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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
ROGER A. MATTSON, M.D., RESPONDENT.	:	(92 MED 005)

The parties to this proceeding for the purpose of Wis. Stats. sec. 227.53 are:

Roger A. Mattson, M.D.
1015 Medical Arts Building
Duluth, MN 55802

State of Wisconsin Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Avenue, Room 194
P.O. Box 8935
Madison, WI 53708-8935

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

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

FINDINGS OF FACT

1. Roger Mattson, Respondent herein, 1015 Medical Arts Building, Duluth, Minnesota 55802 is licensed and currently is registered to practice medicine and surgery in the State of Wisconsin under license number 17403 which was granted on October 22, 1970.

2. At all times relevant hereto, Respondent was licensed to practice medicine and surgery in the State of Minnesota under license number 16767.

3. On May 21, 1987, Respondent's license to practice medicine and surgery in the State of Wisconsin was limited by the Wisconsin Medical Examining Board for a period of one

year. Such limitation required Respondent to have all hospital records and random nursing home records reviewed by a physician selected by the Board who was to provide quarterly reviews to the Board regarding Respondent's prescribing of controlled substances.

3. On December 17, 1991, Respondent's license to practice medicine and surgery in the State of Minnesota was suspended for a period of not less than one year with conditions on reapplication.

4. On May 8, 1993, the Minnesota Board of Medical Practice amended the previous Order on the following terms and conditions:

A. Respondent was suspended for a period of not less than five years to commence on May 8, 1993;

B. At the end of the five year period, Respondent may petition the Board for reinstatement of his license in accordance with the provisions set forth below. The period of suspension will continue to run until Respondent complies with those provisions, and the Board staff notifies Respondent, in writing, that the suspension is lifted and a license or restricted license is issued;

C. During the period of suspension, Respondent shall not in any manner practice medicine or surgery in Minnesota;

D. Respondent may petition in whole or in part for reinstatement of his license to practice medicine and surgery in Minnesota with evidence of the following:

1) The five year period of suspension has expired; and

2) Respondent has successfully completed, as determined by the Board, all terms and conditions of the Order dated December 17, 1991, which is attached as Exhibit A and is incorporated by reference herein in its entirety;

E. Should Respondent seek reinstatement of his license in Minnesota, the Board may reopen its investigation.

5. On March 12, 1992 a Judgment of Conviction was entered by the District Court of St. Louis County in the State of Minnesota upon a jury verdict finding Respondent guilty of seven counts of theft by false representation, a felony, by intentionally deceiving Medicaid with false representations for reimbursement for medical services provided to recipients of Medical Assistance in violation of Minnesota Statutes 609.52 SUBD. 2(3)(C); SUBD. 3(3)(d)(iv); SUBD. 3(5).

6. The crimes upon which the Judgment of Conviction was based as set forth in Paragraph 5 above are substantially related to practice under the license granted Respondent by the Medical Examining Board in the State of Wisconsin.

7. On May 28, 1992, a formal complaint alleging two counts of unprofessional conduct was filed against Respondent by the State of Wisconsin Medical Examining Board.

8. On July 23, 1992, the parties entered into a Stipulation which allowed entry of an Interim Order whereby Respondent's license to practice medicine and surgery in the State of Wisconsin was suspended pending final resolution of the disciplinary proceedings.

CONCLUSIONS OF LAW

1. The Medical Examining Board has jurisdiction in this matter pursuant to Wis. Stats. sec. 448.02(3) and 227.44(5).

2. Respondent's conviction as herein described in Finding of Fact number 5 constitutes conviction of a crime which relates to practice under a license granted by the Medical Examining Board and therefore constitutes unprofessional conduct within the meaning of Wis. Stats. sec. 448.02(3) and Wis. Adm. Code sec. MED 10.02(2)(r).

3. The suspension of Respondent's license to practice medicine and surgery in the State of Minnesota as described herein constitutes unprofessional conduct within the meaning of Wis. Stats. sec. 448/02(3) and Wis. Adm. Code Ch. MED 10.02(2)(q).

ORDER

NOW, THEREFORE, IT IS ORDERED that the Stipulation executed by the parties hereto is accepted by the Board.

IT IS FURTHER ORDERED that Respondent's license to practice medicine and surgery in the State of Wisconsin be suspended for a period of not less than five (5) years commencing on the date of the initial Interim Order suspending Respondent's license which was entered on July 23, 1992.

IT IS FURTHER ORDERED that subsequent to July 23, 1997, Respondent may reapply for reinstatement of his license to practice medicine and surgery in the State of Wisconsin on the following terms and conditions:

1. Respondent shall have met all terms and conditions of the Order of the Minnesota Board of Medical Practice dated December 17, 1991, and amended as of May 8, 1993.

2. Respondent shall have taken and successfully passed the SPEX examination.

3. At the time of reapplication, Respondent shall appear before the Medical Examining Board and satisfy the Board as to his fitness and competence to practice medicine and surgery. It shall be Respondent's responsibility to notify the Board of any intent to reapply for licensure as least sixty (60) days in advance of such application and to make arrangements with the Medical Examining Board for his appearance.

4. Notwithstanding subparagraphs 1, 2 and 3 above, the Medical Examining Board may, in its discretion, deny reinstatement or reinstate Respondent's license on a limited basis with terms and conditions acceptable to the Board.

5. The granting of a limited license under subparagraph 4 above, shall not be considered a denial of a license within the meaning of Wis. Stats. sec. 227.01(2)(a).

IT IS FURTHER ORDERED that pursuant to the authority of Wis. Stats. sec. 448.02(4), should the Medical Examining Board determine that there is probable cause to believe that Respondent has violated the terms of this Order, the Board may order the Respondent's license be summarily suspended pending investigation of the alleged violations.

Dated this 29 day of Jan, 1994, at Madison, Wisconsin.

STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

BY: _____
Secretary

PMS:pw
ATTY-ELG680

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

CERTIFICATION OF DISCIPLINARY ACTIONS

ORDER DATED: DECEMBER 17, 1991

IN THE MATTER OF: ROGER A. MATTSON, M.D.

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

H. Leonard Boche
Executive Director
Minnesota Board of Medical Practice

(SEAL)

Exhibit -A-

STATE OF MINNESOTA

BEFORE THE MINNESOTA
BOARD OF MEDICAL PRACTICE

In the Matter of the
Medical License of
Roger A. Mattson, M.D.
Date of Birth: 5-12-38
License No.: 16,767

FINDINGS OF FACT,
CONCLUSIONS AND ORDER

The Minnesota Board of Medical Practice (hereinafter "Board") convened to consider the above-referenced matter on October 26, 1990, after having reviewed the record. John A. Breviu, Assistant Attorney General, 525 Park Street, Suite 500, St. Paul, Minnesota 55103, appeared on behalf of the Complaint Review Committee of the Minnesota State Board of Medical Practice (Committee). Michael S. Husby, Attorney at Law, 300 Missabe Building, Duluth, Minnesota 55802, appeared on behalf of Roger A. Mattson, MD (Respondent). Both counsel made oral argument to the Board and responded to questions from Board members. Respondent appeared, made a statement and also responded to questions. The Board member who oversaw the investigation and presentation of the case did not attend this meeting or participate in any deliberations of the Board.

The Board members hearing argument, participating in deliberations, and voting in this matter were the following: Melvin E. Sigel, MD; Gloria Perez Jordon; Doris C. Brooker, MD; David Kidder, MD; James F. Knapp, MD; Karen Novak; Stephen P. Kelley; Adrienne Breiner; Meredith Hart; Richard Mulder, MD; David C. Herman, MD; and Frank W. Quattlebaum, MD, participated by teleconference.

Following the oral remarks, the Board excused counsel for the Complaint Review Committee; Respondent and Respondent's counsel; and Board staff. The Board deliberated for the remaining five hours of the meeting. After extensive discussion, the deliberating Board members voted unanimously to issue these Findings of Fact, Conclusions and Order.

The above-captioned matter came on for hearing before Administrative Law Judge Jon L. Lunde (hereinafter "ALJ") on November 5, 6, 7, 8, 13, 14, 15, 16, and December 11, 12, 13, and 14, 1990, at the St. Louis County Courthouse in Duluth, Minnesota. The record before the ALJ closed on May 10, 1991 when the last post-hearing memorandum was filed. The ALJ submitted his Findings, Conclusions and Recommendations to the Board on July 9, 1991.

Based upon all of the proceedings herein, the Board makes the following:[1]

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1. In accordance with Doe v. State Board of Medical Examiners, 435 N.W.2d 45 (Minn. 1989), these findings of fact, conclusions, order and memorandum are intended to include no data reasonably related to any charge against Respondent which the Board may have dismissed.

FINDINGS OF FACT

1. Respondent graduated from the University of Michigan Medical School in 1963. The following year, he was in a rotating internship at St. Mary's Hospital in Duluth, Minnesota. Between 1964 and 1967 Respondent was a captain in the United States Air Force. Upon his discharge, Respondent began a 3-year psychiatric residency at the University of Minnesota working for the University, the Mayo Clinic and the Veterans Administration. Resp. Ex. 4.

2. Respondent is licensed to practice medicine in Minnesota, Wisconsin and Michigan. Since 1973 he has also been certified by the American Board of Psychiatry and Neurology. Respondent has had medical privileges at all three hospitals in Duluth since 1970: St. Mary's, St. Luke's and Miller-Dwan. Resp. Ex. 4. Respondent considers himself competent to treat general, nonpsychiatric medical conditions (Dep. T. Vol. I, 51). For the patients in this case, the Respondent provided primary care as well as psychiatric care. T. Vol. II, 10.

3. Since 1970, Respondent has been in private medical practice in Duluth treating patients for psychiatric and general medical conditions. T. Vol. I, 13, 16-18. Respondent has a general psychiatric patient population composed of an equal number of men and women. About half his patients are over age 50. T. Vol. I, 15. Apart from patient no. 1, the patients whose treatment is relevant in this case are, for the most part, unemployed or underemployed persons with significant medical and psychiatric problems. T. Vol. VI, 106. Due to their psychiatric illnesses, most of his patients were difficult to treat. Patients #1, 2 and 5 were less difficult than the others. T. Vol. IV, 84.

4. In addition to his private medical practice, Respondent has served as a consultant to Moose Lake State Hospital in Moose Lake, Minnesota (1970-71), the Range Mental Health Center in Virginia, Minnesota (1971-1974 and 1989 to present), and the Douglas County Hospital in Superior, Wisconsin (1974-1975). Since 1975 the Respondent has been an Assistant Clinical Professor of Psychiatry at the University of Minnesota-Duluth. Resp. Ex. 4.

5. The Respondent has been disciplined by the Board on two prior occasions. In 1981 he was disciplined for inappropriate prescription practices. T. Vol. XI at 5. In 1985 he was disciplined a second time for inappropriate prescription practices. At that time, Respondent was prohibited from prescribing controlled substances in a outpatient setting for one year and he was required to successfully complete a pharmacology course approved by the Board. Respondent completed the course requirement imposed by the Board and his prescribing privileges were reinstated approximately one year later. Bd. Ex. 22; T. Vol. XI at 8. He completed the course on October 1, 1986. Bd. Ex. 9, 1459.

Patient #1

6. In the fall of 1970, when Patient #1 was 16 years of age, she attempted suicide by overdosing on barbiturates. As a result of her suicide attempt, the patient was ordered by a court to undergo psychiatric treatment and consultation with the Respondent. T. Vol. IV, 99, 101. Between November 17, 1970 and February 9, 1971, the patient had ten office visits

with the Respondent. Bd. Ex. 12. The patient's appointments took place late in the afternoon after school was out. They usually began at 4:30 or 5:00 p.m. and continued until after the Respondent's receptionist had left for the day. T. Vol. IV at 99-100.

7. During the patient's office visits the Respondent asked her questions of a sexual nature. He asked her, for example, what she liked to do sexually and whether she had an orgasm during sex. T. Vol. IV, 100. Following her visit on January 26, 1971, the Respondent escorted the patient into the hallway outside his office and, while in the hallway, asked the patient for a New Year's hug. The patient, though scared, agreed and Respondent hugged her. He held her more tightly than was comfortable for her and when she attempted to pull away from him he tried to kiss her. At the same time his hand touched her breast. T. Vol. IV, 101-102. The patient went immediately to some older friends of hers and described the Respondent's actions to them. They encouraged her to question him about what happened. T. Vol. IV at 102. The patient decided to follow their advice and she scheduled her next appointment with the Respondent earlier in the day when his receptionist would be present. T. Vol. IV, 102-103.

8. During the course of her subsequent office visit with Respondent on February 9, 1971, the patient told Respondent that she felt he had tried to "come on" to her at the last visit and that his actions scared her and she needed to know that she was wrong. Respondent admitted that his actions had been of a sexual nature. He told her he could make her "come" and could get her drugs. Respondent also said or implied that if she didn't "fuck him" he would have her committed. Id. at 103. Respondent's statements terrified the patient and she left his office. She thought about running away because she was afraid she would have to sleep with Respondent or be committed. She didn't run away, but she never returned to see the Respondent. Id. at 103-104.

9. The patient did not report the Respondent's actions and statements to the Board or any other authorities at that time. The patient was reluctant to report Respondent's actions because she was afraid she wouldn't be believed, but she did discuss Respondent's actions with friends. In later years, she discussed the incidents with her therapist and a social worker. During the last semester of her college work, around May 1, 1989, the patient attended a workshop on sexual harassment. After attending the workshop and learning where to report Respondent's actions, the patient decided to file a complaint with the Board. T. Vol. IV, 104-105. The Board promptly initiated an investigation of the patient's complaint. Sexual abuse is frequently reported long after the abuse occurs. T. Vol. IV, 47; T. Vol. XII, 159.

10. The Respondent's actions have had an adverse effect on the patient. Among other things, it has affected her ability to trust therapists when she has sought help for personal problems. T. Vol. IV at 105.

11. When the patient was a teenager she abused barbiturates, hallucinogenics (mushrooms), alcohol, amphetamines and marijuana. T. Vol. IV at 113. However, she never took any of these drugs before her appointments with Respondent and she was not under the influence of any chemicals during her visits with him. T. Vol. IV at 99.

Patient #2

12. Patient #2, who was born on March 13, 1922, is a paranoid schizophrenic with a long history of mental illness. Bd. Ex. 2, 121. Respondent began treating the patient on May 13, 1977. Dep. T. Vol. 1, 4-5. In addition to treating the patient's schizophrenia, Respondent treated her hypertension, nervousness and obesity. T. Vol. I, 208; T. Vol. II, 11; T. Vol. V, 136. In treating the patient's hypertension and obesity, the Respondent acted as a primary care physician for the patient. [2]

13. At various times Respondent prescribed Dyazide for the patient. The initial prescription was made on January 22, 1979 for one capsule daily. T. Vol. V, 146. At that time the patient weighed 196 pounds and her blood pressure was 150/100. T. Vol. V, 146; T. Vol. VI, 24. Between March and October 1983 Respondent again prescribed Dyazide for the patient's hypertension. T. Vol. I, 209. On other occasions, Respondent prescribed Dyazide for edema of the patient's hands and feet. Dep. T. Vol. 1, 30. Respondent did not obtain serum potassium levels of the patient while regularly prescribing Dyazide. He assumed, but did not know, that the serum potassium levels were being monitored by other physicians the patient was seeing. T. Vol. I, 216.

14. In addition to Dyazide, Respondent prescribed Inderal for the patient's hypertension. T. Vol. II, 13. Inderal is a beta blocker and a good drug for hypertension. However, it can cause depression, it slows heart rates, and it can activate allergies and asthma. Id. at 14.

15. Dyazide is a potassium-sparing diuretic. T. Vol. I, 208; T. Vol. II, 13. Diuretics increase urine excretion and can cause sodium and potassium depletion in the body. Diuretics like Dyazide, that contain triamterene, can occasionally cause potassium levels to go up. T. Vol. II, 15. High potassium levels (hyperkalemia) can be fatal. T. Vol. I, 210. Low potassium levels can cause fatigue and potentially dangerous arrhythmias and cardiac irregularities. T. Vol. II, 15; T. Vol. I, 211. Dyazide can cause potassium depletion in the body but the risks are low (T. Vol. I, 14, 216), and few patients have trouble with sodium or potassium levels while on the drug. T. Vol. II, 14.

16. The minimal standard of care usually requires a physician to elicit the patient's chief complaint, get a history of the complaint, and perform a physical examination. T. Vol. II, 100. Hence, the minimal standard of care for the diagnosis of hypertension is to obtain a history of the patient's family, the illness and prior therapies. T. Vol. II, 11; T. Vol. IX, 16. The treating doctor also should take several blood pressure checks, perform a physical examination and take basic lab tests before a diagnosis is made. T. Vol. II, 12; T. Vol. IX, 15-16. In addition, the diagnosing doctor should obtain an electrocardiogram, kidney function test and urinalysis, as well as a measurement of the patient's electrolytes. T. Vol.

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2. A primary care physician is one who provides general medical care for an individual patient. T. Vol. II, 10. Primary care is the initial, "front line" practice of family physicians treating a variety of common medical illnesses. T. Vol. iV, 12-13. A doctor who undertakes treatment of a medical condition generally becomes the primary care physician for the condition treated. When a doctor prescribes medicines for a condition, for example, the doctor becomes a primary care physician for the condition. T. Vol. II, 108.

II, 12. Before Respondent diagnosed the patient's hypertension he did not obtain a urinalysis, perform a physical, obtain a history, or do basic lab tests. T. Vol. II, 13; T. Vol. IX, 17.

17. Once hypertension is diagnosed and before Dyazide is prescribed, the prescribing doctor should obtain a base line potassium reading. Thereafter, the minimal, acceptable standard of care requires a potassium check after the patient is on medication for several months and annually thereafter. T. Vol. II, 15-16. When the prescribing doctor is not the patient's primary care physician, the prescribing doctor must consult with the primary care physician regarding the need for potassium checks. T. Vol. II, 17-18.

18. When Dyazide or Inderal are prescribed, the patient needs to be seen on a routine basis to determine how well the drugs are being tolerated and, with Inderal, whether the patient is tired or having cold feet. T. Vol. II, 14. Also, with Inderal, the patient's heart rate must be monitored. T. Vol. II, 14-15; T. Vol. IX, 18-19.

19. Respondent's treatment of the patient's hypertension fell below minimal standards of care. Respondent's chart does not contain a physical, address the patient's utilization of prescribed medications, show basic laboratory tests to diagnose hypertension, monitor the effects of prescribed drugs, contain basic vital signs (pulse and respiration) to monitor the Inderal prescribed, or contain necessary communications with other doctors the patient was seeing. T. Vol. II, 21.

Patient #3

20. Patient #3 was born on July 16, 1944. Bd. Ex. 3, 225. She began seeing the Respondent in December 1983. Dep. T. Vol. I, 73; T. Vol. VI, 75. During the course of her treatment she reported a history of nine ulcers, gastrointestinal bleeding, gastritis, headaches, and pain in her chest and neck. T. Vol. II, 22. Respondent diagnosed the patient as having high cholesterol, headaches (tension and migraine type), spinal arthritis, anxiety reactions and a severe reality-based panic disorder, weight loss, depression, drug seeking behavior, and neurodermatitis. T. Vol. II, 22; T. Vol. IV, 13.

21. The patient was well known to the Duluth psychiatric community as early as 1977 and had a history of repeated hospitalizations for hyperventilation and somatic complaints which were predominantly without objective basis. Bd. Ex. 3, 222. As a result of her anxiety and panic disorders the patient was severely dysfunctional and emotionally labile. T. Vol. IX, 42. She also suffered from weight loss problems and malnourishment due to anxiety. In August 1973, the patient weighed 82 pounds and appeared malnourished. Bd. Ex. 3, 222-223. In May 1980, she was diagnosed as suffering from malnourishment secondary to anxiety. At that time she weighed 83 pounds. Bd. Ex. 3, 203; T. Vol. VIII, 90. When she was admitted to a hospital on June 22, 1988, she weighed 86 pounds. Bd. Ex. 3, 368. Her low weight at that time resulted from eating only one meal daily and not eating at all for periods up to three days. Bd. Ex. 3, 319. The patient's normal weight is 100-110 pounds. Bd. Ex. 3, 319, 368.

22. The patient has a long history of chemical dependency which the Respondent knew. As early as July 1974, her chart refers to her long-standing abuse of alcohol and drugs. Bd. Ex. 3, 225. On November 21, 1977 the patient was diagnosed as having a probable addiction to Valium, a benzodiazepine, which she took for agitation, fear and chronic inability to function. Bd. Ex. 3, 207. On August 24, 1973 the patient complained of her "dependency on pills" (Bd. Ex. 3, 222) and on December 19, 1978 she was diagnosed as chemically dependent. At that time a doctor recommended, again, that she seek chemical dependency treatment. Bd. Ex. 3, 220. A June 6, 1982, medical chart entry shows that the patient was suspected of a Fiorinal overdose when she sought emergency treatment in April 1982. On December 30, 1983 the Respondent himself noted that the patient had a history of chemical dependency on alcohol and mixed drugs but concluded at that time that it was largely in remission. Bd. Ex. 3, 513.

23. On July 10, 1984 a drug utilization review (DUR) committee of the Minnesota Department of Public Welfare wrote to Respondent expressing concerns about the patient's over-utilization of Fiorinal, Axotal and Ativan and questioning whether Respondent's prescriptions were warranted. Respondent replied to the DUR committee's concerns by noting that he had tried to limit her medications during the 4-month period he had been treating her and recommended that the committee manage the patient's use of drugs by limiting her to the use of one pharmacy. Bd. Ex. 3, 514.

24. On October 2, 1985 a Duluth social worker informed Respondent that the patient sounded intoxicated during the course of several telephone calls and that the patient's daughter had reported that the patient was abusing medications prescribed by the Respondent. The social worker suggested that the patient had a problem with alcohol and drugs and that the Respondent should stop giving her prescription medications. Bd. Ex. 3, 268.

25. On September 23, 1986 the DUR committee wrote to Mattson again expressing concern about his prescription of medications containing butalbital (Axotal and Isollyl). In that letter Respondent was asked if the patient was a candidate for alternative therapies such as nonsteroidal anti-inflammatory agents, antidepressants, calcium channel blockers, ergot alkaloids or other medications for headache treatment. On September 29, 1986 Respondent informed the DUR committee that he had tried other drugs including Triavil 2/25, Rufen and Motrin without much success because some of them aggravated her stomach complaints. Respondent also noted that the Axotal he prescribed had worked reasonably well in keeping the patient out of the hospital and out of the emergency room for Demerol injections, and that she had done fairly well caring for a sick grandchild during the past year. Bd. Ex. 3, 458.

26. From January 2, 1985, through December 2, 1988, the Respondent prescribed the following medications for the patient:

Date	Drug	Quantity
01-2-85	Axotal	50
01-16-85	Axotal	50
02-7-85	Isollyl	40
02-20-85	Isollyl	40

03-7-85	Isollyl	40
03-20-85	Isollyl	40
04-1-85	Isollyl	40
04-1-85	Mellaril	40
04-15-85	Isollyl	40
04-15-85	Mellaril	40
04-26-85	Isollyl	50
04-30-85	Diphenhydramine	30
04-30-85	Axotal	30
05-6-85	Isollyl	30
05-28-85	Isollyl	50
06-14-85	Isollyl	50
07-1-85	Isollyl	50
07-16-85	Isollyl	60
07-30-85	Fioricet	50
08-16-85	Isollyl	50
08-16-85	Mellaril	30
08-30-85	Isollyl	50
09-9-85	Isollyl	50
09-24-85	Isollyl	50
10-7-85	Isollyl	50
10-9-85	Diphenhydramine	20
11-5-85	Triavil	50
11-5-85	Isollyl	50
11-6-85	Diphenhydramine	20
11-19-85	Triavil	30
11-19-85	Axotal	45
12-1-85	Axotal	45
02-4-86	Axotal	45
02-18-86	Axotal	45
03-4-86	Axotal	45
03-4-86	Triavil	30
03-18-86	Axotal	45
03-18-86	Triavil	30
04-8-86	Triavil	30
04-8-86	Axotal	45
04-8-86	Tagamet	90
04-22-86	Axotal	45
04-22-86	Triavil	30
05-6-86	Triavil	32
05-6-86	Axotal	45
05-20-86	Triavil	32
05-20-86	Axotal	45
06-3-86	Axotal	45
06-3-86	Triavil	30
06-18-86	Triavil	30
02-2-87	Triavil	50
02-2-87	Fioricet	50
03-6-87	Triavil	50
03-6-87	Fioricet	50
03-20-87	Amitriptyline w-Perphenazine 25-2 mg.	50
03-20-87	Fioricet	50
04-6-87	Amitriptyline	

	w-Perphenazine 25-2 mg.	50
04-06-87	Fioricet	50
04-23-87	Amitriptyline w-Perphenazine 25-2 mg.	50
04-23-87	Fioricet	50
05-01-87	Fioricet	50
05-15-87	Fioricet	50
05-28-87	Fioricet	50
06-10-87	Fioricet	50
06-18-87	Amitriptyline 25 mg.	60
06-18-87	Fioricet	50
07-01-87	Fioricet	50
07-14-87	Amitriptyline w- Perphenazine 25-2 mg.	60
07-14-87	Amitriptyline 25 mg.	90
07-14-87	Fioricet	90
08-03-87	Fioricet	50
08-24-87	Fioricet	60
09-22-87	Fioricet	60
09-26-87	Fioricet	60
10-20-87	Fioricet	60
11-10-87	Fioricet	60
12-03-87	Fioricet	60
12-11-87	Fioricet	20
12-15-87	Doxepin 50 mg.	14
12-18-87	Fioricet	30
12-21-87	Fioricet	30
12-28-87	Doxepin 50 mg.	14
12-28-87	Fioricet	30
01-04-88	Fioricet	30
01-07-88	Fioricet	30
01-18-88	Fioricet	30
01-19-88	Amitriptyline 25 mg.	7
01-25-88	Amitriptyline 25 mg.	7
01-25-88	Fioricet	30
02-01-88	Amitriptyline 25 mg.	7
02-01-88	Fioricet	30
02-08-88	Fioricet	30
02-09-88	Doxepin 25 mg.	7
02-15-88	Doxepin 25 mg.	7
02-15-88	Fioricet	30
02-22-88	Doxepin 25 mg.	7
02-22-88	Fioricet	30
02-29-88	Doxepin 25 mg.	7
02-29-88	Fioricet	30
03-07-88	Doxepin 25 mg.	7
03-07-88	Fioricet	30
03-11-88	Buspar 5 mg.	45
03-11-88	Fioricet	30
03-14-88	Doxepin 25 mg.	7
03-18-88	Floricet	30
03-21-88	Doxepin 25 mg.	7
03-25-88	Buspar 5 mg.	45
03-25-88	Fioricet	30

04-01-88	Doxepin 25 mg.	7
04-01-88	Fioricet	30
04-08-88	Doxepin 25 mg.	7
04-08-88	Fioricet	30
04-11-88	Doxepin 50 mg.	15
04-11-88	Fioricet	30
04-13-88	Doxepin 25 mg.	21
04-18-88	Buspar 5 mg.	60
04-18-88	Fioricet	30
04-25-88	Fioricet	30
05-02-88	Buspar 5 mg.	60
05-02-88	Fioricet	30
05-03-88	Doxepin 50 mg.	15
05-09-88	Fioricet	30
05-16-88	Buspar 5 mg.	45
05-16-88	Fioricet	30
05-23-88	Doxepin 50 mg.	15
05-23-88	Fioricet	30
05-31-88	Fioricet	30
06-06-88	Buspar 5 mg.	45
06-06-88	Fioricet	30
06-09-88	Doxepin 50 mg.	10
06-09-88	Fioricet	20
06-13-88	Buspar 5 mg.	45
06-13-88	Fioricet	30
06-15-88	Fioricet	30
06-20-88	Fioricet	30
07-01-88	Buspar 5 mg.	60
07-01-88	Doxepin 50 mg.	15
07-01-88	Fioricet	30
07-07-88	Doxepin 50 mg.	14
07-07-88	Fioricet	30
07-15-88	Fioricet	30
07-21-88	Doxepin 50 mg.	14
07-21-88	Isollyl	30
07-28-88	Buspar 5 mg.	60
07-28-88	Isollyl	30
08-04-88	Doxepin 50 mg.	14
08-04-88	Isollyl	30
08-11-88	Isollyl	30
08-18-88	Doxepin 50 mg.	14
08-18-88	Isollyl	30
08-19-88	Doxepin 50 mg.	7
08-23-88	Buspar 5 mg.	56
08-23-88	Doxepin 50 mg.	7
08-23-88	Isollyl	30
08-30-88	Isollyl	30
09-06-88	Buspar 5 mg.	56
09-06-88	Isollyl	30
09-12-88	Doxepin 50 mg.	12
09-12-88	Isollyl	24
09-22-88	Buspar 5 mg.	56
09-22-88	Doxepin 50 mg.	14
09-22-88	Isollyl	24

09-29-88	Isollyl	36
10-06-88	Buspar 5 mg.	56
10-06-88	Doxepin 50 mg.	14
10-07-88	Isollyl	30
10-14-88	Isollyl	30
10-18-88	Doxepin 50 mg.	14
11-04-88	Buspar 5 mg.	56
11-04-88	Doxepin 50 mg.	14
11-04-88	Isollyl	30
11-11-88	Isollyl	30
11-17-88	Doxepin 50 mg.	14
11-17-88	Isollyl	30
11-25-88	Isollyl	30
12-01-88	Buspar 5 mg.	56
12-01-88	Doxepin 50 mg.	14
12-02-88	Isollyl	30

T. Dep. of Respondent at 70-71.

27. Fiorinal is a pain medication and muscle relaxer containing butalbital (a barbiturate), caffeine and aspirin. T. Vol. II, 25. Isollyl is another brand of Fiorinal. Axotal is like Isollyl but contains no caffeine. Fioricet is similar to Fiorinal and Isollyl but it contains acetominopen in place of aspirin. T. Vol. II, 25-26, 29-30. Barbiturates are addictive. T. Vol. IV, 14. Lorazepam (Ativan), Centrax and Librium (chlordiazepoxide) are benzodiazepines and are addictive or habituating. Librium and Valium are addicting while other benzodiazepines are habituating. T. Vol. IV, 14; T. Vol. VIII, 46, 48. Doxepin and Amitriptyline are nonaddicting, antidepressant medications.

28. Among other things, Respondent treated the patient for pain. Dep. T. Vol. 1, 74. By so doing, he was acting as a primary care physician. T. Vol. II, 43. The pain arose from TMJ syndrome diagnosed in 1983 (Dep. T. Vol. I, 75), arthritis of the neck initially diagnosed in March, 1988, and headaches related to the patient's arthritis or other factors.

29. Respondent's work-up of the patient's headaches did not meet minimal standards of care. T. Vol. II, 32. The patient's chart does not describe the nature of the headaches she experienced in any meaningful detail. For example, it does not show the frequency or timing of the headaches, or their location (e.g., unilateral). In addition, Respondent's work-up did not include an appropriate neurologic examination (T. Vol. II, 32, 35) or a treatment plan. T. Vol. II, 39-40.

30. The Respondent's follow-up of the patient's headaches also did not meet minimal care standards. Respondent did not determine how prescribed medications were tolerated, how they worked, or whether the nature of her headaches changed. T. Vol. II, 35-36. Also, Respondent did not regularly record the patient's vital signs (blood pressure, respiration and pulse) or perform routine physicals during the patient's office visits. T. Vol. II, 24, 37, 41.

31. For the patient's headaches and arthritis, the Respondent prescribed Isollyl or Axotal. T. Vol. II, 24, 28-30. Both medications contain aspirin. Aspirin will irritate the

stomach and can cause ulcers and gastrointestinal bleeding. A problem arises, therefore, when drugs containing aspirin are prescribed to a patient who has had ulcers, gastritis or gastrointestinal (GI) bleeding. T. Vol. II, 27. In such patients, drugs containing acetominophin or specially-bonded salicylates like Disalcid and Trilisate are used. Nonsteroidal anti-inflammatories, like Motrin, may be better than aspirin, but all nonsteroidal anti-inflammatories can cause gastric irritation. T. Vol. II, 122; Dep. T. Vol. 1, 97.

32. When an aspirin compound is prescribed for a patient with a history of GI problems, the patient's chart should justify its use. The Respondent's chart contains no such explanation. T. Vol. II, 28. However, the patient did not have any known problems as a result of the aspirin-containing medications Respondent prescribed. T. Vol. II, 27.

33. For chemically dependent patients, or those exhibiting drug-seeking behavior, a physician must closely monitor all prescriptions having an addictive potential. T. Vol. IV, 15. Barbiturates are addicting. T. Vol. VIII, 107. Therefore, the long-term prescription of drugs containing butalbital, a barbiturate, is generally avoided in patients with a mixed chemical dependency diagnosis. T. Vol. IV, 15-16. The Respondent's charts do not specifically state the reasons why drugs containing butalbital, like Axotal and Isollyl, were prescribed for the patient or the conditions they were intended to treat. It is clear, however, that they were prescribed to treat the pain associated with the patient's headaches and cervical arthritis. T. Vol. II, 28-29. Axotal is one of the most common drugs prescribed for migraine (T. Vol. IX, 27), but it is not the treatment of choice for arthritis because of its addicting potential. T. Vol. IX, 27, 31-31.

34. The patient suffered from chronic headaches and was frequently hospitalized for intense headache pain. The treatment of headaches is very difficult. T. Vol. II, 34-35. The treatment of the patient's headaches and other medical conditions was made more difficult due to her psychiatric problems. She was, in short, a very difficult patient to treat. T. Vol. IV, 84. Generally speaking, the usual medications prescribed for arthritis and headaches begins with over-the-counter medications such as aspirin and other salicylates or Motrin-type nonsteroidal anti-inflammatories. Dep. T. Vol. 1, 96; T. Vol. VIII, 11. When over-the-counter and prescription nonsteroidal anti-inflammatories are ineffective, stronger medication is required. T. Vol. VIII, 11. The second level of intervention, at least for headaches, consists of drugs containing a barbiturate because barbiturates potentiate the effectiveness of other pain relievers. T. Vol. VIII, 17; T. Vol. VIII, 105. The Respondent's prescription of Fioricet, Isollyl and Axotal was within recommended dosages. T. Vol. VIII, 11. Also, the daily dosage was well below the levels that would produce a serious addiction problem. T. Vol. VIII, 17.

35. Prescribing pain relievers containing butalbital to patient #3 was below the minimal accepted standards of medical practice because other nonaddicting pain relievers and alternative treatments were not attempted before they were prescribed.

36. When aspirin and other salycilates, including Motrin-type nonsteroidal anti-inflammatories, and other nonaddicting pain relievers are ineffective in treating the pain experienced by persons suffering from cervical arthritis and frequent headaches,

alternatives to the prescription of potentially addicting or habituating medications include physical therapy, and biofeedback. T. Vol. IX, 18; T. Vol. II, 35; T. Vol. VIII, 16. Respondent did not pursue these alternatives.

Patient #5

37. Patient #5 was born February 21, 1948. Bd. Ex. 5, 558. He is a paranoid schizophrenic with a personality disorder who suffered from depression and hallucinations. He had a history of ulcers, epigastric pain and nonspecific back and bone pain. T. Vol. II, 43; T. Vol. VI, 123; T. Vol. VIII, 109. The patient began seeing Respondent in 1977. Dep. T., Vol. 2, 161-162. Thereafter, Respondent acted as a primary care physician to the patient. T. Vol. II, 44; Dep. T., Vol. 2, 166.

38. From December 31, 1984, through June 9, 1988, Respondent inappropriately prescribed compounds containing barbiturates for patient #5 for long-term continuous use. T. Vol. II, 46. Respondent's prescribing for patient #5 included the following:

Date	Drug	Quantity
12-31-84	Valium 10 mg.	15
12-31-84	Axotal	30
12-31-84	Cogent in	30
01-24-85	Axotal	30
03-19-85	Axotal	30
03-19-85	Valium 10 mg.	7
05-?-85	Axotal	30
06-6-85	Valium 10 mg.	15
06-6-85	Benztropine	15
06-13-85	Axotal	50
06-17-85	Valium 10 mg.	15
06-20-85	Benztropine	30
07-1-85	Valium 10 mg.	15
07-9-85	Valium 10 mg.	15
07-9-85	Rufen	30
07-12-85	Axotal	50
07-20-85	Benztropine	30
07-22-85	Axotal	50
07-22-85	Valium 10 mg.	15
08-12-85	Valium 10 mg.	15
08-12-85	Axotal	50
09-9-85	Valium	30
09-9-85	Axotal	50
09-18-85	Darvon compound	24
09-19-85	Cogentin	15
10-4-85	Diazepam	20
11-12-85	Benztropine	15
11-12-85	Axotal	30
11-21-85	Rufen	30

04-14-86	Triavil 4-25	45
09-29-87	Axotal	50
03-17-86	Triavil 4-25 mg.	45
03-20-86	Axotal	30
03-27-86	Axotal	30
03-31-86	Axotal	30
03-31-86	Cogentin	15
04-09- 86	Axotal	30
04-10-86	Triavil 4-25 mg.	45
04-14-86	Triavil 4-25 mg.	45
04-18-86	Axotal	30
04-25-86	Axotal	30
04-28-86	Axotal	40
04-28-86	Triavil 4-25 mg.	40
05-06-86	Axotal	40
05-16-86	Axotal	40
05-23-86	Axotal	40
06-02-86	Axotal	50
06-2-86	Cogentin	15
06-2-86	Dimetane-sample	4
06-9-86	Axotal	15
06-23-86	Axotal	30
06-30-86	Axotal	30
07-10-86	Triavil 4-25 mg.	40
07-14-86	Axotal	50
07-28-86	Axotal	50
08-04-86	Triavil 4-25 mg.	40
08-11-86	Axotal	30
08-18-86	Axotal	30
08-22-86	Inderal	15
08-22-86	Cogentin	30
08-28-86	Axotal	20
09-02-86	Axotal	30
09-08-86	Axotal	30
09-?-86	Haldol	15
09-?-86	Cogentin	15
09-18-86	Axotal	30
09-26-86	Axotal	30
10-3-86	Axotal	50
11-2-86	Axotal	60
11-2-86	Prolixin	15
11-17-86	Axotal	40
11-28-86	Axotal	40
12-16-86	Axotal	40
01-09-87	Axotal	40
03-3-87	Axotal	40
12-11-87	Haldol 5 mg.	30
12-11-87	Benztropine	30
12-11-87	Orudis	30

12-17-87	Haldol 5 mg.	3
12-17-87	Cogentin	3
12-17-87	Xanax 5 mg.	6
01-12-88	Orudis - sample	8
06-9-88	Axotal	50

Dep. T., Vol. II, 161. Valium (diazepam) and Xanax (alprazolam) are benzodiazepines. Axotal is a pain reliever and muscle relaxer containing butalbital and aspirin. Finding 27, supra. Triavil is a tricyclic antidepressant prescribed for schizophrenia. It contains Amitriptyline for depression and Trilafon for anxiety. Dep. T. Vol. 2, 175-176. Orudis is an anti-inflammatory nonsteroidal. Id. at 186.

39. The patient is a street person who was frequently admitted to hospitals in Duluth for complaints of pain or traumatic injuries. T. Vol. VIII, 110. He was hostile, obnoxious, violent, agitated, and very difficult to handle. The patient also was chemically dependent on alcohol. T. Vol. II, 43; T. Vol. VI, 123; Dep. T. Vol. 2, 163, 181. He had a long history of chemical abuse. This is reflected in medical records dated December 23, 1979 (Bd. Ex. 5, 743) and July 21, 1982. Bd. Ex. 5, 550, 566. The Respondent's medical records of November 4, 1986 and December 11, 1987 specifically note the patient's abuse of alcohol and drugs. See Bd. Ex. 5, 549, 684. The patient's medical records also show hospital admissions for the overdose of Valium and Dalmane on November 25, 1977 (Bd. Ex. 5, 819-820) and for the abuse of alcohol, Valium and Ritalin on January 12, 1980. Bd. Ex. 5, 839. Ritalin, a stimulant, is a controlled substance. Minn. Rule pt. 6860.4220, subp. D(4).

40. For the patient's various pains the Respondent prescribed Axotal on a long-term basis. Axotal contains butalbital and aspirin. Dep. T. Vol. II, 176. Axotal was contraindicated for the patient because it contained aspirin which irritates the stomach and can cause ulcers. T. Vol. II, 46. Also, Axotal is contraindicated for the patient because he is chemically dependent on alcohol and had abused other drugs. Medicines containing barbiturates are never drugs of first choice in treating arthritic pain. T. Vol. IX, 32. For patients with a chemical dependency diagnosis the use of such drugs is even less prudent. T. Vol. IX, 32. The prescription of barbiturates to alcohol-dependent persons is particularly troublesome because barbiturates and alcohol are cross tolerant. Therefore, alcoholics are readily able to break down large amounts of barbiturates and obtain a similar kind of feeling they get from alcohol. T. Vol. IV, 22-23. The long-term prescription of Axotal to the patient given his history of chemical abuse and other information available to the Respondent fell below accepted minimal standards of medical care. T. Vol. IV, 23.

41. When a physician knows that a patient has been selling prescribed drugs on the street or "getting high" on them, those prescriptions should not be reissued. T. Vol. IX, 46. On July 6, 1982 a concerned roommate of the patient wrote to the Respondent indicating that the patient was abusing the Respondent's prescriptions of Ritalin by selling them on the street. Bd. Ex. 5, 771; T. Vol. IV, 25-26.

42. Based on the testimony of the experts at the hearing the standards of care for prescribing benzodiazepines are as follows. In treating panic and anxiety, a physician must first perform a competent work-up and diagnosis of the patient's panic and anxiety. Before prescribing benzodiazepines, it is the physician's obligation first to assess whether the

patient is chemically dependent. T. Vol. VIII, 45. Next, the physician must document an adequate trial of non-addicting drugs. Dep. T. Vol. 2, 109-111; T. Vol. IV, 16, 52-55; Vol. VIII, 59-60, 68-69. If the patient is chemically dependent, the physician must weigh the risks of continuing the dependency by prescribing benzodiazepines against the benefit to the patient of prescribing the drugs. T. Vol. VIII, 107; Vol. IX, 65-57. Finally, after all of the above, the physician may prescribe benzodiazepines for the patient, if necessary. The physician must then carefully monitor and document any intended, beneficial effects, as well as any adverse effects such as signs of drug tolerance or abuse.

43. The Respondent's prescription of Valium to the patient fell below minimal standards of accepted medical care due to the patient's prior abuse of alcohol and drugs, including Valium. Other sedative and anxiety-reducing medications were available that did not pose a risk of abuse or addiction. Id. They include at least a dozen drugs of the Mellaril type, drugs like Haldol, and antihistamines like Vistaril and Benadryl. T. Vol. IV, 26-27.

44. The minimal standard of care for the treatment of osteoarthritis would first require the treating physician to obtain a history of the disease and perform a physical examination which could include X-rays of the back. T. Vol. VIII, 56. Once arthritis is diagnosed the standard of care dictates conservative treatment measures such as physical therapy, exercise and the prescription of over-the-counter medications like aspirin or ibuprofen. T. Vol. VIII, 58. If those measures are ineffective, the physician would go to a trial of nonsteroidal anti-inflammatories. Id. For chemically dependent patients, with a history of selling and abusing prescription drugs the minimal standard of care requires the treating physician to give a thorough trial of nonaddicting methods of treating pain before prescribing addicting medications. T. Vol. VIII, 60. The Respondent did not give a thorough trial of nonaddicting medications for patient #5 before prescribing Axotal. He prescribed Feldene on one occasion, which the patient could not tolerate, and prescribed Motrin (Rufen) twice in 1985. Dep. T. Vol. II, 179, 180-182. This was not an effective or sufficient trial of alternatives to the prescription of addicting barbiturates. T. Vol. VIII, 62.

45. The Respondent's diagnosis of osteoarthritis did not meet minimal standards of acceptable medical care because it was not based on a history, physical and tests. T. Vol. II, 50; T. Vol. IX, 43; T. Vol. VIII, 56. Moreover, the medical records the Respondent allegedly relied on in reaching his diagnosis of osteoarthritis did not contain any objective finding supporting that diagnosis. T. Vol. XI, 21-28.

Patient #6

46. Patient #6 became a patient of the Respondent on June 28, 1979. Dep. T. Vol. 2, 199. Thereafter, Respondent became a primary care physician, treating her for scoliosis, headaches, chronic back pain, depression, anxiety, fear of crowds, chronic bronchitis, emphysema, and diabetic neuropathy. Dep. T. Vol. 2, 197, 232; T. Vol. 2, 50-51.

47. From July 31, 1984 through June 28, 1990 Respondent prescribed the following medications for patient #6:

Date	Drug	Quantity
07-31-84	Fiorinal w-codeine	30
07-31-84	Xanax .5 mg.	50
09-12-86	Mellaril	90
12-15-86	Xanax .5 mg.	60
01-08-87	Xanax 1 mg.	60
01-22-87	Acetaminophen #3	30
01-22-87	Xanax 1 mg.	60
01-27-87	Triavil	60
02-03-87	Xanax 1 mg.	60
03-06-87	Xanax 1 mg.	60
04-06-87	Xanax 1 mg.	60
04-24-87	Darvocet N-100	4
05-04-87	Terpin Hydrate w-codeine	120 ml.
05-04-87	Xanax 1 mg.	60
05-14-87	Terpin Hydrate w-codeine	120 ml.
06-02-87	Xanax 1 mg.	60
06-29-87	Terpin Hydrate w-codeine	120 ml.
06-29-87	Xanax 1 mg.	60
07-27-87	Terpin Hydrate w-codeine	120 ml.
07-27-87	Xanax 1 mg.	60
08-27-87	Terpin Hydrate w-codeine	120 ml.
08-27-87	Xanax 1 mg.	60
09-28-87	Terpin Hydrate w-codeine	120 ml.
09-28-87	Xanax 1 mg.	60
10-23-87	Xanax 1 mg.	60
11-19-87	Fiorinal #3	15
11-19-87	Xanax 1 mg.	30
12-04-87	Fiorinal #3	15
12-04-87	Xanax 1 mg.	30
12-15-87	Fiorinal #3	15
12-15-87	Xanax 1 mg.	30
12-28-87	Fiorinal #3	15
12-28-87	Xanax 1 mg.	30
01-04-88	Propoxyphene N-APAP-100	30
01-11-88	Fiorinal #3	15
01-11-88	Xanax 1 mg	30
01-19-88	Terpin Hydrate w-codeine	120 ml.
01-26-88	Fiorinal #3	15
01-26-88	Terpin Hydrate w-codeine	120 ml.
01-26-88	Xanax 1 mg.	30
02-01-88	Propoxyphene N-APAP-100	15
02-11-88	Fiorinal #3	30
02-11-88	Guiatussin DM	120 ml.
02-11-88	Xanax 1 mg.	30
02-25-88	Fiorinal #3	30
02-25-88	Xanax 1 mg.	30
03-07-88	Guiatussin DM	120 ml.

03-11-88	Fiorinal #3	30
03-11-88	Xanax 1 mg.	30
03-28-88	Fiorinal #3	30
03-28-88	Xanax 1 mg.	30
04-11-88	Fiorinal #3	30
04-11-88	Xanax 1 mg.	30
04-26-88	Fiorinal #3	28
04-26-88	Xanax 1 mg.	28
05-10-88	Fiorinal #3	28
05-10-88	Xanax 1 mg.	28
05-20-88	Fiorinal #3	28
05-20-88	Xanax 1 mg.	28
06-03-88	Fiorinal #3	28
06-03-88	Xanax 1 mg.	28
06-13-88	Fiorinal #3	30
06-13-88	Xanax 1 mg.	30
06-22-88	Fiorinal #3	30
06-22-88	Xanax .5 mg.	6
06-27-88	Xanax 1 mg.	30
06-27-88	Fiorinal #3	30
07-7-88	Xanax .5 mg.	3
07-11-88	Fiorinal #3	30
07-11-88	Xanax 1 mg.	30
07-27-88	Fiorinal #3	30
08-01-88	Fiorinal #3	30
08-01-88	Xanax 1 mg.	30
08-8-88	Fiorinal #3	30
08-16-88	Fiorinal #3	30
08-16-88	Lorazepam 1 mg.	45
08-16-88	Ativan	45
08-30-88	Fiorinal #3	30
08-30-88	Xanax .5 mg.	45
09-05-88	Xanax .5 mg.	45
09-15-88	Doxepin 50 mg.	15
09-15-88	Fiorinal #3	30
09-25-88	Xanax .5 mg.	45
09-29-88	Doxepin 50 mg.	15
09-29-88	Fiorinal #3	30
09-29-88	Xanax .5 mg.	45
10-13-88	Doxepin 50 mg.	30
10-13-88	Fiorinal #3	30
10-13-88	Xanax .5 mg.	30
10-27-88	Doxepin 50 mg.	30
10-27-88	Fiorinal #3	30
10-27-88	Xanax .5 mg.	30
11-07-88	Doxepin 50 mg.	30
11-07-88	Fiorinal #3	30
11-07-88	Xanax .5 mg.	30
11-21-88	Fiorinal #3	30

12-05-88	Fiorinal #3	30
05-3-90	Fioricet #3	60
05-3-90	Xanax .5 mg.	15
05-3-90	Fiorinal	30
05-3-90	Triavil	45
05-17-90	Xanax .5 mg.	15
05-29-90	Triavil	45
05-29-90	Fioricet #3	60
05-29-90	Xanax .5 mg.	15
06-14-90	Fioricet #3	60
06-14-90	Triavil	45
06-14-90	Xanax .5 mg.	15
06-28-90	Triavil	45
06-28-90	Xanax .5 mg.	15
06-28-90	Fiorinal #3	30

48. The patient's chronic tension headaches, migrainoid, were initially mentioned by Dr. Robert J. Goldish in 1984. T. Vol. IV, 28; Bd. Ex. 6, 2223. The patient's medical chart contains records of repeated emergency hospitalizations for migraine headaches between 1987 and 1990. See, e.g., Bd. Ex. 6, 2148, 2150, 2155, 2200. The patient's double-curved scoliosis of the thoracic spine was diagnosed on October 6, 1983. Bd. Ex. 6, 2104, 2191.

49. Dr. Goldish was the primary care physician for the patient's diabetes, but both Dr. Goldish and the Respondent treated her for headache pain, back pain and diabetic neuropathy. On June 23, 1986, Dr. Goldish wrote the Respondent stating that the patient tends to overuse her pain medications and had admitted taking two rather than one Darvocet-N tablets four times daily, as prescribed for headache and chest wall pain. Goldish said he thought it would be better for the patient to get all her analgesic medications from Respondent. Bd. Ex. 6, 2206. On July 3, 1986 Respondent wrote Goldish stating he would prefer that Goldish prescribe the Darvocet-N or any other pain medications to the patient.

50. After July 3, 1986, Respondent resumed prescribing analgesic medications including Darvocet-N to the patient without any form of documented communication with Goldish. This created a risk that the patient would abuse pain medications by getting prescriptions from both doctors. T. Vol. IV, 30. If the Respondent had an oral agreement with Dr. Goldish to change the terms of the July 3 letter, the minimal standard of acceptable medical care required that the Respondent's chart reflect that agreement. T. Vol. IV, 34; T. Vol. II, 55. It doesn't.

51. The patient has suffered from headaches for over 20 years. The headaches varied in number and intensity over the years. On February 6, 1986, Respondent noted that the patient was slightly better (Bd. Ex. 6, 2105) and in April 1987, Dr. Goldish noted that she tolerated her headache pain quite well. Bd. Ex. 6, 2081. Beginning in June 1989, her headaches became considerably more frequent and intense, averaging two to three regular weekly headaches and one severe headache every two to three weeks. Her regular headaches were bifrontal and bitemporal, but her more severe headaches were left-sided with nausea but no vomiting. Bd. Ex. 6, 1973. Even after her headaches became worse, they were not disabling. Bd. Ex. 6, 1969. The patient also suffered from recurrent back

pain which was attributable, in part, to her scoliosis. T. Vol. II, 53; T. Vol. VIII, 26, 112-113.

52. When the patient first consulted with the Respondent on June 28, 1979, her chief complaint concerned "migraines, nightmares and left-sided pounding headaches." Bd. Ex. 6, 2105. Her headache complaints, as well as her complaints about back pain persisted in subsequent years and the Respondent treated them. Dep. T. Vol. 2, 202-204; T. Vol. VI, 156.

53. Between November 19, 1987 and June 28, 1990, the Respondent usually prescribed Fiorinal #3 to the patient for her pain although he wrote a few prescriptions for Fioricet #3. Fiorinal #3 contains butalbital, aspirin, caffeine and codeine. Fioricet #3 is similar but contains acetaminophen in place of aspirin. Both Fiorinal #3 and Fioricet #3 are useful medications for the treatment of a variety of pain including the treatment of headache pain (T. Vol. IV, 31) and back pain. T. Vol. VIII, 26. Fiorinal #3 contains 50 milligrams of butalbital and 30 milligrams of codeine. Physicians Desk Reference, 1867 (42 ed., 1988). Both are addicting. Finding 27, supra; T. Vol. VIII, 54.

54. The package insert for Fiorinal #3 contained in the Respondent's records states that it is "particularly well-suited for acute, short-range periods of pain and discomfort." Bd. Ex. 6, 1899-1900. It does not discuss - long-term use. Moreover, long-term use is not described in the Physicians Desk Reference, 1867 (42 ed. 1988) and 1775 (41 ed. 1987). However, it is usually prescribed for periods not exceeding three months due to the potential for addiction concomitant with longer use. T. Vol. IV, 31; T. Vol. II, 56-57. After three months, other treatments must be considered. They include pain clinics, biofeedback, nonaddicting analgesics, Ergot compounds to abort headaches, physical therapy and neurologic consultations. T. Vol. II, 56; T. Vol. IV, 31-32; Dep. T., Vol. 2, 239. Respondent's failure to pursue these alternatives fell below minimal standards of acceptable medical practice. T. Vol. IV, 32-33; T. Vol. II, 55-57.

55. As early as July 31, 1984, Respondent prescribed Fiorinal with codeine for the patient. On February 6, 1986, he was prescribing Elavil, Mellaril and Fioricet. Bd. Ex. 6, 2105. At that time the patient was doing slightly better than she had in the past, but she continued to have an adjustment reaction to adult life with depression and headaches, possibly on a conversion basis. She also had frequent colds (which were possibly related to old tuberculosis and her scoliosis), severe diabetes, chronic bronchitis and chronic emphysema. Bd. Ex. 6, 2105. About one year later, Dr. Goldish found that the patient was tolerating her headache pain quite well. Bd. Ex. 6, 2081. Nonetheless, between November 19, 1987 and December 5, 1988, the Respondent regularly prescribed Fiorinal #3 to the patient for her headaches and back pain even though the frequency and severity of her headaches had not yet worsened. Findings 52 and 56, Supra. He never prescribed Fiorinal #3 in excess of the daily limitations contained in Physicians Desk Reference. However, the duration of the Fiorinal prescriptions was too long and fell below minimal standards of acceptable medical care due to the addictive nature of Fiorinal #3, the patient's drug-seeking behavior, and the Respondent's failure to try other treatments and nonaddicting medications. T. Vol. IV, 32-33.

56. The patient had a long history of drug dependency tendencies. These tendencies were noted in a hospital discharge summary Dr. Goldish drafted on September 6, 1981.

Bd. Ex. 6, 2089. In February 1982, the patient was on a "drug alert" issued by another physician. Bd. Ex. 6, 2071. On that date, Dr. Goldish refused to prescribed Empirin #3 as the patient requested, but on the same date Respondent prescribed Axotal for her. Bd. Ex. 6, 2071; T. Vol. VI, 157. Due to the patient's "drug shopping" habits, she was restricted to the use of one pharmacy by the Medical Assistance program in 1984 or before. Dep. T. Vol. 2, 211-212. Respondent was aware of the pharmacy restriction and the reasons for it.

57. The Respondent's chart includes records from Dr. Goldish's office Duluth Internal Medicine Associates. Those records contain many entries by Dr. Goldish and Dr. Robert M. Olson regarding the patient's request for specific codeine-containing drugs and their allusions to her drug-seeking behavior. Her charts show no less than 14 drug requests and 8 entries about her overuse of prescription drugs. Bd. Ex. 6, 2071-2087. Generally, a patient's request for drugs is an unhealthy sign for the patient and a red flag for the physician. T. Vol. IV, 19. Respondent knew or should have known about the contents of the patient's medical records at Duluth Internal Medicine Associates. T. Vol. II, 52. He had specific notice of some of them. Also, on June 23, 1986, when the patient had a prescription for Axotal from the Respondent, she was seeking Darvocet-N from Dr. Goldish. Darvocet-N is an addicting analgesic containing propoxyphene napsylate and acetaminophen. Dr. Goldish wrote to Respondent advising him that the patient was seeking a prescription of Darvocet-N, even though she had a prescription for Axotal, and that the patient admitted overusing a Darvocet-N prescription Goldish had given her. Bd. Ex. 6, 2100. Due to the patient's drug-seeking behavior, Respondent should have experimented with the use of alternative treatments and nonaddicting medications for her chronic pain.

58. Before Respondent began prescribing Fiorinal #3 to the patient on a regular basis in November 1987, he did not undertake a reasonable trial of nonaddicting medications and treatments. On June 28, 1979, he prescribed Cafergot suppositories for the patient's headaches. T. Vol. VI, 159. On July 19, 1979, he prescribed Darvon (T. Vol. VI, 157); on October 6, 1983, he prescribed Triavil and Axotal; and on October 11, 1983, he prescribed Motrin. T. Vol. VI, 157. Much earlier, on December 4, 1980, the patient was evaluated at St. Luke's Hospital in Duluth and it was concluded that she was not then a good candidate for biofeedback. Bd. Ex. 6, 2012; T. Vol. VI, 165.

Patient #7

59. Patient #7 is 54-year-old woman who was born on April 3, 1937. She became the Respondent's patient following her hospitalization for drug addiction in September 1971. T. Vol. III, 8. At that time, Respondent diagnosed her as a barbiturate abuser and alcoholic (inebriate) having a personality disorder. Bd. Ex. 7, 945; 7. Vol. I, 61. After her detoxification, the patient began seeing the Respondent on a regular basis for depression, adjustment reaction, anxiety-depressive neurosis, personality disorder, and chemical dependency. T. Vol. I, 60-62, 72-73; T. Vol. III, 8; T. Vol. IV, 48, 72. The patient is not psychotic, but she has a dependent personality and has engaged in "psychopathic" behavior consisting of sexual exploits and acting out against society. She tends to dream and fantasize, but can tell the difference between reality and fantasy. 7. Vol. IV, 76-80.

60. Before her hospitalization in September 1971, the patient had a long history of hospitalizations and treatment for chemical dependency (drugs and alcohol) and psychiatric problems. In the 1960s and 70s, she abused alcohol, Valium, Librium, and barbiturates. 7. Vol. III, 5-7. By 1970, she had been treated for chemical dependency at least 30 times. 7. Vol. III, 7. Respondent was aware that the patient had a long history of drug and alcohol abuse when he began regularly treating her. Bd. Ex. 7, 956; 7. Vol. I, 19, 21. At that time Respondent also knew that the patient had manipulated prescriptions and obtained drugs by fraud. Bd. Ex. 7, 945.

61. Some of the patient's specific hospitalizations before and after the Respondent began treating her include the following:

Date	Facility	Diagnosis
05-2-57	St. Mary's	Overdose of Sparine
02-3-58	St. Mary's	Injury after excessive drinking
03-8-58	St. Mary's	Overdose of Pacatal and alcohol
1958	Moose Lake	Mental illness and alcoholism
1960	Willmar State	Alcoholism
04-1-64	St. Mary's*	Overdose of Nembutal
12-6-64	St. Mary's	Overdose of Nembutal
10-30-65	St. Mary's	Overdose of barbiturates
04-21-66	St. Mary's	Possible overdose of Nembutal
06-5-66	St. Mary's	Overdose
08-2-66	St. Mary's	Drug addiction, barbiturates
02-3-67	St. Mary's	Overdose of Nembutal
07-9-67	St. Mary's	Alcoholism
08-28-69	St. Mary's	Alcoholism; personality disorder
10-26-70	St. Mary's	Overdose of Carbrital
07-23-71	St. Luke's	Overdose of Seconal
08-31-71	St. Luke's	Inebriate, drug abuse, Barbiturates, personality disorder
11-10-78	St. Mary's*	Chemical dependency
11-26-78	St. Mary's*	Hypertension, chemical dependency
03-5-79	St. Mary's*	Chemical dependency, mixed, alcohol and tranquilizers
02-18-81	Miller-Dwan	Chemical dependency, multiple drugs

*Respondent was admitting and/or primary care physician. T. Vol. III, 5-6.

62. The basic tenet of medical practice is to do no harm to the patient. Being sexual with a patient is harmful. T. Vol. IV 62-63. Patients, especially psychiatric patients, are vulnerable to sexual abuse and advances. T. Vol. IV, 81-82. Patient #7 was particularly vulnerable due to her history of sexual abuse. T. Vol. IV, 72-82; T. Vol. XII, 138-139.

63. When a psychiatrist crosses the boundary between professional and personal conduct, patients can suffer shame and other emotional damage due to their vulnerability.

That can lead to silence and depression. T. Vol. IV, 44-45. Crossing the boundary also breaks the trust between the psychiatrist and the patient and confuses treatment and therapy. T. Vol. IV, 63-65. In the long run, therapy and treatment cannot progress without trust. T. Vol. IV, 95. Trust is more fragile with vulnerable patients and the boundaries with respect to those patients must be clearer. T. Vol. IV, 96; T. Vol. XII, 140.

64. The proper physician-patient boundary is crossed by any kind of sexual touching, kissing or intercourse. T. Vol. IV, 63. The boundary is also breached by psychiatrists who buy gifts for their patient, employ them in their office, loan them money, provide them with meals, give them birthday cakes, offer them rides, or by engaging in any other conduct which makes the patient feel special. T. Vol. IV, 63-70. In psychiatry, a patient often develops loving, caring and respectful feelings for the psychiatrist in a process called "transference". /3 Gift-giving and other conduct of a personal nature promotes transference in a negative way. T. Vol. IV, 63-64, 71; T. Vol. XII, 139..

65. During the early 1970s, the patient had monthly appointments with Respondent. In those years she was feeling anxious and was having problems in a personal relationship with a man. At these appointments the patient would discuss with Respondent how things were going in her life. T. Vol. III, 10.

66. During the period from 1973-1975, the Respondent's relationship with the patient starting becoming more personal. On one occasion, when the patient was working a volunteer referral clerk at an information center for alcoholism, Respondent stopped by the center to visit with her. T. Vol. III, 13-14. During the course of his visit, Respondent came around behind the patient, put his hands over her shoulders and placed them on a desk where she was seated to examine her log book. Due to his closeness to her, the patient became excited and felt very special. Id. at 15.

67. In 1974 the patient was a part-time student at Duluth Business University taking a medical secretary course. T. Vol. III, 139-140. On one occasion in March 1974, while she was still a student, Respondent asked the patient to type some letters for him and she did so. T. Vol. III, 16-18. Subsequently, on May 9, 1975, Respondent offered part-time employment to the patient. She accepted the offer but someone else was eventually hired. T. Vol. III, 20-21. Nonetheless, the patient worked for the Respondent on June 2 and 3, 1975 (Bd. Ex. 15; T. Vol. III, 22-24) and on October 9, 1975. Bd. Ex. 16; T. Vol. III, 29-31. She worked at the Respondent's front desk answering phones, greeting patients, making appointments, and pulling patient charts. T. Vol. III, 22. The Respondent paid the patient a nominal amount for the work she performed for him. T. Vol. III, 18, 24. As a result of the work the patient did for the Respondent, she felt very special. T. Vol. III, 32. On one of the occasions during the time that the patient was working for the Respondent, the Respondent asked her to talk to another patient on the telephone. The Respondent said he didn't want to talk to the other patient because she was "paranoid as hell." Patient #7

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3. Transference is defined as "the unconscious tendency to assign to others in one's present environment feelings and attitudes associated with significant persons in one's early life, especially the patient's transfer to the therapist of feelings and attitudes associated with a parent. The feelings may be affectionate (positive transference) or hostile (negative transference)." Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, 1254 (4th Ed. 1987). See also, T. Vol. XII, 136.

talked to the other patient for about 15 minutes. When she was done, the Respondent complimented her. T. Vol. III, 108-109.

68. In late 1977 the patient had developed strong feelings for the Respondent and believed that she was "somebody special to him." T. Vol. III, 45. The patient felt special because she could call Respondent on the phone, got prescriptions from him when she was on extended vacations, had worked for him on a sporadic basis, and had appointments that frequently were extended beyond their alloted time. T. Vol. III, 45-46. Her strong feelings for the Respondent are reflected in a letter she sent to him on a trip to California late in 1977. On November 17, 1977, she concluded a letter to the Respondent with the words "Love you (and I don't mean transference--I just plain love you-okay!)" and signed with the patient's nickname. Bd. Ex. 7, 1017. Other notes to the Respondent at that time also contained expressions of love. Bd. Ex. 7, 1011. However, some of them don't. Bd. Ex. 7, 1034, 1027, 1030.

69. In 1978 the patient's relationship with Respondent became increasingly more personal. On February 27, 1978, the Respondent gave her a check for $95 to rent a different residence and during the appointment the Respondent hinted that he might be interested in dating her. T. Vol. III, 88-89. Subsequently, on April 3, 1978, the Respondent had a birthday cake for the patient at the time of an appointment which lasted for approximately 3 hours. T. Vol. III, 88-90; T. Vol. I, 94-95.

70. On one occasion in 1979 the patient had an appointment with Respondent late in the day. It lasted until after the receptionist was gone. During the appointment, which lasted two hours or more, the patient and Respondent had oral sex and intercourse on a recliner in the Respondent's office. T. Vol. III, 99-101. Following a late appointment on another occasion that year, the Respondent gave the patient a ride home. Seeing that the patient's male friend was at home, and knowing that the male friend had made remarks about him, Respondent kissed the patient goodnight saying "We'll give him something to talk about." T. Vol. III, 104-105.

71. On three occasions in 1980 the Respondent gave the patient a ride to Minneapolis for the weekend. On each occasion the Respondent was going to an Air Force Reserve meeting and the patient asked to ride along to visit her daughter. T. Vol. III, 91-93. The trips occurred on January 4, 1980, February 29, 1980 and March 2, 1980. T. Vol. III, 93-94. On one of the trips, the Respondent requested oral sex from the patient and exposed his penis. She tried to comply but her mouth was too dry due to medicine she was taking. T. Vol. III, 101-102. On another occasion the Respondent and the patient lay naked together in a room at the Air Force Reserve base in Minneapolis. That evening the patient told the Respondent that she didn't want to continue in a sexual relationship with him and she explained the nature of the relationship a psychiatrist had with a psychiatric patient that was the subject of a book the patient had read. She told him she only wanted to be held. The Respondent complied. T. Vol. III, 102-104. At this point in time, the patient would have killed for the Respondent. T. Vol. III, 105.

72. In the period from 1978 to 1980 the Respondent gave the patient a large bottle of cologne for Christmas one year and also gave her a key ring he obtained on a trip. Attached to the key ring was a small male figurine with an exaggerated penile erection. T. Vol. III, 106-107; Bd. Ex. 20.

73. Respondent prescribed controlled substances on a long-term basis to patient #7, who had a serious history of chemical dependency:

Date	Drug	Quantity
10-8-71	Librium l0 mg. tid	30
01-20-72	Librium 10 mg.	24
07-14-72	Librium l0 mg.	22
08-25-72	Darvon	30
	Ionamin	30
08-30-72	Librium 10 mg.	24
09-8-72	Beminal	30
09-29-72	Librium 10 mg.	24
10-22-72	Triavil	50
11-14-72	Librium 10 mg.	24
02-5-73	Darvon NASA	30
02-13-73	Ionamin 15 mg.	30
03-7-73	Darvon NASA	30
03-19-73	Librium l0 mg.	24
03-28-73	Darvon NASA	30
	Ionamin	30
05-10-73	Librium l0 mg.	24
	Darvon NASA	30
06-5-73	Darvon NASA	30
06-14-73	Librium 10 mg.	24
06-21-73	Darvon cpd	40
07-24-73	Ionamin 15 mg.	30
08-2-73	Darvon-N	30
08-21-73	Darvon-N	30
08-27-73	Valium 5 mg.	30
08-30-73	Darvon-N	30
09-27-73	Darvon-N	30
10-11-73	Darvon NASA	40
	Valium 5 mg.	30
11-27-73	Darvon NASA	40
12-11-73	Valium 5 mg.	30
12-27-73	Ionamin 15 mg.	30
01-2-74	Librium 10 mg.	24
	Darvon NASA	40
01-7-74	Valium 2 mg.	40
01-23-74	Valium 10 mg.	40
01-18-74	Darvon NASA	4
02-4-74	Darvon NASA	40
	Valium 2 mg.	4
02-14-74	Valium 2 mg.	40
02-26-74	Valium 2 mg.	40
	Darvon NASA	40
03-14-74	Valium 2 mg.	40

	Darvon NASA	40
04-1-74	Valium 2 mg.	40
	Darvon NASA	40
04-22-74	Darvon NASA	40
	Valium 2 mg.	40
05-10-74	Librium 2-25 10 mg.	24
05-21-74	Valium 2 mg.	50
06-6-74	Librium 10 mg.	24
	Darvon NASA	40
07-2-74	Darvon NASA	40
07-19-74	Librium l0 mg.	24
08-1-74	Valium 2 mg.	50
08-7-74	Darvon NASA	40
08-20-74	Valium 2 mg.	50
08-30-74	Valium 2 mg.	50
10-15-74	Darvon NASA	50
	Librium 10 mg.	24
10-22-74	Valium 2 mg.	50
11-12-74	Valium 2 mg.	50
	Librium 10 mg.	24
12-20-74	Valium 2 mg.	50
12-31-74	Librium 5 mg.	24
	Darvon NASA	50
01-13-75	Valium 2 mg.	50
01-14-75	Librium 5 mg.	24
01-27-75	Librium 5 mg.	24
	Valium 2 mg.	50
02-6-75	Librium 25 mg.	24
02-18-75	Librium 5 mg.	24
	Valium 2 mg.	50
Feb?	Librium 5 mg.	50
	Valium 2 mg.	50
04-8-75	Librium 5 mg.	50
	Valium 2 mg.	50
03-17-75	Librium 5 mg.	50
	Valium 2 mg.	50
04-18-75	Valium 2 mg.	50
	Librium 5 mg.	50
09-2-75	Librium 5 mg.	50
09-22-75	Librium 5 mg.	50
	Valium 2 mg.	50
10-10-75	Valium 2 mg.	50
12-1-75	Valium 2 mg.	50
01-19-76	Valium 2 mg.	50
	Librium 5 mg.	50
	Darvon Cpd	60
03-19-76	Valium	
04-28-76	Valium 2 mg.	50
06-11-76	Valium 2 mg.	9-ok 20

07-05-78	Empirin #3	50
07-06-78	Dalmane 30 mg.	20
07-06-78	Valium 5 mg.	50
07-18-78	Dalmane 30 mg.	30
07-18-78	Empirin #3	60
08-03-78	Empirin #	60
08-03-78	Valium 5 mg.	50
08-18-78	Dalmane 30 mg.	15
08-18-78	Empirin #3	30
08-28-78	Empirin #3	50
08-28-78	Valium 5 mg.	50
09-11-78	Empirin #3	50
09-25-78	Empirin #3	50
	Valium 2 mg.	50
10-16-78	Valium 2 mg.	50
	Empirin #3	50
12-16-78	Dalmane 30 mg.	15
12-21-78	Dalmane 30 mg.	30
12-29-78	Dalmane 30 mg.	30
01-18-79	Dalmane	30
02-1-79	Dalmane	30
02-15-79	Dalmane	15
03-18-79	Dalmane 30 mg.	30
04-5-79	Librium	12
	Combid	4
	Elavil	
05-17-79	Dalmane 30 mg.	10
05-18-79	Dalmane 30 mg.	30
05-29-79	Librax	60
06-02-79	Dalmane 30 mg.	30
06-06-79	Dalmane 30 mg.	15
06-25-79	Librax	60
07-05-79	Dalmane 30 mg.	30 x2
	Valium 2 mg.	30 x2
07-19-79	Dalmane	30 x2
08-15-79	Dalmane 30 mg.	30
08-15-79	Valium 5 mg.	60
09-10-79	Dalmane 30 mg.	30
09-10-79	Empirin #3	30
09-10-79	Valium 5 mg.	30
09-24-79	Dalmane 30 mg.	30
09-24-79	Empirin #3	30
09-24-79	Valium 5 mg.	30
10-01-79	Empirin #3	30
10-12-79	Empirin #3	30
10-12-79	Librax	60
10-12-79	Valium 5 mg.	30
10-17-79	Dalmane 30 mg.	30
10-19-79	Empirin #3	30

10-26-79	Dalmane 30 mg.	30
10-26-79	Empirin #3	50
10-26-79	Valium 5 mg.	50
11-06-79	Dalmane 30 mg.	30
11-06-79	Empirin #3	50
11-06-79	Valium 5 mg.	50
11-21-79	Empirin #3	50
11-30-79	Dalmane 30 mg.	30
11-30-79	Empirin #3	30
11-30-79	Valium 5 mg.	50
	Triavil	12
12-07-79	Librax	60
12-10-79	Empirin #3	50
12-17-79	Empirin #3	50 x2
	Valium 5 mg.	50 x2
	Dalmane	30 x2
12-28-79	Empirin #3	50
?-01-79	Dalmane 30 mg.	30
?-02-79	Librax	30
?-05-79	Dalmane 30 mg.	15
?-09-79	Librax	60
?-?-79	Dalmane 30 mg.	7
01-07-80	Dalmane 30 mg.	30
01-07-80	Empirin #3	50
01-07-80	Valium 5 mg.	50
01-14-80	Empirin #3	50
01-22-80	Dalmane 30 mg.	30
01-22-80	Valium 5 mg.	50
01-28-80	Empirin #3	50
01-28-80	Librax	60
02-15-80	Dalmane 30 mg.	30
02-15-80	Empirin #3	50
02-15-80	Valium 5 mg.	50
02-22-80	Dalmane 30 mg.	30
02-22-80	Empirin #3	50
02-22-80	Valium 5 mg.	50
03-07-80	Empirin #3	50 x1
03-18-80	Empirin #3	50
03-20-80	Dalmane 30 mg.	30
03-20-80	Valium 5 mg.	50
03-25-80	Fiorinal	30
03-31-80	Fiorinal	30
04-04-80	Valium 5 mg.	50
04-04-80	Fiorinal #3	50
04-14-80	Fiorinal #3	30
04-18-80	Dalmane 30 mg.	30
04-24-80	Fiorinal #3	30
04-28-80	Valium 5 mg.	50
05-01-80	Dalmane 30 mg.	30 x1

05-01-80	Fiorinal #3	30 x1
05-09-80	Fiorinal #3	30
05-16-80	Dalmane 30 mg.	30
05-16-80	Fiorinal #3	30
05-16-80	Valium 5 mg.	50
05-24-80	Fiorinal #3	30
05-30-80	Dalmane 30 mg.	30
05-30-80	Fiorinal #3	30 x1
05-30-80	Valium 5 mg.	30
06-06-80	Fiorinal #3	30
06-13-80	Valium 5 mg.	30
06-18-80	Fiorinal #3	30
06-20-80	Dalmane 30 mg.	30
06-20-80	Fiorinal #3	30 x1
06-20-80	Valium 5 mg.	30 x1
07-01-80	Fiorinal #3	30
07-05-80	Valium 5 mg.	30
07-13-80	Fiorinal #3	30
07-17-80	Dalmane 30 mg.	15 x1
07-17-80	Fiorinal #3	30 x1
07-17-80	Valium 5 mg.	30 x1
07-30-80	Dalmane 30 mg.	15
07-30-80	Fiorinal #3	30
07-30-80	Valium 5 mg.	30
08-15-80	Dalmane 30 mg.	15 x1
08-15-80	Fiorinal #3	30 x1
08-15-80	Valium 5 mg.	30 x1
08-27-80	Dalmane 30 mg.	15
08-27-80	Fiorinal #3	30
08-27-80	Valium 5 mg.	30
09-14-80	Dalmane 30 mg.	15
09-14-80	Fiorinal #3	30
09-14-80	Valium 5 mg.	30
09-22-80	Dalmane 30 mg.	30
09-22-80	Empirin #3	60
09-22-80	Valium 5 mg.	30 x1
9-29-80	Dalmane - samples	20
10-06-80	Empirin #3	60
10-06-80	Valium 5 mg.	30
10-9-80	Dalmane 30 mg.	10
	Dalmane 15 mg.	4
	Combid	4
10-17-80	Dalmane 30 mg.	30
10-17-80	Empirin #3	60
10-17-80	Valium 5 mg.	30
10-26-80	Dalmane 30 mg.	30
10-26-80	Empirin #3	60
10-26-80	Valium 5 mg.	30
11-7-80	Empirin #3	60

	Dalmane	60
11-10-80	Dalmane 30 mg.	30
11-10-80	Empirin #3	60
11-10-80	Valium 5 mg.	60
11-25-80	Dalmane 30 mg.	30
11-25-80	Empirin #3	60
11-25-80	Valium 5 mg.	30
12-05-80	Dalmane 30 mg.	30
12-05-80	Empirin #3	60
12-05-80	Valium 5 mg.	60
12-15-80	Stelazine	14
	Dalmane	20
12-22-80	Dalmane 30 mg.	30
12-22-80	Empirin #3	60
12-22-80	Valium 5 mg.	60
12-29-80	Empirin #3	60
12-29-80	Valium 5 mg.	60
	Centrax	12
01-02-81	Empirin #3	30
	Dalmane	20
01-5-81	Dalmane	30
	Dalmane - sample	20
01-12-80	Acetaminophen #3	60
01-16-81	Dalmane 30 mg.	30
01-19-81	Acetaminophen #3	30 x1
01-19-81	Dalmane 30 mg.	30
01-19-81	Valium 5 mg.	60
01-26-81	Acetaminophen #3	30
02-1-81	Acetaminophen #3	30
02-5-81	Acetaminophen #3 - sample	4
	Dilantin	30
	Phenobarbital	30
02-09-81	Valium 5 mg.	30
02-13-81	Dalmane 30 mg.	30
02-17-81	Dalmane 30 mg.	15
?-?-?	Dalmane 30 mg.	15

T. Vol. I, 65-66, 71.

74. Between 1972 and 1978 Respondent treated the patient's personality disorders and her chemical dependency on an outpatient basis. T. Vol. I, 72. During that time, Respondent prescribed Valium or Librium to the patient for chest pain, anxiety, depression tension headaches, panic and high blood pressure. Id. at 73-74. Between 1972 and 1975 the Respondent prescribed Darvon for the patient's pain. On August 15, 1977 the Respondent began prescribing Empirin #3 instead. T. Vol. I, 76-77. In May 1978, Respondent began prescribing Dalmane to the patient in addition to her prescriptions for Valium and Empirin #3. T. Vol. I, 106. Dalmane is a long-acting benzodiazepine used for

sedation at bedtime. Id. Between May 1978 and August 1978, the Respondent prescribed Valium, Empirin #3 and Dalmane to the patient. Thereafter, his prescriptions of Dalmane temporarily stopped.

75. In early November 1978 the patient was hospitalized for cardiac related concerns and chemical dependency. Her hospitalization was precipitated in part by alcohol and drug consumption. Before her hospitalization, the patient had been consuming at least a six-pack of beer daily for several weeks. Bd. Ex. 7, 1857; T. Vol. I, 116. During her hospitalization the patient was detoxified and she was interviewed by a chemical dependency counselor who referred her to the Port Rehabilitation Center for Women. Bd. Ex. 7, 1856, 1858. The patient refused treatment at Port Rehabilitation opting to go instead to AA meetings. Bd. Ex. 7, 1856. The Respondent's plan after the patient's detoxification was to treat her with Mellaril and Ascriptin rather than Valium and Empirin #3. T. Vol. VII, 1858. The Respondent subsequently limited her prescriptions to Dalmane for several months. Finding 74, supra.

76. On March 6, 1979 the patient was readmitted to the hospital for chemical dependency. Upon her admission the patient stated that she had difficulty getting drugs and had turned to alcohol, drinking a 12-pack daily for the past week or two. Ex. 7, 1865. The patient reported that she had run out of Empirin #3 but she had used some of her daughter's Valium. Id. On her discharge from the hospital the Respondent's plan was to detoxify the patient. His notes indicate that a longer treatment program had been discussed with the patient numerous times but that she was basically unwilling to give up her dependence on some type of tranquilizers especially codeine, Dalmane or Valium. The Respondent concluded that the patient's dependence on codeine, Dalmane and Valium were preferable to her prior dependence on barbiturates and were necessary to enable her to function in society. T. Vol. I, 140-141. The Respondent rejected sobriety for the patient believing that she needed some kind of a crutch and couldn't function without them in a healthy, productive manner. T. Vol. I, 143-146.

77. Approximately one month after the patient's March 6, 1979 hospitalization, the Respondent began prescribing Dalmane for her again. At the same time, he prescribed Elavil. T. Vol. I, 148. Beginning December 17, 1979, the Respondent began prescribing Dalmane, Valium and Empirin #3 to the patient. T. Vol. I, 152-154. On January 4, 1980, the patient was out of her medications, even though refills of her prior prescriptions had been authorized, so the Respondent reissued prescriptions for them. T. Vol. I, 155-156. The patient came to the Respondent's office. During her appointment she requested a prescription for Fiorinal and advised the Respondent that she had been selling drugs on the street. T. Vol. I, 157-159. He did not give her a prescription for Fiorinal but gave her a prescription for Empirin #3 instead. The patient came back on March 25, 1980 again requesting a prescription for Fiorinal. T. Vol. I, 160. Her request for a specific drug did not make him suspicious and he wrote her a prescription for a small amount of Fiorinal. Id. at 161-162. Throughout 1980, the Respondent was prescribing drugs like Dalmane, Valium, Empirin #3 and Fiorinal #3, thereby feeding her dependency. T. Vol. I, 164. Respondent's prescriptions following the patient's hospitalization in November 1978, fell below minimal standards of acceptable and prevailing medical practice. Respondent should have required chemical dependency treatment followed by counseling.

78. On February 17, 1981, the patient advised the Respondent that she was getting Dalmane on the street and the Respondent became concerned about her dependency and decided to have her admitted for treatment. T. Vol. I, 165-166. While waiting for prior authorization to have her treated, the Respondent wrote another prescription for Dalmane. Id. at 167.

79. On February 26, 1981, while the patient was hospitalized, the Respondent was removed as her primary care physician. T. Vol. III, 82. The hospital's psychiatric medical director took over the case after two head nurses expressed concerns about the patient's chemical dependency, off-ward passes that enabled her to get additional chemicals, and Dr. Mattson reports that the patient might be getting drugs from the police department. The history Dr. Spencer obtained from the patient at that time was inconsistent with the Respondent's dictated history on February 18, 1981 on the subject of Dr. Mattson's prescriptions for Dalmane. The medical director, Dr. J. Spencer, determined on the basis of the patient's history and her acute state of intoxication that a withdrawal regimen was in order and that if the patient did not voluntarily consent to chemical dependency treatment, actions to commit her should be undertaken. Bd. Ex. 7, 1739-1740, 1009.

80. On March 6, 1981, the patient was admitted to Port Rehabilitation. One afternoon shortly after her admission, the Respondent came to the facility to see the patient. Because he appeared to be under the influence of chemicals, as evidenced by his slurred speech, nervousness and constant pacing, he was refused permission to see her. T. Vol. III, 195-196; T. Vol. IX, 126. At this time the Respondent was informed that he had to leave or the authorities would be called to come and remove him. T. Vol. III, 199.

81. During the course of her treatment, the Respondent never discussed with her the need for chemical dependency treatment or withdrawing her from prescription medications. During the course of her treatment the patient slept a great deal of the time, failed to take care of and communicate with her children, and sometimes stumbled when she walked, having to grab on to walls or furniture. T. Vol. V, 6-8, 38. On a number of occasions she suffered blackouts and she was frequently under the influence ("stoned") of the medications she was taking. Because of the number of medicines the patient was taking, her daughter did not trust her to baby-sit for her grandchildren. T. Vol. V, 16-17. Since completing treatment, the patient has rebuilt normal relations with most of her children who now permit her to baby-sit for her grandchildren. T. Vol. V, 21-22. The patient now does her own cooking, cleaning, laundry and maintains her own apartment. T. Vol. V. 44. She also has been regularly employed as a volunteer at a local hospital.

Patient #8

82. Patient #8 began seeing the Respondent on February 3, 1984. At that time, the patient was complaining about problems resulting from an automobile accident on January 19, 1984. The patient stated that she felt like she had a toothache on her whole face and was having difficulty remembering what she read. Bd. Ex. 8, 1130. During the next 14 months the patient frequently complained about skin problems, a chronic cough, back pain, and gastroenteritis. Bd. Ex. 8, 1130. During the time that the Respondent treated her, the patient had a variety of diagnoses: tension headaches, diarrhea, neuorodermatitis of the hands, back and neck pain, tension state, tobacco bronchitis, paranoid schizophrenia, cervical arthritis and disc degeneration, and possible drug addiction. T. Vol. II, 58-59.

With respect to the patient's diarrhea, persistent cough, neurodermatitis, and back and neck pain, Respondent was acting as the patient's primary care physician. Id; Dep. T. Vol. 2, 250-251; Dep. T. Vol. 3, 279-280.

83. The Respondent treated the patient's chronic cough with Tussionex which he prescribed every month while the patient was seeing him. T. Vol. II, 60; Dep. T. Vol. 2, 252-253. Tussionex is the finest antitussive (cough suppressant) on the market. Vol. VIII, 130. However, it is a narcotic containing hydrocodone. Hydrocodone is a very addictive compound. Hence, general practitioners usually do not prescribe it for chronic coughs. They use other alternatives. T. Vol. II, 61. Without a thorough evaluation, Tussionex should not be prescribed for more than four weeks.

84. From February 1984 through April 24, 1990, Respondent prescribed the following medicines for patient #8:

Date	Drug	Quantity
02-?-84	Soma	50
02-9-84	Soma	50
04-17-84	Soma	50
05-?-84	Tylenol #3	24
06-12-84	Soma	60
	Robitussin AC	
07-16-84	Soma	60
	Robitussin AC	
07-?-84	Soma	75
08-31-84	Soma	60
10-9-84	Robitussin AC	240 ml.
10-22-84	Tussionex	120 ml.
?-85	Tussionex	
03-4-85	Percodan	50
	Tussionex	240 ml.
03-?-85	Tylenol #4	50
	Tussionex	240 ml.
04-27-85	Tylenol #4	50
	Tussionex	240 ml.
?-85	Tylenol #4	50
07-? -85	Tylenol #4	60
	Tussionex	240 ml.
08-?-85	Tussionex	240 ml.
	Tylenol #4	60
09-2-85	Tylenol #4	60
08-29-88	Acetaminophen #3	30
11-28-88	Tylenol #3	30
	Robitussin AC	120 ml.
12-13-88	Tussionex Suspension	120 ml.
12-30-88	Tylenol #3	60
	Tussionex Suspension	120 ml.
01-09-89	Tylenol #3	60

	Tussionex Suspension	240 ml.
01 -23-89	Tussionex Suspension	240 ml.
02-4-89	Tylenol #3	60
	Tussionex Suspension	120 ml.
03-13-89	Tylenol #3	60
	Tussionex Suspension	240 ml.
03-16-89	Tussionex Suspension	120 ml.
03-28-89	Tylenol #3	60
	Tussionex Suspension	240 ml.
04-25-89	Tylenol #3	60
	Tussionex Suspension	240 ml.
05-22-89	Acetaminophen #3	60
	Tussionex Suspension	240 ml.
06-08-89	Acetaminophen #3	60
	Tussionex Suspension	240 ml.
06-12-89	Acetaminophen #3	60
	Tussionex Suspension	240 ml.
06-27-89	Acetaminophen #3	60
	Tussionex Suspension	240 ml.
07-14-89	Tussionex Suspension	240 ml.
07-25-89	Acetaminophen #3	20
	Tussionex Suspension	240 ml.
08-07-89	Acetaminophen #3	20
	Tussionex Suspension	240 ml.
08-21-89	Tussionex Suspension	240 ml.
08-22-89	Acetaminophen #3	20
09-1-89	Tussionex Suspension	240 ml.
10-18-89	APAP #4	50
12-13-89	Penntuss	120 ml.
12-21-89	Acetaminophen #3	90
	Penntuss	240 ml.
01-4-90	Penntuss	240 ml.
	Acetaminophen 33	90
	Fioricet	90
	Diphenhydramine	50
01-5-90	Guiatuss AC	180 ml.
01-17-90	Guiatuss AC	180 ml.
01-18-90	Tussionex Suspension	240 ml.
02-1-90	Tussionex Suspension	240 ml.
02-13-90	Tussionex Suspension	240 ml.
02-28-90	Tussionex Suspension	240 ml.
03-8-90	APAP #4	90
	Diphenhydramine	30
03-14-90	Tussionex Suspension	240 ml.
03-27-90	Tussionex Suspension	240 ml.
04-3-90	Guiatuss AC	120 ml.
04-5-90	Fioricet	60
	APAP #4	60
	Diphenhydramine	30

04-13-90	Tussionex Suspension	120 ml.
04-24-90	Tussionex Suspension	240 ml.

85. When the patient first came to the Respondent, she was complaining of muscle tension headaches, neck and back pain and coughing. Dep. T. Vol. 3, 268. At that time the patient had tenderness in the lower back that radiated to her left leg. To treat her pain, tension and anxiety, the Respondent initially prescribed Soma, a muscle relaxant. Later, he also prescribed Valium. Dep. T. Vol. 3, 268-271. The Valium was prescribed through 1985 and then resumed in 1989.

86. On February 24, 1984, shortly after she first consulted Respondent, the patient was evaluated by Dr. Matthew Eckman, a psychiatrist T. Vol. II, 63; Pep. T. Vol. 3, 275; Bd. Ex. 8, 1264-1265. Dr. Eckman found a mild scoliosis, headaches and back pain. Id. He recommended conservative treatment measures including salycitates, physical therapy, and exercise. Dep. T. Vol. 3, 275-276; Bd. Ex. 8, 1264-1265. The patient was allergic to aspirin, which caused her hands to swell. However, other nonaddicting anti-inflammatories should have been tried before Respondent prescribed potentially addicting medicines like Darvocet for the patient's headaches and back pain. T. Vol. II, 69-70. At least ten nonsteroidals were available for trial use. They included Ibuprofen (Motrin or Rufen), Indomethacin, Feldene, Naprosyn, Naproxen, Clinoril, Voltaren and Tylenol. T. Vol. II, 70. The Respondent's long-term use of codeine containing compounds for the patient's headaches and back pain, which included Tylenol #3 and 4 and acetaminophen #3, fell below minimal levels of accepted medical care. Nonsteroidal anti-inflammatories should have been tried first and the patient's alleged allergy to "aspirin" should have been explored. When dealing with chronic pain, a physician needs a drawer full of drugs that the patient experiments with by taking each one for two weeks until one is found that has satisfactory results. T. Vol. II, 70. Before going to potentially addicting medications the Respondent did not exhaust other treatment modalities. He only referred the patient to Dr. M.J. Eckman for physical therapy and exercise programs. T. Vol. II, 65.

87. Beginning in March 1975, Respondent prescribed Tylenol #4 until September 15, 1975. Thereafter, there were no prescriptions for several years. On August 29, 1988 the Respondent prescribed Tylenol #3 and Acetaminophen #3 on a regular basis. All three contain codeine, which is addicting. The long-term prescription of codeine-containing medications for back pain is not accepted practice in Minnesota. T. Vol. II, 67.

Patient #9

88. Patient No. 9 was born on June 22, 1928 and died August 31, 1990, Bd. Ex. 9, 1410. The patient began seeing Respondent on August 16, 1985. He had a variety of medical problems. They included multiple psychiatric problems, arteriosclerotic heart disease, tibial fracture with complications, cardiac irregularities, munchaunsen syndrome, borderline intelligence, transurethral resection of the prostate, back surgery, and chronic pain. T. Dep. Vol. 3, 294-195, 303, 309; T. Vol. II, 82-83; T. Vol. IV, 38. His psychiatric

problems primarily consisted of munchausen's syndrome (Bd. Ex. 9, 1646) and anxiety neurosis with depression -- chronic and serious. Bd. Ex. 9, 1469.

89. While treating the patient, Respondent failed to document a physical examination or indication of the patient's pain, visits to other physicians, the treatment plans of those physicians or their follow-up. T. Vol. II, 83, 85, 87-89. In short, the history he took as well as his work-up was below minimal standards of prevailing and accepted medical practice.

90. In August 1988, the patient's wife (patient #10) was nagging the patient for more pain medicine, including her Darvocet. Respondent was not aware of this problem and continued to prescribe Darvocet for both patients. T. Vol. IV, 40-41; Bd. Ex. 9, 1676. Darvocet, which contains propoxyphene, is an addicting narcotic. T. Vol. II, 84; Minn. Rule pt. 6800.4240, subp. B(2).

91. Respondent prescribed addicting analgesics to the patient without an adequate history of chronic pain, a physical examination, a trial of nonaddicting pain medications or any inquiry as to the efficacy of previous treatments. T. Vol. II, 83-85, 91.

92. Respondent prescribed Lasix (furosemide), a diuretic, to the patient for congestive heart failure but failed to monitor the patient's potassium levels. T. Dep. Vol. III, 313-316. The Respondent prescribed Lanoxin, an artificial digitalis, to the patient but failed to monitor him for potential toxicity. T. Dep. Vol. III, 316. Respondent also failed to document communications with other physicians regarding the patient's heart condition. T. Vol. II, 87-88.

93. From August 1985 through August 10, 1989, Respondent prescribed the following for patient #9:

Date	Drug	Quantity
08-?-85	Motrin	40
	Triavil	30
09-6-85	Triavil	35
	Darvocet-N 100	50
10-21-85	Mellaril	12
09-?-88	Doxepin	30
	Darvocet-N 100	30
	Lanoxin	30
	Lasix	30
09-19-88	Lasix	30
	Lanoxin	30
	Doxepin	30
	Darvocet-N 100	30
10-19-88	Furosemide (i.e., Lasix)	30
10-19-88	Lanoxin	30
10-19-88	Doxepin	30
10-19-88	Propoxyphene Napsylate w-acetaminophen	30
10-25-88	Propoxyphene Napsylate	

	w-acetaminophen	30
11-01-88	Propoxyphene Napsylate w-acetaminophen	30
11-08-88	Propoxyphene Napsylate w-acetaminophen	30
11-15-88	Propoxyphene Napsylate w-acetaminophen	30
11-22-88	Propoxyphene Napsylate w-acetaminophen	30
12-09-88	Propoxyphene Napsylate w-acetaminophen	40
12-22-88	Propoxyphene Napsylate w-acetaminophen	40
12-29-88	Propoxyphene Napsylate w-acetaminophen	40
01-05-89	Propoxyphene Napsylate w-acetaminophen	40
01-12-89	Propoxyphene Napsylate w-acetaminophen	42
01-19-89	Propoxyphene Napsylate w-acetaminophen	42
01-26-89	Propoxyphen Napsylate w-acetaminophen	42
02-02-89	Propoxyphene Napsylate w-acetaminophen	42
02-09-89	Propoxyphene Napsylate w-acetaminophen	42
02-16-89	Propoxyphene Napsylate w-acetaminophen	42
02-23-89	Propoxyphene Napsylate w-acetaminophen	42
03-02-89	Propoxyphene Napsylate w-acetaminophen	42
03-09-89	Propoxyphene Napsylate w-acetaminophen	42
03-16-89	Propoxyphene Napsylate w-acetaminophen	42
03-23-89	Propoxyphene Napsylate w-acetaminophen	42
03-30-89	Propoxyphene Napsylate w-acetaminophen	42
04-06-89	Propoxyphene Napsylate w-acetaminophen	42
04-13-89	Propoxyphen Napsylate w-acetaminophen	42
04-20-89	Propoxyphene Napsylate w-acetaminophen	42
04-27-89	Propoxyphene Napsylate w-acetaminophen	42

05-11-89	Propoxyphene Napsylate w-acetaminophen	42
05-25-89	Propoxyphene Napsylate w-acetaminophen	42
06-08-89	Propoxyphene Napsylate w-acetaminophen	42
06-17-89	Propoxyphene Napsylate w-acetaminophen	30
06-22-89	Propoxyphene Napsylate w-acetaminophen	30
06-29-89	Propoxyphene Napsylate w-acetaminophen	20
07-06-89	Propoxyphene Napsylate w-acetaminophen	20
07-13-89	Propoxyphene Napsylate w-acetaminophen	20
07-14-89	Acetaminophen E st	100
07-20-89	Propoxyphene Napsylate w-acetaminophen	20
07-27-89	Propoxyphene Napsylate w-acetaminophen	20
08-03-89	Propoxyphene Napsylate w-acetaminophen	20
08-10-89	Propoxyphene Napsylate w-acetaminophen	20

Patient #10

94. Patient #10, who is the wife of patient #9, was born on July 4, 1930 and died July 9, 1990. On August 16, 1985, the patient began seeing the Respondent. At that time, she had multiple psychiatric diagnoses, diabetes, glaucoma, post-menopausal symptoms, and osteoporosis. For the patient's post-menopausal symptoms, diabetes, and leg pain, the Respondent acted as a primary care physician. T. Vol. 11, 91-92, 95. T. Dep. Vol. 3, 324-325.

95. Respondent prescribed habituating analgesics to the patient without an adequate examination, a trial of nonhabituating pain relievers or any indication if previous treatments worked. T. Dep. Vol. 3, 337; T. Vol. II, 97. The Respondent also prescribed Premarin, an estrogen compound, to the patient but failed to document an examination, work-up or follow-up of the condition being treated. T. Vol. 11, 92-94; T Vol. IX, 90-91.

96. Respondent prescribed habituating analgesics on a longterm basis to the patient. From August 16, 1985 through August 15, 1989, Respondent prescribed the following for patient #10:

Date	Drug	Quantity

08-16-85	Ativan	45
	Darvocet-N 100	40
08-27-85	Ativan	60
	Darvocet-N 100	40
01-2-86	Elavil	30
09-26-88	Premarin	30
	Darvocet-N 100	45
	Ativan	45
10-24-88	Glucotrol	100
10-31-88	Propoxyphene Napsylate w-acetaminophen	45
10-31-88	Lorazepam 1 mg.	45
11-14-88	Propoxyphene Napsylate w-acetaminophen	45
11-14-88	Lorazepam 1 mg.	45
11-15-88	Glucotrol	100
11-22-88	Lorazepam 1 mg.	45
11-22-88	Propoxyphene Napsylate w-acetaminophen	45
11-29-88	Propoxyphene Napsylate w-acetaminophen	25
12-05-88	Lorazepam 1 mg.	45
12-05-88	Propoxyphene Napsylate w-acetaminophen	25
12-09-88	Propoxyphene Napsylate w-acetaminophen	25
12-09-88	Lorazepam 1 mg.	45
12-12-88	Glucotrol	100
12-15-88	Propoxyphene Napsylate w-acetaminophen	25
12-19-88	Premarin	30
12-22-88	Propoxyphene Napsylate w-acetaminophen	25
12-22-88	Lorazepam 1 mg.	45
12-30-88	Propoxyphene Napsylate w-acetaminophen	25
12-30-88	Lorazepam 1 mg.	45
01-05-89	Glucotrol	100
01-07-89	Propoxyphene Napsylate w-acetaminophen	21
01-12-89	Propoxyphene Napsylate w-acetaminophen	21
01-12-89	Lorazepam 1 mg.	21
01-19-89	Propoxyphene Napsylate w-acetaminophen	21
01-19-89	Lorazepam 1 mg.	21
01-20-89	Premarin	30
01-26-89	Lorazepam 1 mg.	21
01-26-89	Propoxyphene Napsylate	

	w-acetaminophen	21
02-02-89	Glucotrol	100
02-02-89	Propoxyphene Napsylate w-acetaminophen	21
02-02-89	Lorazepam 1 mg.	21
02-09-89	Lorazepam 1 mg.	21
02-09-89	Propoxyphene Napsylate w-acetaminophen	21
02-16-89	Premarin	30
02-16-89	Propoxyphene Napsylate w-acetaminophen	45
02-16-89	Lorazepam 1 mg.	45
02-16-89	Glucotrol	60
03-02-89	Glucotrol	60
03-02-89	Lorazepam 1 mg.	45
03-02-89	Propoxyphene Napsylate w-acetaminophen	45
03-16-89	Glucotrol	60
03-16-89	Lorazepam 1 mg.	45
03-16-89	Propoxyphene Napsylate w-acetaminophen	45
03-28-89	Premarin	30
03-30-89	Propoxyphene Napsylate w-acetaminophen	45
03-30-89	Lorazepam 1 mg.	45
04-13-89	Propoxyphene Napsylate w-acetaminophen	45
04-13-89	Lorazepam 1 mg.	45
04-17-89	Glucotrol	100
04-26-89	Premarin	30
04-27-89	Propoxyphene Napsylate w-acetaminophen	45
04-27-89	Lorazepam 1 mg.	45
05-11-89	Lorazepam 1 mg.	45
05-11-89	Propoxyphene Napsylate w-acetaminophen	45
05-12-89	Glucotrol	100
05-25-89	Propoxyphene Napsylate w-acetaminophen	45
05-25-89	Lorazepam 1 mg.	45
06-08-89	Propoxyphene Napsylate w-acetaminophen	45
06-08-89	Lorazepam 1 mg.	45
06-08-89	Glucotrol	100
06-22-89	Propoxyphene Napsylate w-acetaminophen	45
06-22-89	Lorazepam 1 mg.	45
07-06-89	Lorazepam 1 mg.	45
07-06-89	Propoxyphene Napsylate	

	w-acetaminophen	45
07-06-89	Glucotrol	100
07-06-89	Premarin	30
07-20-89	Propoxyphene Napsylate w-acetaminophen	45
07-20-89	Lorazepam 1 mg.	45
08-01-89	Glucotrol	100
08-03-89	Lorazepam 1 mg.	45
08-03-89	Propoxyphene Napsylate w-acetaminophen	45
08-10-89	Premarin	30

Based upon the foregoing Findings of Fact, the Board makes the following:

CONCLUSIONS OF LAW

1. The Board and the Administrative Law Judge have jurisdiction in this matter pursuant to Minn. Stat. §§ 147.091 and 14.50 (1990).

2. The Complaint Review Committee of the Board gave proper notice of the hearing in this matter and the Board fulfilled all relevant substantive and procedural requirements of statute and rule.

3. The Complaint Review Committee has the burden of proof in this proceeding and must establish the facts at issue by a preponderance of the evidence as provided in Minn. Rule pt. 1400.7300, subp. 5 (1990).

4. The Complaint Review Committee has proven that the Respondent prescribed habituating and addicting medications to patients 3 and 5-10 without legitimate medical need in violation of Minn. Stat.§ 147.091, subd. 1(g), (k) and (s) (1988).

5. The Complaint Review Committee has proven that Respondent engaged in incompetent medical practice in his care of patients no. 2-3 and 5-10 by failing to take necessary histories, perform necessary physicals, and make necessary laboratory tests; by failing to monitor the efficacy of prescriptions and patient tolerance of medications; and by prescribing inappropriate medicines to patients, among other things, thereby creating unnecessary danger to his patients' lives, safety and welfare in violation of Minn. Stat. § 147.091, subd. 1(g) (1988).

6. The Complaint Review Committee has proven by a preponderance of the evidence that Respondent prescribed narcotics and other medications to patients 3 and 5-10 without a medically accepted therapeutic purpose in violation of Minn. Stat. § 147.091, subd. 1(s) (1988).

7. The Complaint Review Committee has proven by a preponderance of the evidence that the Respondent failed to conform to the minimal standards of acceptable prevailing medical practice in his care of patients 1, 3 and 5-10 as evinced by his long-term prescription of controlled substances without medical justification, the prescription of

(3) The boundaries course offered at the University of Minnesota by John Hung, PhD.

Successful completion shall be determined by the Board.

b. Intensive psychiatric and psychological evaluation by an evaluator or facility approved in advance by the Complaint Review Committee to determine whether Respondent can practice medicine and surgery with reasonable skill and safety, including specifically whether Respondent poses a risk of further sexual misconduct with patients;

c. Successful completion of the Special Purpose Examination (SPEX), as determined by the testing authorities, to be accomplished in no more than three attempts;

d. Surrender of Respondent's Drug Enforcement Agency (DEA) certificate. Respondent shall not reapply unless and until he receives reinstatement of his controlled substance prescribing privileges by this Board;

e. A civil penalty of $15,000, reduced by Respondent's verified tuition costs for the courses listed in paragraph a above and verified cost of the evaluation(s) listed in paragraph b above, as well as reasonable lodging expenses, cost of mileage and meals incurred in attending the courses and evaluation(s). Respondent shall be reimbursed for mileage and meals according to the schedules set forth in the State of Minnesota's Commissioner's Plan.

Dated: December 17, 1991

STATE OF MINNESOTA
BOARD OF MEDICAL PRACTICE

Melvin E. Sigel, MD
President

MEMORANDUM

The Findings and Conclusions. The Board believes that, with a few exceptions, the Findings of Fact and Conclusions of Law of the Administrative Law Judge (ALJ) are supported by the weight of record evidence in this case. The Board therefore hereby adopts most of the ALJ findings. The significant amendments are as follows.

There is no question that Respondent frequently functioned as a primary care physician in treating most of the patients at issue here. Respondent's own charts, as they existed at the time he provided treatment, leave no doubt of that. There is similarly no question that he failed to perform adequate work-up, diagnosis, and monitoring of the medications he prescribed in his primary care capacity, and failed to communicate with the patients' other physicians. Having made the choice to treat conditions such as hypertension in patient no. 2, headaches in patient no. 3, and chronic cough in patient no. 8, Respondent was obligated to adhere to the minimum standards of care in diagnosing and treating these problems. He did not do so.

controlled substances to patients who are chemically dependent, the failure to maintain physician-patient boundaries, and the failure to try alternatives to the prescription of potentially addicting and habituating benzodiazepines and a variety of pain relievers in violation of Minn. Stat. § 147.091, subd. 1(g) and (k) (1988).

8. The Complaint Review Committee established by a preponderance of the evidence that the Respondent provided primary care to patients 2-3 and 5-10 but failed to follow the minimal standards of acceptable primary care prevailing in this state in violation of Minn. Stat. § 147.091, subd. 1(k) (1988).

9. The Complaint Review Committee established by a preponderance of the evidence that the Respondent violated physician-patient boundaries by engaging in sexual conduct with patient #1 and patient #7 in violation of Minn. Stat. §§ 147.02, subd. 3(10) (1969) and 147.091, subd. 1(g) and (k) (1988).

10. The Complaint Review Committee established by a preponderance of the evidence that Respondent violated patient-physician boundaries with respect to patient #7 by giving her gifts, employing her as his receptionist, lending her money, providing her with rides to the Twin Cities and treating her in a personal manner, in violation of Minn. Stat. § 147.091, subd. 1(g) and (k) (1988).

11. The Complaint Review Committee established by a preponderance of the evidence that the Respondent's medical records were inadequate in that they failed to contain necessary information in violation of Minn. Stat. § 147.091, subd. 1(o) (1988).

12. The Respondent has not established unreasonable delay and prejudice requiring that the charges regarding patient #1 be dismissed.

Based upon the foregoing Conclusions, the Board makes the following:

ORDER

THEREFORE, IT IS HEREBY ORDERED AS FOLLOWS:

1. Respondent's license to practice medicine and surgery is suspended, effective as of the date of this Order;

2. Respondent may petition for reinstatement in whole or in part no earlier than one year from the date of this Order;

3. Prior to filing any petition for reinstatement, Respondent must provide the Board with evidence of the following:

a. Successful completion of the following courses:

(1) The chronic pain management course at Sister Kenny Institute under its director, Matthew Monsein, MD;

(2) The chemical dependency awareness course at St. Mary's Hospital Rehabilitation Center;

The Board differs with the ALJ on one point. Most of the patients at issue had multiple medical diagnoses and were seeing other physicians during the time Respondent treated them. The wording of the ALJ findings suggest that Respondent became the only primary care physician for patient nos. 2, 3, 5, 6, 8, 9 and 10. Clearly patients can, and these often did, have more than one primary care physician. The Board has therefore amended the relevant findings to make clear that Respondent became a primary care physician for a particular patient by choosing to treat one or more general medical conditions. See Board's Findings of Fact 12, 28, 37, 46, 82, and 94.

In addition, the Board believes the standards for prescribing benzodiazepines as set out by the ALJ were not entirely clear, although they were properly applied to Respondent's prescription of benzodiazepines to patients 5 and 7. See Findings 43 and 77. The Board has therefore added finding 42 to avoid any misimpressions about the standards of care applied in this case. The finding blends the testimony of all the expert witnesses. The Board notes, moreover, that these standards are not unique to the use of benzodiazepines. They apply any time a physician is considering prescribing any addicting or habituating medication.

The Board also adopts the ALJ's Conclusions of Law. However, the Board hereby amends the conclusions to specify, for each, the patients for whom Respondent's treatment violated the cited statutory provision. These changes derive from the factual findings made hereinabove with respect to each patient. Moreover, the Board amends conclusion no. 11 to specify the manner in which Respondent's medical records violated § 147.091, subd. 1(0). This change also flows from the findings themselves.

The Sanction. After careful review of the record, the Board has serious doubts about Respondent's potential for rehabilitation. He made significant misjudgments in a variety of areas of medical practice. He casually prescribed habituating and addicting medications to patients known to be chemically dependent, sometimes reinstituting the very drug a patient had previously abused and in the face of current drug-seeking behavior. He treated general medical conditions without minimally adequate diagnostic steps, monitoring, or communication with other physicians. He combined personal and professional relationships in his dealings with patient #7 and engaged in sexual contact with two patients.

The misconduct now found by the Board began in 1970, the year after Respondent was licensed in Minnesota. It has continued in one form or another through 1988. It is particularly noteworthy that Respondent already was twice disciplined by this Board for malprescribing. His failure now, as shown in his testimony, to recognize even one of the deficiencies cited only increases the Board's doubts. Moreover, Respondent's deficiencies are not simply due to a lack of knowledge in one or more areas of medicine. Instead, they appear to go to something more fundamental: Respondent's capacity for and ability to exercise sound medical judgment in treating patients.

The Board is convinced that Respondent's practices pose a present danger to his patients and that the sanction here must address that risk. The Board is also convinced that Respondent and others in the profession must be deterred from the prescribing practices, boundary violations, and sexual misconduct set out herein. Nevertheless, the

Board concludes that the Complaint Review Committee has not proved that Respondent is beyond rehabilitation and consequently should have his license revoked. There exist rehabilitative measures which the Board has employed in the past which have not been attempted here. These include the chronic pain management and chemical dependency awareness classes ordered. These courses are designed to help Respondent identify and manage patients for whom controlled substances are contraindicated or who require ongoing pain management. The SPEX exam will provide evidence that Respondent possesses basic medical knowledge.

Perhaps the most disturbing aspect of Respondent's conduct is that a psychiatrist is unable to recognize appropriate professional boundaries, non-physical as well as physical. Maintenence of such boundaries is critical to the well-being and effective treatment of all patients, but most particularly of psychiatric patients. The boundaries course is intended to address this deficiency. The psychiatric and psychological evaluation is supported by Respondent's plethora of boundary violations with patient #7 and his sexual contact with patients #1 and 7. It is further supported by portions of Respondent's own hearing testimony. Examples include his statement that his prescribing deviated from PDR recommendations because he was aware of "sometimes secret information" about patient care (T. Vol. VI, 58) and other similarly grandiose, irrelevant or confusing testimony. T. Vol I, 43, 44; Vol I, 54-55. The evaluation is intended to provide the Board with information about Respondent's ability to practice safely in the future and steps which may be taken, if necessary, to prevent further transgressions. The suspension will both protect the public while Respondent receives his retraining and emphasize to the physician community the gravity of misconduct such as that found here.

The civil penalty is authorized under Minn. Stat. § 147.141(4). The amount of the penalty is to be fixed, among other things, to reimburse the Board for "the cost of the investigation and proceeding." Id. The Complaint Review Committee submitted verification of the cost of three categories of expenses: court reporter/transcript costs; expert witness expenses and fees; and photocopying and printing costs. These costs totaled $15,230.00. Respondent submitted no rebuttal evidence contesting the amounts claimed. Pursuant to § 147.141(4) and applicable case law, the imposition of a monetary penalty is justified. The kinds of expenses claimed are allowable and the amounts were sufficiently proved. See In the Matter of Wang, 441 N.W.2d 488 (Minn. 1989). The civil penalty of $15,000.00 is thus proper. To encourage the Respondent's pursuit of the courses and completion of the evaluation, the Board has ordered that verified tuition and evaluation costs be deducted from the penalty amount.

BY THE BOARD

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	STIPULATION
ROGER A. MATTSON, M.D., RESPONDENT.	:	(92 MED 005)

It is hereby stipulated between Roger A. Mattson, M.D., and Pamela M. Stach, Attorney for the Department of Regulation and Licensing, Division of Enforcement, as follows:

1. Roger Mattson, Respondent herein, 1015 Medical Arts Building, Duluth, Minnesota 55802, is duly licensed to practice medicine and surgery in the State of Wisconsin under license number 17403 which was granted on October 22, 1970.

2. A Complaint, consisting of two counts was filed against and duly served upon Respondent on May 28, 1992.

3. Respondent has read the Complaint and understands the nature of the allegations against him.

4. Respondent is aware of and understands each of the Respondent's rights including the right to a hearing on the allegations against him at which time the state has the burden of proving these allegations by preponderance of the evidence; the right to confront and cross-examine witnesses against him; the right to call witnesses in his behalf and to compel their attendance by subpoena; the right to testify himself; the right to file objections to any proposed decisions and to present briefs or oral arguments to the officials who are to render the Final Decision; the right to petition for rehearing; and all of the rights afforded the Respondent under the United States Constitution, the Wisconsin Constitution and the Wisconsin Administrative Code.

5. Respondent freely, voluntarily and knowingly waives each and every one of the rights set forth in paragraph 4 above.

6. The Division of Enforcement recommends that the Wisconsin Medical Examining Board adopt this stipulation and issue the attached Final Decision and Order in resolution of this matter.

7. For the purpose of this Stipulation only, Respondent withdraws his previously filed Answer and, while neither admitting nor denying the allegations, voluntarily agrees to entry of the attached Final Decision and Order by the Medical Examining Board.

8. Violation of the terms and conditions specified in this Stipulation and Final Decision and Order shall constitute a basis for disciplinary action by the Medical Examining Board.

9. The parties to this Stipulation understand that the Department of Regulation and Licensing, Division of Enforcement will take no further action against Respondent's license based on the allegations contained in the Complaint unless Respondent violates the terms and conditions of this Stipulation and Final Decision and Order in which event the Department may reinstate the Complaint and reinstitute proceedings against Respondent.

10. This agreement in no way prohibits the Medical Examining Board from any further action against Respondent based on acts not alleged in the present Complaint which might be violative of Wisconsin Medical Examining Board statutes and rules.

11. The parties agree to waive the Proposed Decision of the Administrative Law Judge and submit this Stipulation directly to the Medical Examining Board. All parties agree that counsel for the parties and the board advisor assigned to this case, may appear before the Board in open session to argue on behalf of acceptance of this Stipulation.

12. This Stipulation and Final Decision and Order, if adopted and entered by the Medical Examining Board, shall become effective on the date of signing.

13. In the event any term or condition of this Stipulation and Final Decision and Order is not accepted or entered by the Medical Examining Board, then no term of this Stipulation; and Final Decision and Order shall be binding in any manner on any party to this Stipulation.

Dated: Jan 3, 1994

PAMELA M. STACH, Attorney
Department of Regulation and Licensing

I, Roger A. Mattson, M.D., having read the above Stipulation and having discussed its contents with my attorney and understanding its terms, do hereby, freely, voluntarily and knowingly enter into this Stipulation.

Dated: Dec 28, 1993

ROGER A. MATTSON, M.D.
Respondent

PMS:pw
ATTY-ELG681

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.

Serve Petition for Rehearing or Judicial Review on:

STATE OF WISCONSIN MEDICAL EXAMINING BOARD

1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708.

The Date of Mailing this Decision is:

FEBRUARY 8, 1994

1. REHEARING

Any person aggrieved by this order may file a written petition for rehearing within 20 days after service of this order, as provided in sec. 227.49 of the *Wisconsin Statutes*, a copy of which is reprinted on side two of this sheet. The 20 day period commences the day of personal service or mailing of this decision. (The date of mailing this decision is shown above.)

A petition for rehearing should name as respondent and be filed with the party identified in the box above.

A petition for rehearing is not a prerequisite for appeal or review.

2. JUDICIAL REVIEW.

Any person aggrieved by this decision may petition for judicial review as specified in sec. 227.53, *Wisconsin Statutes* a copy of which is reprinted on side two of this sheet. By law, a petition for review must be filed in circuit court and should name as the respondent the party listed in the box above. A copy of the petition for judicial review should be served upon the party listed in the box above.

A petition must be filed within 30 days after service of this decision if there is no petition for rehearing, or within 30 days after service of the order finally disposing of a petition for rehearing, or within 30 days after the final disposition by operation of law of any petition for rehearing.

The 30-day period for serving and filing a petition commences on the day after personal service or mailing of the decision by the agency, or the day after the final disposition by operation of the law of any petition for rehearing. (The date of mailing this decision is shown above.)

SECTIONS 227.49 AND 227.53, OF THE WISCONSIN STATUTES

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.

227.53 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, the consumer credit review board, the credit union review board, the savings and loan review board or the savings bank 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 5.

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.

5. The savings bank 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 bank 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, the savings and loan review board and the savings bank 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.