evaluation and treatment, and Respondent failed to take other appropriate measures for an individual voicing homicidal ideation.

The complaint alleges that Dr. Gordon's conduct created the following risks:

> Respondent's conduct in prescribing Dilaudid to Patient 3, while treating Patient 3 for depression and while knowing that Patient 3 was using alcohol, created the unacceptable risk that Patient 3's depression would be aggravated, rather than effectively treated.
>
> Respondent's failure to obtain further information regarding the neurologic evaluation and brain scan that Patient 3 reported having undergone created the unacceptable risk that Patient 3 could have a central nervous system metastases, which could contribute to observed psychosis and depression.
>
> Respondent's failure to refer Patient 3 for psychiatric evaluation and treatment in February of 1985 created the unacceptable risk that Patient 3 could present a significant danger to himself or others.

A.

There is some slight risk that prescribing narcotic analgesics to a person who is also being treated with antidepressants and who continues to use alcohol will result in undesirable consequences. However, it is also true that failure to provide a patient with narcotic analgesics because he is receiving antidepressant medication, with or without using alcohol, presents a significant risk that the patient will either suffer needless pain or self-medicate with less appropriate drugs, such as increased use of alcohol. The physician is not in a position, usually, to insist that the patient change his circumstances sufficiently to remove all complicating factors before the physician begins a course of treatment. This is particularly true in the case of depression, where it is common for the patient to self-medicate with alcohol until effective antidepressant medication is provided. The textbooks and the Physicians' Desk Reference will predictably advise that the physician not mix alcohol, antidepressants, and narcotics. The physician will undoubtedly prefer not to do so; nonetheless, the patient may present with the complicating factors and it is not below the standard of minimally competent practice for the physician to attempt to treat the patient.

B.

Dr. Gordon could have obtained the records of the brain scan Patient 3 reported having undergone, and those records might have told him something they did not tell the physician who performed the brain scan, or that the physician who performed

the brain scan did not tell Patient 3, or that Patient 3 did not tell Dr. Gordon. The issue is, did Dr. Gordon fall below minimally competent standards of practice by not getting the results of the brain scan Patient 3 told him about? The State theorizes that had Dr. Gordon obtained the brain scan, he might have diagnosed a CNS metastasis of Patient 3's cancer, which would explain the observed psychosis and depression. The speculation involved in applying that theory to Dr. Gordon to determine that his practice in this case was less than competent is fatal to any substantially sound finding of fact or conclusion of law.

C.

Patient 3 declined to return to Dr. Gordon's office for a more detailed consultation about his report of hearing voices telling him to do harm to his family. The only reasonable inference from this fact is that he would have declined to voluntarily admit himself to a psychiatric ward. As a matter of law at the time of the event, as explained by the current circuit court judge of the jurisdiction, the circumstances were plainly insufficient to support an emergency detention or involuntary commitment of Patient 3. The State's allegation that Dr. Gordon should have taken more aggressive action appears to be founded on Dr. Radant's opinion that more should have been attempted, without regard to the fact that more aggressive action would have been entirely fruitless and quite possibly counter-productive. A physician ought not be branded less than minimally competent because he did not attempt or succeed at doing the legally impossible and the medically questionable.

COUNT XI.

Count XI of the Amended Complaint alleges that Dr. Gordon's conduct in treating Patient 3 fell below the minimum standards established in the profession in the following respects:

> Respondent failed to consistently take and record Patient 3's blood pressure when Patient 3 presented at Respondent's office.
>
> Respondent began treating Patient 3's high blood pressure with Hygroton on February 3, 1984, without documenting an adequate physical examination and without assessing whether Patient 3 had already suffered organ damage or other adverse effects from the high blood pressure.
>
> Respondent prescribed Hygroton to Patient 3 on May 7, 1984, without monitoring Patient 3's blood pressure on that date.
>
> Respondent prescribed Hygroton to Patient 3 from February 3, 1984, to May 20, 1985, without any monitoring of Patient

3's electrolytes or kidney function.

Respondent failed to adequately evaluate Patient 3 for his angina and irregular heartbeat in June, 1984, and continued to prescribe Hygroton, an agent which could contribute to those complaints.

The complaint alleges this conduct created the following risks:

Respondent's failure to consistently monitor Patient 3's blood pressure, especially when Respondent prescribed Hygroton to Patient 3 on May 7, 1984, created the unacceptable risk that Patient 3 could have high or low blood pressure that would not be timely identified and treated, thus exposing Patient 3 to risks, which could include a stroke and death.

Respondent's failure to adequately assess whether Patient 3 had suffered any organ damage or other adverse effects from the high blood pressure, before Respondent began treating Patient 3's high blood pressure in February, 1984, created the unacceptable risk that any such organ damage or other adverse effects from the high blood pressure would not be timely diagnosed and treated.

Respondent's failure to monitor Patient 3's electrolytes and kidney function, while prescribing Hygroton to Patient 3 from February 3, 1984, through May 20, 1985, created the unacceptable risk that Patient 3 could develop an electrolyte imbalance, which could result in circulatory collapse, arrhythmia and death.

Respondent's failure to adequately evaluate Patient 3 for his angina and irregular heartbeat in June 1984 created the unacceptable risk that Patient 3 could have a cardiac condition which would not be timely diagnosed and treated and which could be aggravated by the Hygroton.

The factual allegations of this count of the complaint, and the conclusions which the State speculates flow from the factual allegations, are all premised on one foundation: that is, if Dr. Gordon did not write it down and maintain it in his file, it did not happen. Having previously discussed the State's burden to prove its case, and the difficulty inherent in maintaining a presumption that observations which are not recorded were not made, or, alternatively, the difficulties of sustaining a shift of the burden of proof from the State to prove misconduct to the physician to prove good conduct, I am not going to repeat the analysis. Dr. Talley testified that Dr. Gordon should have kept better records, and that is clearly true. The State is also clearly correct that it is very bad policy to allow a physician to escape discipline on the grounds that his records are poor, so that it is not possible to prove that he did not do something he ought to have done. The State argues that the lesson in such a case would be,

"keep bad records and protect yourself from discipline." In some cases, that will undoubtedly be true. The presumption is, however, that physicians are competent, and the presumption is based on the observed fact that the great majority are. Consequently, the lesson most frequently resulting from poor records is likely to be "Better records reduce the chances of having to defend your license in the first place."

Dr. Steidinger testified in his deposition that the chances of there being any organ damage in a new found borderline hypertensive like Patient 3 are remote. The probability that Dr. Gordon missed something important on his examinations of Patient 3 is unknown; the fact is, there is no evidence that Patient 3 had any serious cardiac condition to which Hygroton contributed. Speculation is an appropriate tool in an investigation, but it is not an appropriate basis for a conclusion that a physician has practiced in a less than minimally competent fashion.

CONCLUSION

The main reason for this case being here is Dr. Gordon's prescription of Dilaudid to Patients 1, 2, and 3. The second reason for this case being here is that Dr. Radant believes that Dr. Gordon's evaluation of these Patients' condition was less than minimally competent because Dr. Gordon's records are not detailed.

The evidence which supports the State's allegations that Dr. Gordon should not have prescribed Dilaudid to these Patients in the manner he did consists of the Patients' race, the lack of provable pain, the distance which the Patients travelled to see Dr. Gordon, the lack of detail in Dr. Gordon's notes, Dr. Gordon's admitted suspicion that the Patients might be less than they appeared to be, and Dr. Radant's opinion that each of the Patients fits his profile of an addiction prone personality.

The overwhelming weight of the credible evidence in this case demonstrates that the State's allegations are speculative. Dr. Radant is clearly a good physician, but it is just as clear that he is not an expert on narcotics, interactions of narcotics and other medications, or narcotic addictions and abuse. Dr. Shannon is very clearly an expert on all those things and his testimony that Dr. Gordon's treatment of these Patients was medically competent is entitled to far greater weight.

Dr. Steidinger is a respected Wisconsin physician, and his deposition testimony to the effect that Dr. Gordon made reasonable judgment calls on the prescriptions of Dilaudid and the treatment of the Patients' hypertension and possible cardiac conditions is entitled to at least as much weight as Dr. Radant's criticisms of Dr. Gordon.

Dr. Talley has a tendency to hyperbole, but his experience with the treatment of patients of similar background to Patients 1, 2, and 3, and Dr. Shannon's corroboration of his observations of the effects of cultural and economic conditions on such patients' perceptions of medical treatment support the conclusion that his conclusions are both well founded and accurate. Dr. Talley's conclusions about the quality of Dr. Gordon's treatment of these Patients were that Dr. Gordon had chosen an appropriate course in each case, and in some respects deserved great accolades. As with Drs. Shannon and Steidinger, Dr. Talley exhibits substantially greater relevant experience on the topics of his testimony than Dr. Radant does on his.

Beyond the determinative weight which I accord to the testimony of Drs. Shannon, Steidinger and Talley in finding in Dr. Gordon's favor, there is the substantial impact of the testimony of Dr. Gordon's patients and colleagues. Dr. Radant necessarily based his opinion of Dr. Gordon's practice regarding these three Patients on Dr. Gordon's records and depositions. The conclusions Dr. Radant drew from that limited evidence are the foundation upon which the State argues that Dr. Gordon practiced in a less than competent fashion, and outside the bounds of legitimate practice. It is clearly relevant that large numbers of people who know his practice first hand vehemently disagree with the State's conclusions. Their uniform description of his method and habit of practice in treating patients is of a careful, insightful, imaginative, thoughtful, skilled physician.

Dated this 19th day of March, 1993.

James E. Polewski

James E. Polewski
Administrative Law Judge

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