TRUE AND EXACT COPY OF ORIGINAL

BEFORE THE MINNESOTA BOARD OF MEDICAL PRACTICE

COMPLAINT REVIEW COMMITTEE

In the Matter of the
Medical License of
Faruk S. Abuzzahab, M.D.
Birth Date: 10/12/1932
License Number: 17,068

AGREEMENT FOR CORRECTIVE ACTION

This agreement is entered into by and between Faruk S. Abuzzahab, M.D. ("Respondent"), and the Complaint Review Committee of the Minnesota Board of Medical Practice ("Committee") pursuant to the authority of Minn. Stat. § 214.103, subd. 6(a) (2004). Respondent has been advised by Board representatives that Respondent may choose to be represented by legal counsel in this matter. Although aware of this opportunity, Respondent has elected not to be represented by counsel. The Board was represented by Stephen B. Masten, Assistant Attorney General, 1400 Bremer Tower, 445 Minnesota Street, St. Paul, Minnesota 55101, telephone (651) 296-7575. Respondent and the Committee hereby agree as follows:

FACTS

1. This agreement is based upon the following facts:

a. Respondent was licensed by the Board to practice medicine and surgery in the State of Minnesota on November 5, 1965. Respondent is board-certified in psychiatry.

b. On September 13, 2005, Respondent met with the Committee to discuss allegations that he wrote prescriptions for at least three patients using false names for the patients and that he failed to provide records for a patient.

2. Based on the discussion, the Committee views Respondent's conduct as inappropriate under Minn. Stat. § 147.091, subd. 1(f), (g), (k), and (o) (2004), and Respondent

agrees that the conduct cited above constitutes a reasonable basis in law and fact to justify corrective action under these statutes.

CORRECTIVE ACTION

3. Respondent agrees to address the concerns referred to in paragraph 1 by taking the following corrective action, which shall be completed within six months from the date of this agreement. Respondent shall submit to the Committee for review and approval, a written policy addressing the following:

a. The appropriate response by a physician to a patient requesting that his/her prescription be issued under a pseudonym or a name other than the patient's current legal name; and

b. The appropriate response by a physician to patients and other health care professionals regarding prescriptions issued under a pseudonym or a name other than the patient's current legal name.

4. The agreement shall become effective upon execution by the Committee and shall remain in effect until Respondent successfully completes the terms of the agreement. Successful completion shall be determined by the Committee. Upon Respondent's signature and the Committee's execution of the Agreement for Corrective Action, the Committee agrees to close the complaint(s) resulting in the information referred to in paragraph 1. Respondent understands and further agrees that if, after the matter has been closed, the Committee receives additional complaints similar to the information in paragraph 1, the Committee may reopen the closed complaint(s).

5. If Respondent fails to complete the corrective action satisfactorily or if the Committee receives additional complaints similar to the allegations described in paragraph 1, the

Committee may, in its discretion, reopen the investigation and proceed according to Minn. Stat. chs. 147, 214, and 14. Failure to complete corrective action satisfactorily constitutes failure to cooperate under Minn. Stat. § 147.131. In any subsequent proceeding, the Committee may use as proof of the allegations of paragraphs 1 and 2 Respondent's agreements herein.

6. Respondent understands that this agreement does not constitute disciplinary action. Respondent further understands and acknowledges that this agreement and any letter of satisfaction are classified as public data.

7. Respondent hereby acknowledges having read and understood this agreement and having voluntarily entered into it. This agreement contains the entire agreement between the Committee and Respondent, there being no other agreement of any kind, verbal or otherwise, which varies the terms of this agreement.

Dated: 06 06 08

Dated: 6/15/6

FARUK S. ABUZZAHAB, M.D.
Respondent

FOR THE COMMITTEE

AG: #1613611-v1

AFFIDAVIT OF SERVICE BY U.S. MAIL

Re: In the Matter of the Medical License of Faruk S. Abuzzahab, M.D.
License No. 17,068

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

TAMMIE L. REEVES, being first duly sworn, deposes and says:

That at the City of St. Paul, County of Ramsey and State of Minnesota, on June 21, 2006, s/he caused to be served the AGREEMENT FOR CORRECTIVE ACTION, by depositing the same in the United States mail at said city and state, true and correct copy(ies) thereof, properly enveloped with prepaid first-class postage, and addressed to:

FARUK S ABUZZAHAB MD
2601 E LAKE OF ISLES PKWY
MINNEAPOLIS MN 55408-1052

TAMMIE L. REEVES

Subscribed and sworn to before me

this 21st day of June, 2006.

NOTARY PUBLIC

AG: #1629087-v1

TRUE AND EXACT
COPY OF ORIGINAL

Name of Licensee:

Faruk S. Abuzzahab, M.D.

Address of Licensee:

Riverside Park Plaza
701 25th Avenue South, #303
Minneapolis, MN 55454

Nature of Misconduct:

(1) Unethical conduct, conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare or safety of a patient; or medical practice which is professionally incompetent, in that it may create unnecessary danger to any patient's life, health, or safety; (2) unprofessional conduct; (3) improper management of medical records.

Action Taken by the Board:

Temporary suspension of license, effective December 19, 1997.

TRUE AND EXACT
COPY OF ORIGINAL

Name of Licensee:

Faruk S. Abuzzahab, M.D.

Address of Licensee:

Riverside Park Plaza
701 25th Avenue South, #303
Minneapolis, MN 55454

Nature of Misconduct:

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Action Taken by the Board:

On May 15, 1998, the Board ordered the temporary suspension of December 19, 1997, to be continued.

Public Document

STATE OF MINNESOTA

OFFICE OF THE ATTORNEY GENERAL

HUBERT H. HUMPHREY III
ATTORNEY GENERAL

July 13, 1998

HEALTH & LICENSING SECTION
525 PARK STREET
SUITE 500
ST. PAUL, MN 55103-2106
TELEPHONE: (612) 297-1050

RECEIVED
JUL 15 1998
MN BOARD OF
MED PRACTICE

Marcy S. Wallace
Cox, Goudy, McNulty & Wallace
676A Butler Square
100 North Sixth Street
Minneapolis, MN 55403

**Re: In the Matter of the Medical License of Faruk S. Abuzzahab, M.D.
License No. 17,068**

Dear Ms. Wallace:

Enclosed and served upon you by United States mail please find a copy of the Stipulation and Order in the above-referenced matter.

In addition, the Board voted to extend the time for completion of the Medical Ethics course required by Paragraph 1(f) of the Stipulation and Order to December 31, 1998.

Very truly yours,

Marcia A. Johnson for

SHARON A. LEWIS
Assistant Attorney General

(612) 296-8954

Enclosure
cc: Board of Medical Practice
abuzz.ck1

TRUE AND EXACT COPY OF ORIGINAL

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE BOARD OF MEDICAL PRACTICE

In the Matter of the
Medical License of
Faruk S. Abuzzahab, M.D.
Date of Birth: 10-12-32
License Number: 17,068

STIPULATION AND ORDER

It is hereby stipulated and agreed upon by and between Faruk S. Abuzzahab, M.D. ("Respondent") and the Complaint Review Committee ("Committee") of the Minnesota Board of Medical Practice ("Board") as follows:

1. During all times herein, Respondent has been and now is subject to the jurisdiction of the Board from which he holds a license to practice medicine and surgery in the State of Minnesota.

FACTS

2. In the interest of settling this matter and avoiding the necessity for further proceedings, the Board may consider the following facts as true, for the purpose of this stipulation and for Board proceedings only. It is the intent of the parties that this stipulation shall have no collateral estoppel effect, no res judicata effect, and no evidentiary value in any proceeding in a forum other than the Minnesota Board of Medical Practice and that Respondent will not be precluded from litigating any issue that may arise out of any facts and circumstances that form the basis of this contested case and the Stipulation and Order and that is not otherwise within the Board's jurisdiction.

a. In July 1996, the Committee initiated a contested case proceeding seeking disciplinary action against Respondent's license because of a pattern of practices in approximately 43 patients which may have caused or contributed to the deterioration of their conditions. These were very ill patients as some of them suicided. As required by the

minimum standard of care, a more adequate diagnosis, treatment selection, monitoring and documentation would have been necessary to insure safe and proper care and avoid unnecessary risk of harm. The Committee subsequently amended the Notice of Hearing twice to allege violations relating to Respondent's treatment of three additional patients, patients #44, #45 and #46, and sought a temporary suspension of Respondent's license pending resolution of the contested case involving all 46 patients.

b. A contested case hearing had been begun prior to the temporary suspension petition and continued for some time during its pendency but the Committee's case in chief was not completed as of the date it was recessed.

c. In an Order dated December 19, 1997, the Board suspended Respondent's license without any evidentiary hearing pursuant to Minn. Stat. § 147.091, subd. 4 based on findings that the Board had probable cause to believe certain violations occurred concerning patients #44, #45 and #46 and that Respondent's continued practice posed a serious risk of harm to the public.

d. Thereafter, an evidentiary hearing was held before an administrative law judge, which hearing was limited by his order to the issues involving patients #44, #45 and #46 on which the Temporary Suspension Order was based. Other issues involving these patients and all issues involving the other patients were reserved to be litigated in the underlying case. Completion of the underlying case was deferred until completion of the temporary suspension proceedings. Following this evidentiary hearing, the ALJ issued his report and both parties filed exceptions and made oral argument to the Board.

e. In Orders dated December 19, 1997 and May 15, 1998, the Board suspended Respondent's license for violations relating to patients #44, #45, and #46. The May 15 Order also specified conditions under which the Board would enter a temporary stay of the Temporary Suspension pending completion of this contested case and imposition of final disciplinary action. These Orders are attached hereto as Exhibits A and B.

f. Respondent's license was temporarily suspended under Minn. Stat. § 147.091, subd. 4 which provides that the Board may temporarily suspend a physician's license if it finds that a physician has violated the Medical Practice Act and that his continued practice would create a serious risk of harm to the public.

g. Respondent has not sought judicial review of these orders. The orders are not directly appealable under Minnesota law but would be reviewable only by discretionary review, extraordinary writ or on an appeal from a final order of the Board in the underlying contested case proceeding.

h. As of the date hereof none of the issues in the underlying contested case have been litigated to their conclusion.

i. Both parties wish to resolve this contested case without incurring further delay and expense and Respondent is willing to agree to restrictions on his license which the Committee believes will protect the public.

STANDARD OF CARE

3. The minimum standard of care required of a physician prescribing psychoactive drugs mandates that he establish a diagnosis, identify the relevant symptoms that will be targeted with treatment, choose medications that are appropriate to the diagnosis and symptoms, and monitor the patient's response to assess whether the desired effects are occurring and that the adverse effects do not outweigh the benefits of the medication. A physician's obligation to comply with these minimum standards is even more rigorous when there are indications that the patient is or is becoming dependent upon drugs. This is so because there is an inherent risk of harm in prescribing any drugs, controlled or uncontrolled, which becomes even greater in a patient with a history of substance abuse or dependency.

4. Respondent is aware of the steps to take when setting an initial medication dosage and agrees that coordination of care is the best approach, that controlled substances must be cautiously dispensed under close supervision, that one must be alert to signs of drug

dependency and addiction and respond to them, and that prior medical records should be obtained.

PATIENT CARE

5. The pattern that emerges from Respondent's treatment of the approximately 46 patients at issue in the contested case proceeding is that he regularly fails to substantiate his diagnoses, monitor whether the combination of drugs is appropriate for the symptoms being treated and is having the desired effect, and evaluate whether the benefit outweighs the adverse effects noted in the chart. This fundamental failure shows a reckless, if not willful, disregard of the patients' welfare, exposes the patients to an unnecessary risk of harm and contributes to their deterioration while under his care.

6. In the substantial majority of these patients Respondent prescribed controlled substances in combination with multiple other drugs, often on a long-term basis, without adequate justification or monitoring and continued to do so despite indications that the drugs were not having their desired effect, that the patient was dependent on or abusing drugs and/or that the patient's condition was deteriorating.

7. In a number of cases (including but not limited to patients #35, #36 and #40, for example), Respondent enrolled psychiatrically disturbed and vulnerable patients into investigational drug studies without ensuring that they met the eligibility criteria to be in the study and then kept them in the study after their conditions deteriorated.

8. Examples of this continuing pattern include patients ##1, 11, 12, 13, 19, 23, 35, 36, 38, 40, 43, 44, 45 and 46.

9. Patient #1 was a young adult male treated by Respondent for four years from February, 1982 until February, 1986. Although Respondent diagnosed patient #1 as depressed, he did not begin an adequate trial with antidepressants for almost eighteen months. Respondent, however, prescribed controlled substances to patient #1 on a long-term continuous basis without adequate justification and despite evidence, such as admission to rehab, suicidal

ideation, incarceration and detoxification, that he was (or was becoming) dependent upon or abusing drugs and his functioning was deteriorating. For example:

a. Respondent prescribed large amounts of controlled substances, specifically benzodiazepines, without justification and after charting patient #1's drug abuse and impairments. For example:

i. On August 6, 1982, Respondent informed patient #1 that he needed to reduce his diazepam and possibly use other medications. On this date, Respondent prescribed diazepam 5 mg. t.i.d., #25 with 4 refills. Similarly, after advising patient #1 on August 6, 1982 to reduce diazepam and use other medications, on December 30, 1982, Respondent increased the dosage of diazepam (10 mg. t.i.d. #25 with 4 refills) without explanation, without a diagnosis to support the use of this medication and despite previous documentation warning the patient of the addictive nature of the drug and advising him to decrease its use. On February 3, 1983, at the same time Respondent warned patient #1 to reduce his use of diazepam, he continued to prescribe the same amount of the medication with four refills.

ii. On numerous occasions, Respondent gave patient #1 samples of Valrelease (a benzodiazepine) in addition to prescribing high doses of diazepam (also a benzodiazepine). For example, on May 14, 1982, in addition to prescribing diazepam 5 mg. t.i.d. #25 with five refills, Respondent also gave patient #1 five samples of Valrelease, 15 mg. On June 13, 1984, Respondent gave patient #1 ten samples of Valrelease 15 mg. in addition to prescribing diazepam 10 mg. b.i.d. #15 with four refills. On September 26, 1984, Respondent increased the dose of diazepam to 30 mg. daily and also gave patient #1 15 samples of Valrelease 15 mg. On October 31, 1984, Respondent prescribed diazepam 30 mg. daily, #15 with four refills, and also gave patient #1 20 samples of Valrelease 15 mg. On December 20, 1984, Respondent prescribed diazepam 30 mg. daily, #15 with four refills, and dispensed ten samples of Valrelease 15 mg.

iii. On a number of occasions, Respondent prescribed a narcotic, Talwin, to patient #1 in addition to the large amounts of benzodiazepines and prescribed this narcotic notwithstanding his warnings to patient #1 that he should not take the narcotic. On September 3, 1983, Respondent prescribed Talwin 15 mg. #10 for patient #1 after noting "he was advised not to take pentazocine (Talwin)." He prescribed ten more Talwin over the phone on September 6 and ten more on September 16, 1983. He again prescribed fifteen of Talwin-NX to patient #1 on November 7, 1983, the same date Respondent documented that patient #1's wife, also a patient of Respondent (Patient #38), died of a possible Talwin overdose. On this same date, Respondent also prescribed diazepam 10 mg. t.i.d. #25 with four refills, 10 samples of Valrelease, and triazolam 0.5 mg. HS #10 plus 20 samples.

b. On December 20, 1984, Respondent prescribed eight different drugs to patient #1, including three benzodiazepines (diazepam, Valrelease, and flurazepam), an antidepressant (Triavil), diflunisal, propanolol, chlorpromazine, and Nicorette. Respondent claims that all eight drugs were clinically indicated because he was trying to get the patient to quit smoking.

c. Respondent exposed patient #1 to serious risk of harm by continuing to prescribe controlled substances to patient #1 after clear signs that he was abusing drugs and his condition was deteriorating. For example:

i. On August 2, 1985, Respondent continued to prescribe high doses of benzodiazepines and added a small dose of Empirin No. 3 #5 despite notes from June 28, 1985, that he referred patient #1 for chemical dependency treatment because he was not motivated and despite a current note that the patient was talking about suicide. On that date he discontinued Librium 25 mg. t.i.d. but started Tranxene 22.5 mg. b.i.d. #14 plus 4 refills and continued flurazepam 30 mg. HS plus 1x repeat, #14 plus 4 refills.

ii. Despite the fact that patient #1 was in jail on October 7, 1985, Respondent renewed his prescriptions for controlled substances (Tranxene 45 mg. daily and flurazepam 60 mg. daily) on November 20, 1985.

iii. Despite the fact that patient #1 was admitted for detoxification on December 31, 1985, Respondent renewed patient #1's prescription over the phone for benzodiazepines (Tranxene 45 mg. daily #20 and Dalmane 30 mg. + 1x repeat #15) on January 3 and Dalmane/flurazepam 30 mg #20 on January 14, 1986.

iv. On February 6, 1986, Respondent noted that patient #1 had to find another physician because he had "forged prescriptions for the second time" and Respondent refused to refill a prescription when called by patient #1's pharmacy. There is no indication in Respondent's medical records for patient #1 that he ever wrote a termination letter or referred the patient to the care of another doctor. On May 2, 1986, patient #1 committed suicide by shooting himself in the head.

8. Patient #11 was a married housewife who was referred to Respondent by her milkman because she was experiencing stress. Respondent diagnosed her with depressive neuroses. She treated with Respondent, first, from April 26, 1984 until May 15, 1985 when she was hospitalized in St. Mary's rehab unit, and then again, from March 27, 1986 until her last appointment on July 31, 1986, two days before her death. Respondent maintained patient #11 without justification on addicting, sedating medications despite indications that she was becoming dependent upon and abusing drugs and that her functioning was deteriorating such as her DWI arrests, her admission to drug rehabilitation, and a hospitalization for overdosing on her medications. Respondent only treated her with antidepressants when patient #11 participated in a drug study. For example:

a. From patient #11's first visit with Respondent on April 26, 1984, until July 14, 1984, Respondent prescribed her large amounts of controlled substances despite a family history of alcohol abuse and despite signals, such as her husband dumping her pills and her requests for early refills, that patient #11 was possibly developing dependency on these drugs.

b. Respondent continued to prescribe drugs with abuse potential to patient #11 even though documentation clearly indicated drug-seeking behavior and abuse.

i. On April 11, 1985, Respondent prescribed three sedating, addictive substances, chloral hydrate, diazepam, and oxycodone with acetaminophen, to patient #11, despite her recent conviction for driving while intoxicated.

ii. On April 29, 1985, Respondent refilled prescriptions for chloral hydrate and diazepam, despite a call from a pharmacist stating that patient #11 was getting medications from other physicians.

iii. Patient #11 was admitted to rehabilitation on May 15, 1985.

c. On April 10, 1986, two weeks after entering patient #11 in an antidepressant drug study on March 27, 1986, Respondent prescribed chloral hydrate 500 mg. HS plus 1 repeat and then refilled it for 1 gr HS plus 1 repeat (an amount above the recommended amount) twice, first over the phone on April 14, 1986 and again on April 17, 1986 despite a call from the pharmacist that she was not taking her medications as directed.

d. Patient #11 overdosed on her medications on May 5, 1986 and was hospitalized. She was discharged with a prescription for two sedating controlled substances, chloral hydrate and a benzodiazepine (Dalmane), and then Respondent gave two telephone refills for a small amount of these drugs on May 10 and May 13, 1986. At the same time Respondent also maintained patient #11 on fluoxetine, a stimulating antidepressant, which worsened patient #11's insomnia, the apparent reason why Respondent prescribed her sedating medications.

e. From the date of patient #11's discharge from the hospital in May 1986 until her death on August 2, 1986, Respondent continued his pattern of prescribing weekly refills of chloral hydrate and Dalmane over the telephone and providing early refills, including a refill for Valium (10 mg. t.i.d. #30), opiates (#5 Percocet) and a small amount of antidepressants (50 mg. HS #10) two days before her death.

9. Respondent prescribed controlled substances to patient #12, a 35-year-old woman diagnosed with "obesity nutritional, exogenous," over a five-year period without adequate

justification and despite evidence of her drug dependency and abuse and of her deteriorating condition. For example:

a. Despite a documented substance-abuse history in her initial intake record, Respondent prescribed diazepam (Valium) 30 mg. daily for patient #12 over the telephone on July 6, 1982, without indicating his rationale. Respondent continued to prescribe diazepam for this patient over the next five years.

b. On October 23, 1982, Respondent started patient #12 on pentazocine (a narcotic) 50 mg. t.i.d. #25 (two refills) over the telephone when she complained of headaches. A prescription for pentazocine 50 mg. q.i.d. #30 (four refills) was renewed eleven days later (November 2, 1982). On November 12, 1982, Respondent was notified by a pharmacist that patient #12 was trying to get refills of pentazocine and Compazine early. Documentation indicated that patient #12 had received 375 tablets of pentazocine 50 mg. over a six-week period, for a daily average of more than eight (8) tablets per day.

c. On April 30, 1982, Respondent prescribed flurazepam (Dalmane) for stress-related insomnia. At that time, patient #12 was already taking three other controlled substances (diazepam, pentazocine, pemoline) as well as metoclopramide and synthroid. All these medications have psychiatric side effects associated with them. The flurazepam was continued for over three years with pemoline, diazepam, and various narcotics.

d. Respondent maintained patient #12 on pemoline 225 mg. daily for over three years even though the patient did not lose weight. On May 9, 1984, Respondent "congratulated" patient #12 on her weight loss even though she weighed more than when she had started the medication.

10. Respondent prescribed controlled substances to patient #13, a 30-year-old woman diagnosed with "depressive neuroses", over a six-year period despite evidence that she was dependent upon or abusing drugs and that her functioning was deteriorating. Respondent continued to prescribe drugs after he learned of her two pregnancies, both of which resulted in premature births and the death of one baby. For example:

a. Even though documentation clearly indicated that patient #13 was chemically dependent and abused her medications, Respondent prescribed hydromorphone (a narcotic) 2 mg. t.i.d. #12 on patient #13's first visit on February 26, 1981 and, one week later on March 7, 1981, he telephoned in a prescription for ten Tylenol #4. Respondent continued to prescribe several drugs with an abuse potential (Valium, Tylenol #4, Tussionex, Percocet).

b. From March 27, 1981, through August 3, 1987, Respondent maintained patient #13 on diazepam (Valium) 20 to 40 mg. daily without justification and without any significant attempt to withdraw the patient.

c. In April 1981, documentation indicated that patient #13 left St. Mary's Hospital against medical advice and refused a "proper withdrawal program." She readmitted herself and was discharged on May 1. Respondent nonetheless prescribed diazepam 10 mg. t.i.d. #100 on that date.

d. On November 12, 1981, Respondent was notified that patient #13 was going to multiple pharmacies. Two days later, Respondent prescribed diazepam 40 mg. per day #30 plus 5 refills.

e. On several occasions, Respondent called in prescriptions for medications with codeine over the telephone e.g., February 23, May 26, June 9, June 19, July 21, and December 22, 1982.

f. On May 16, 1983, Respondent prescribed a narcotic (8 Percocet) after patient #13 had been released from jail and claimed the police had taken her medications.

g. On March 28, 1984, Respondent prescribed 10 tablets of ethchlorvynol (Placidyl) 750 mg. qhs, a schedule IV drug which is notorious for abuse.

h. On February 28, 1987, patient #13 admitted to using cocaine. Respondent nonetheless prescribed diazepam 10 mg. t.i.d. #100 and 5 Percocet, a narcotic.

i. Respondent continued to prescribe multiple controlled substances for patient #13 and refilled prescriptions early for reasons that suggest drug abuse even after he charted he would no longer write prescriptions for controlled substances. For example:

Date refill provided	Patient's excuse
10/15/81	"son dropped her medications in toilet"
05/07/83	"fell and broke bottle"
05/09/83	"due to memory loss from ECT she claims she can't find bottle of her medications"
08/31/83	"picked up hitchhiker who took all her medications"
01/26/84	"raped and medications stolen"
11/22/86	"lost her diaper bag and diazepam"
06/09/87	"prescriptions were lost from her diaper bag"

j. From December 23, 1983, to January 24, 1984, patient #13 underwent chemical dependency treatment at St. Mary's Hospital. On January 24, 1984, Respondent prescribed Valium and 14 Tylenol #4 for her, and on March 7, 1984, she was given ten Percocet, a narcotic.

k. During patient #13's two pregnancies, Respondent advised her to "not take any of her medications" but regularly prescribed controlled substances, including benzodiazepines and small amounts of narcotics, during her second and third trimesters. Both pregnancies ended with premature delivery, with the first baby dying shortly after birth.

11. Respondent prescribed a combination of controlled and non-controlled substances to patient #19, a 24-year-old woman diagnosed with "depressive neuroses", over a period of approximately 10 years despite evidence of her drug dependency and abuse, her deteriorating functioning and her pregnancy. For example:

a. Even though patient #19 had a known history of stimulant abuse, Respondent prescribed methylphenidate (Ritalin, a stimulant) 80 mg. daily on her second outpatient visit which occurred after a five week hospitalization. In addition, Respondent prescribed thiothixene 18 mg. daily for patient #19 even though she did not have a history of psychosis and her diagnosis was "depressive neuroses," a nonpsychotic disorder.

b. On May 3, 1976, Respondent prescribed oxycodone for no documented reason. On May 14, 1976, Respondent changed this to pentazocine 50 mg. b.i.d., again without documenting his rationale for prescribing this medication.

c. On July 15, 1976, Respondent increased the methylphenidate to 100 mg. daily, which is well above the maximum dosage recommended in the PDR (60 mg.).

d. On December 27, 1976, patient #19 admitted to taking up to 240 mg. daily of methylphenidate. Respondent nonetheless refilled a prescription early for 200 pills on this date, although it was noted that patient #19's prescription would not be renewed early again.

e. Documentation in the spring and summer of 1977 clearly indicated that patient #19 was abusing her medications and desired to "get off all medications." On July 1, 1977, Respondent noted, "She has been for one week off all medications." Despite this progress, Respondent prescribed pentazocine 50 mg. p.r.n. on October 25, 1977, without indicating his rationale.

f. On January 6, 1978, Respondent noted that patient #19 is "depressed which is a change from her manic state . . . ." On this date, Respondent restarted the patient on methylphenidate 80 mg. daily.

g. Respondent continued to add medications to patient #19's regimen so that by September 1978 she was taking seven different drugs, three of which were controlled substances. For the remainder of her care, patient #19 was usually taking seven to eight medications, including at various times combinations of a narcotic, stimulant, benzodiazepine, and/or a barbituate.

h. In October 1978, patient #19 began expressing paranoid ideas, which may have been caused by the long-standing use of methylphenidate. Despite these symptoms, Respondent continued to prescribe methylphenidate 80 mg. daily.

i. Between November 1978 and January 1979, Respondent prescribed Fiorinal in quantities of 100 tablets without indicating its necessity.

j. Respondent continued to renew prescriptions for controlled substances even though patient #19 was clearly abusing her medications. For example:

i. On June 12, 1979, patient #19 admitted that she had been abusing her medication; yet, Respondent continued to refill her prescriptions.

ii. In June 1981, documentation indicated that a physician covering for Respondent received ten phone calls from patient #19's family members, a lawyer and her husband's employer saying that they would like her hospitalized and treated for mental illness and/or chemical dependency. At this time, Respondent was prescribing four controlled substances for patient #19.

iii. On November 10, 1986, patient #19 called, claiming that she lost her prescription for chloral hydrate. In response, Respondent provided a refill for 100 pills of chloral hydrate 500 mg. Nine days later (November 19, 1986), another 100 tablets were called in. This took place while patient #19 was pregnant. On December 22, 1986 patient #19 was hospitalized with pre-eclampsia.

12. Patient #23 was an adult woman whom Respondent treated over a 12-year period, with a combination of up to 12-14 drugs, including high doses of stimulants, sedatives, and opiates, all addicting controlled substances, without justification and despite clear evidence that she was being harmed by them, such as vision and balance problems, a number of hospitalizations and suicide attempts. For example:

a. There was no diagnosis at the initial visit with Respondent or any time thereafter to establish what Respondent was treating and to provide a rationale for the medications he was prescribing. There is no indication throughout this record that Respondent assessed the benefit of continuing to prescribe this combination of medications in light of the obvious deleterious effects on patient #23.

b. On September 3, 1975, Respondent prescribed an antidepressant (Imipramine), a stimulant (a Class II controlled substance, Ritalin), a diuretic, a stool softener, two antihistamines, a neuroleptic, and a sedative hypnotic (the controlled substance, Placidyl).

Notwithstanding the absence of a diagnosis to support these medications, there would be no justification for prescribing a stimulant at the same time one is prescribing an antipsychotic and a sedative. The stimulant would aggravate the psychosis and make it more difficult to sleep.

c. Patient #23 accidentally overdosed on her medications as early as January 24, 1976. Despite this early sign that the medications were harming her, Respondent maintained patient #23 on this same combination of controlled and noncontrolled substances and often added another Class II controlled substance, such as Percodan, for the next 11½ years.

d. Respondent continued to prescribe these addicting and dangerous drugs even after he noted their adverse effects and advised her that she had to reduce them.

i. On August 19, 1978, despite notes that patient #23 should gradually reduce her medications, Respondent actually doubled the stimulant (Ritalin) so that patient #23 was prescribed 120 mg./day, which is twice the recommended dose that Respondent had noted in his writings.

ii. On January 2, 1979, Respondent mailed a prescription to patient #23 for 200 Ritalin (the stimulant), 100 Placidyl, and 100 of the chloral hydrate (both sedatives) despite Respondent's previous note on November 4, 1978 that "the patient is taking too many sleeping pills and appeared slowed down this morning."

iii. Because patient #23 was showing signs of increased depression and drug seeking behavior, Respondent referred patient #23 to another physician for her complaints about pain. This physician would not prescribe opiates for her pain, yet Respondent continued to prescribe opiates to her.

e. In March of 1980, Respondent prescribed an opiate (3 Darvon) and multiple other substances including controlled substances such as a stimulant (Ritalin) and sedatives (Valium and Placidyl). During this period, Respondent's notes indicated that he was aware that these medications were likely contributing to the patient's dizziness, hostility and

vision problems yet he made no effort to get her off the medications or to justify continuing them.

f. Respondent continued this pattern of prescribing a combination of drugs, including multiple controlled substances with the potential to cause psychosis and aggravate anxiety and insomnia despite numerous hospitalizations for increased depression, patient #23's documented substance abuse, and adverse effects such as dizziness and loss of vision. By April 1981, there was no explanation to justify the doses of controlled substances Respondent was prescribing to this deteriorating patient.

g. On August 15, 1981, patient #23 was admitted to the hospital with an overdose. On the day she was released, September 3, 1981, Respondent started her back on an opiate, two sedatives, a stimulant, and also gave a potentially lethal supply of her antidepressant.

h. On September 21, 1982, Respondent prescribed 14 different medications, including chloral hydrate, lorazepam and a narcotic (Tylenol with Codeine) for patient #23, despite the fact that on August 11, 1982, she was in the Hennepin County Medical Center's detoxification unit. On October 12, 18, 27, and 29, 1982, respectively, Respondent prescribed over the phone chloral hydrate, Cylert, and Tranxene and chloral hydrate in addition to the Tranxene and Ativan he prescribed at the appointment on October 13, 1982. This prescribing was a gross departure from minimum standard.

i. On June 23, 1987 shortly after he received the Board's subpoena for numerous patient charts, Respondent charted "I had a long talk with patient on the phone. I informed her that this is the last time meds will be refilled without her being examined in the office. . . . This is a continuation of our phone conversation. She was informed that she has to make an appointment before she runs out of her monthly supply since no refills will be given. If she plans to stay in Austin for more than 30 days, she needs to find a physician in Austin. She was informed that she should resume attending women's group to look at other

non-drug means to lift her depression. She was informed that she has to reduce her medication and find out if her depression can be controlled at a lower dose."

j. These notes show that Respondent knew what steps needed to be taken to properly treat her depression and to control patient #23's drug abuse and addiction yet he failed to do so for the previous 12 years during which time his prescribing practices contributed to, if not caused, significant deterioration and harm to patient #23.

13. Patient #35 was a psychiatrically vulnerable patient diagnosed with schizophrenia whom Respondent placed into an investigational drug study without ensuring that she met the eligibility criteria. He then kept her in the study and allowed her to leave the hospital on an unaccompanied pass to her apartment despite indications she was suicidal, had a specific plan to jump off a bridge and the study protocol prohibited a pass. For example:

a. On May 7, 1994, patient #35 was admitted to the hospital with schizophrenia residual type with concommitant depression and suicidal ideation. Documentation indicated that the patient was very suicidal during the first three weeks of hospitalization. On May 20, 1994, the patient was started on venlafaxine and began to show improvement. By May 26, 1994, nursing notes indicated that patient #35 "feels ready to leave soon."

b. On May 27, 1994, patient #35 was referred to Respondent for participation in a haloperidol-sertindole investigational drug study, even though the study specifically excluded suicidal patients or those with serious suicidal ideation in the opinion of the investigator. There was no documentation to indicate why this very suicidal patient, who was beginning to respond to antidepressant therapy, was entered into a study in which her antidepressant medication would have to be stopped.

c. From May 27 to 31, 1994, pursuant to investigational protocol, Respondent discontinued patient #35's antidepressant medication prescribed by her previous physician. During the study, patient #35 was allowed to have Ativan and chloral hydrate.

d. From June 1 to 7, 1994, patient #35 underwent the sertindole placebo wash-out phase. During the first two days of the wash-out period, patient #35's suicidal feelings intensified, but then began to ease up.

e. Although the study protocol did not permit leave from the hospital until Study Day 26, Respondent allowed patient #35 to leave the hospital at Study Days 4 and 5 (June 4 and 5, 1994), while she was still in the placebo wash-out phase of the study.

f. On June 8, 1994, patient #35 was started on the investigational medication (sertindole 20 mg. or 24 mg. or haloperidol 15 mg. or placebo).

g. During the study, Respondent recorded patient #35's adverse effects as "0." Nursing documentation as well as Respondent's June 3 chart note indicated that patient #35 experienced repeated problems with leg restlessness and jerkiness and that the patient requested Cogentin on June 3, 1994 for the symptoms, but Respondent increased the Ativan instead.

h. Patient #35 was maintained in the study even though documentation indicated repeated suicidal ideation such as the following:

Date	Documentation
6/3/94	"Reported feeling suicidal last evening"
6/8/94	"Passive thoughts of suicide with hopeless/helplessness in coping with changes from study. 2355: patient feels hopeless, has suicidal thoughts of leaving the unit and jumping off the bridge on Franklin Ave. She has made no attempts to leave unit. Feel hopeless about meds working but says she is safe in the the hospital."
6/9/94	"'I feel so hopeless. I give up. I don't think this new med is going to work.' Patient states she feels suicidal and has been actively thinking about suicide, stating she's different from others because when she attempts, she will succeed. Refused to divulge method she has planned, however states she is unable to use the method while hospitalized. States she can agree to not harm self while in hospital."

i. On June 10, 1994, Respondent authorized an unaccompanied pass for patient #35 to leave the hospital on June 11, 1994 (which was only Study Day 11). During

this unaccompanied pass, patient #35 committed suicide by jumping off the Franklin Avenue Bridge, the method mentioned by patient #35 on June 8.

14. Patient #36 is a psychiatrically vulnerable patient, diagnosed with bipolar disorder with psychosis or paranoid schizophrenia, whom Respondent placed into one or more investigational drug studies without ensuring that she met the eligibility criteria and then kept her in the study after her condition deteriorated and the patient wanted to be taken off the study. For example:

a. When patient #36 was not in an investigational drug study for schizophrenia, Respondent maintained patient #36 on various mood stabilizers as well as neuroleptics and other medications to treat her mood disorder.

b. On November 27, 1982, after evaluating patient #36, who had her first seizure just prior to discharge from the psychiatric ward, a consulting physician noted his concern that the seizure and other abnormal conditions were because of the psychotropic medications (Cylert, Asendin and Lithium) patient #36 had been receiving.

c. Even though patient #36 displayed significant affective symptoms, in 1991 and 1994, Respondent entered patient #36 into two investigational drug studies (remoxipride and sertindole) which were exclusively for patients with schizophrenia. Specifically:

i) On December 30, 1991, Respondent entered patient #36 in a two-year outpatient study for remoxipride. This study, as well as the sertindole study, defined rehospitalization or extended initial hospitalization as serious adverse events requiring justification for continuing the study medication.

ii) Respondent maintained patient #36 on the investigational drug for a period of twenty-three (23) months even though patient #36 was hospitalized on five occasions, one of which was for four weeks and another was for six weeks. Respondent did not, however, document his rationale for maintaining patient #36 in the study, particularly after noting that she was non-compliant with her medications.

iii) Both the patient and her significant other reported that patient #36 was worse on the investigational medication. She was extremely sedated and was maintained on a combination of two to four different sedatives at the same time (lorazepam, temazepam, chloral hydrate, diphenhydramine) for several periods. Respondent nonetheless maintained patient #36 on the study throughout the twenty-three (23) month period, without documenting any justification for continuing the study medication.

iv) After stopping the remoxipride study, patient #36 was put back on a mood stabilizer, various neuroleptics were added and she did fairly well from approximately November 1993 to May 1994.

v) On May 27, 1994, patient #36 was readmitted because she had been non-compliant with medication and was thought to be a danger to herself. On this date, Respondent documented that patient #36 was "agitated, paranoid, and delusional with racing thoughts." Despite the patient's confused and agitated conditions, patient #36 was presented with and signed a consent form to participate in the double-blind sertindole study vs. haloperidol vs. placebo.

vi) Respondent's documentation regarding patient #36's participation in the sertindole study differed from the staff's documentation. While Respondent documented at more than one point that patient #36 was much improved and mildly ill, staff consistently noted her deterioration throughout the study. It was also documented that patient #36 made several references indicating that she did not want to take the medications. Respondent failed to document his rationale for continuing the investigational medication under these circumstances.

vii) On June 19, 1994, Respondent rated patient #36 "mildly ill and much improved" despite nursing notes from June 18 that patient #36 was "pacing," "hallucinating" and complaining about being a "guinea pig". On June 20 Respondent shifted the patient into the open label sertindole study. On July 7, 1994, Respondent terminated patient #36's participation in the investigational study and started her on Loxitane. One week

later (July 16, 1994), Respondent permitted patient #36 to leave the hospital on a pass, despite staff stating she was not ready. The patient refused to return from her pass and was discharged by Respondent.

viii) One week later (July 21, 1994), patient #36 was readmitted to the hospital in a very disorganized state. During the next several weeks, patient #36 continued to deteriorate, refused to take medication, eat or get out of bed, and became catatonic and incontinent.

ix) Finally, on September 2, 1994, patient #36 was committed to Anoka Metropolitan Regional Treatment Center for prolonged care. There, she recovered quickly and was discharged on depot neuroleptic medication and the mood stabilizer, Depakote, a medication Respondent regularly prescribed when patient #36 was not in an investigational study and on which she did well.

15. Respondent prescribed multiple drugs, both controlled and non-controlled, to patient #38, a 34-year-old woman whom Respondent treated for anxiety, chronic pain and depression, a diagnosis he never substantiated. From April, 1981 until her suicide on November 3, 1983, Respondent kept patient #38 on high doses of potentially lethal and/or addicting substances despite her drug abuse and dependency and her deteriorating condition. For example:

a. Documentation indicated that patient #38 had more than ninety (90) hospital admissions and lived in a house with other patients treated by the Respondent who were also substance abusers (patients #1 and #7).

b. Although Respondent gave patient #38 a diagnosis of depression, the basis for this diagnosis was never provided. In addition, Respondent treated patient #38 with neuroleptics without documenting his rationale for doing so.

c. From 1981 to 1983, Respondent maintained patient #38 on very high doses of addictive and/or potentially lethal medications (chloral hydrate, pentazocine, chlordiazepoxide, diazepam, temazepam, triazolam, Valrelease) even though data clearly

indicated that patient #38 was a substance abuser and was unable to function adequately on the medications.

d. On October 22, 1982, patient #38 underwent a chemical dependency evaluation after losing custody of her children (she was required to undergo an evaluation in order to regain custody). During this evaluation, another physician diagnosed patient #38 with "chemical abuse and dependency." It appears that the recommended 3-day evaluation could not be funded, however, so Respondent discharged the patient on this same date. In his discharge summary, Respondent failed to list chemical abuse/dependency as one of the patient's diagnoses. Respondent discharged patient #38 on the same medications which she had been taking on admission (including pentazocine 300 mg., diazepam 30 mg. daily, and chloral hydrate 2 gm daily) despite being told by consultants that these drugs should be stopped.

e. On February 11, 1982, August 4, 1982 and August 29, 1983, Respondent complied with patient #38's request for early renewal of controlled substances when told that the previous prescription had been lost or stolen.

f. On more than one occasion, Respondent renewed prescriptions with large supply of potentially lethal medications shortly after a serious suicide attempt. For example, on June 10, 1982, patient #38 was admitted to the hospital after overdosing on amitriptyline. Respondent discharged patient #38 on June 13, 1982, with the following medications: amitriptyline 100 mg. HS #10 (5 refills); chloral hydrate 1 gm HS + 1x repeat #25 (5 refills); pentazocine 50 mg. prn up to t.i.d. #25 (5 refills); and diazepam 10 mg. t.i.d. #25 (5 refills). Then, approximately two weeks later, on June 29, 1982, he prescribed patient #38 75 tablets of 150 mg. of Amitriptyline, a highly lethal supply.

g. On or about November 2, 1983, patient #38 committed suicide on an overdose of medication.

16. Patient #40 was a psychiatrically vulnerable patient diagnosed with paranoid schizophrenia whom Respondent placed into an investigational drug study without ensuring

that she met the eligibility criteria of the study protocol and then kept in the study despite the fact that her condition worsened and her caseworker asked that he put her back on medications that she was taking before the drug study and which were working for her. For example:

a. Prior to seeing Respondent, patient #40 had spent thirteen (13) years as an inpatient in a state hospital. Five weeks after starting clozapine she had such a good response that she was discharged in 1991. She continued to do well, to the point that she was able to get a job. However, patient #40 did not like the weekly blood draws that were required with the clozapine and felt that the clozapine was making her "depressed, unable to think and moody" and, therefore, decided to get a second opinion from Respondent.

b. During the patient's first visit on July 28, 1994, Respondent decided to start patient #40 on an investigational drug study (olanzepine vs. haloperidol). Respondent charted that patient #40 did not want weekly blood drawing and and her chief complaint was that she could hardly think on 400 mg. of clozapine HS. Respondent charted that the patient had experienced an "intolerable adverse event" (required for study entry in the absence of symptoms of psychosis), but failed to chart what that event was.

c. Respondent failed to obtain patient #40's medical records to determine if the benefits of the study medication outweighed the risks of stopping clozapine.

d. Shortly after initiating the drug study (August 4, 1994), patient #40's case worker talked to Respondent and told him that patient #40 had done well on clozapine and should be put back on it. Respondent, however, continued to maintain the patient in the study until August 8 when he put her back on clozapine briefly. From August 8 until she returned to her previous physician, the patient continued to deteriorate, experiencing insomnia, an e.r. visit for panic and vomiting. She then returned to her previous physician. Documentation indicated that her mental status restabilized quickly after being restarted on clozapine with this physician.

17. Patient #43 was an adult male with a documented history of substance abuse. During the five-year period that patient #43 was treated by Respondent from October, 1987

through October 14, 1992, Respondent prescribed excessive amounts of benzodiazepines, a controlled substance, alone or in combination with other medications, long after they were justified by any medical rationale and after it became imperative to taper patient #43 off these substances because of clear indications that he was becoming dependent upon and abusing these drugs and/or that he was suicidal. For example:

a. During his initial visit with Respondent on October 28, 1987, patient #43's chief complaints were depression and insomnia. Respondent made a diagnosis of unipolar depression and started patient #43 on bupropion 75 mg. t.i.d. and flurazepam 15 mg. HS to prevent seizures.

b. At the next visit on November 3, 1987, Respondent prescribed another benzodiazepine (clonazepam 2 mg. at HS), even though patient #43 had a documented history of substance abuse, and had taken six times the amount of the prescribed flurazepam. Respondent then gave a telephone refill on November 20, 1987.

c. After staff noted in the chart that patient #43 had "strong alcohol breath," Respondent prescribed 300 tablets of clonazepam between November 20, 1987, and December 5, 1987 and on December 21, 1987, Respondent began authorizing simultaneous benzodiazepines by prescribing alprazolam 0.5 mg. q.i.d. for no apparent reason even though the patient would still have had clonazepam left.

d. Respondent continued to prescribe high doses of benzodiazepines even after he became aware that Patient #43 was abusing alcohol and drugs and warned Patient #43 that the drugs would no longer be prescribed. For example:

i. After charting on November 8, 1988 that Patient #43 should be in an Antabuse program, Respondent made a brief gesture at tapering patient #43 off benzodiazepines and reinstituted them with weekly refills once the patient was enrolled in the program. Respondent authorized a refill of clonazepam two weeks early on January 5, 1989, and for undocumented reasons increased the previous dosages to 6 mg. nightly. Early refills

were provided on February 9, 1989 (two weeks early) and on February 23, 1989 (one month early).

ii. On April 14, 1990, Respondent documented that patient #43 should not be taking chloral hydrate with clonazepam, but two weeks later (April 28, 1990), Respondent renewed the clonazepam (100 tablets) and added chloral hydrate 150 mg. daily (100 tablets). At this point, Respondent was treating a patient known to be abusing alcohol with two sedating controlled substances with a cross-transference from alcohol abuse to drug abuse.

e. On June 1, 1990, patient #43 was hospitalized after overdosing on his medication and alcohol. Three weeks later, Respondent represcribed a lethal supply of the same medication on which patient #43 overdosed.

f. Between July 7 and August 11, 1992, Respondent prescribed approximately 335 tablets of Klonopin. There was no clinical reason to prescribe this amount of this medication.

g. Despite patient #43's obvious deterioration on the drugs prescribed by Respondent, Respondent made no effort to assess whether he had appropriately diagnosed patient #43 or was treating drug interactions as opposed to the underlying disorder until August, 1992, when he received a letter from a colleague questioning whether patient #43's abuse of his prescribed medication may have caused or contributed to patient #43's sleep disorder.

18. Patient #44 is a recovering alcoholic and cocaine addict who sought expert help from Respondent to treat his anxiety. Respondent prescribed high doses of a benzodiazepine, Xanax, without adequate justification and monitoring, and then failed to recognize and respond to patient #44's withdrawal symptoms. Examples of Respondent's care of patient #44 are more fully set forth in paragraphs 14 through 41 of the Temporary Suspension Order dated May 15, 1998 (Exhibit B) and are hereby incorporated into and made a part of this Stipulation and Order.

19. Patient #45 was a 33 year-old man whom Respondent treated for depression on and off over a nine-year period with a combination of antidepressants and multiple controlled substances, including high doses of benzodiazepines and for about a year a narcotic, without adequate justification and monitoring and despite evidence that the medications were not having their desired effect and that patient #45 was dependent upon or abusing drugs. Examples of Respondent's care of patient #45 are more fully set forth in paragraphs 42 through 99 of the Temporary Suspension Order dated May 15, 1998 (Exhibit B) and are hereby incorporated into and made a part of this Stipulation and Order.

20. Patient #46 was a young adult male diagnosed with schizophrenia. Despite a history of nine hospitalizations and four suicide attempts prior to being placed on Clozaril, Respondent took patient #46 off Clozaril without adequate justification and monitoring and failed to appreciate and respond to patient #46's suicidality when making medication changes, during patient #46's hospitalizations and upon discharge. Examples of Respondent's care of patient #46 are more fully set forth in the Temporary Suspension Order dated May 15, 1998 (Exhibit B) and are hereby incorporated into and made a part of the Stipulation and Order.

STATUTES

The Committee views Respondent's practices as inappropriate in such a way as to require Board action under Minn. Stat. § 147.091, subd. 1(g), (k), (o), and (s) (1996) and Respondent agrees that the conduct cited above constitutes a reasonable basis in law and fact to justify the disciplinary action. Respondent does not agree that there is a sufficient basis in law and fact to justify a finding that he possessed an intent to prescribe drugs to any of the patients discussed herein for their recreational use or other illegal purpose by them.

REMEDY

1. Upon this stipulation and all of the files, records, and proceedings herein, and without any further notice or hearing herein, Respondent does hereby consent that until further order of the Board, made after notice and hearing upon application by Respondent or upon the Board's own motion, the Board may make and enter an order conditioning and restricting

Respondent's license to practice medicine and surgery in the State of Minnesota. This Order supersedes and replaces the Temporary Suspension Orders dated December 19, 1997 and May 15, 1998 as follows:

a. Effective the date of the Board's order. Respondent's license to practice medicine and surgery in the State of Minnesota is SUSPENDED for the conduct cited in paragraphs 1-20 which constitute violations of Minn. Stat. § 147.091, subd. 1(g), (k), (o)and (s) (1996);

b. The suspension of Respondent's license is STAYED subject to the following conditions and restrictions. The stay shall not become effective, however, until the Board has approved the prescription monitoring agreement and approved the supervising physician.

c. The Board receives a signed agreement from one of Respondent's partners agreeing to:

(1) review each of Respondent' s prescriptions for a controlled substance;

(2) co-sign when the prescription is appropriate:

(3) retain copies of each prescription written by Respondent which is co-signed: and

(4) report to the Board once a month each prescription which was not co-signed and explain the reason it was not co-signed.

The Board agrees to make a decision promptly on the proposal submitted by Respondent.

d. Respondent submits each prescription for a controlled substance to this partner for co-signature, maintains a log for each prescription and provides a copy of the log to the Board upon request.

e. Respondent completes a records management course approved in advance by the Board.

f. Respondent must successfully complete a medical ethics course approved in advance by the Board specifically designed for physicians engaged in research and the Board must receive written notice of successful completion from the training program by October 1, 1998 or any stay in effect at that time will be revoked.

g. Respondent neither directs nor assists with any drug study.

h. Respondent is supervised by a psychiatrist selected and approved by the Board who has the skill and time needed and agrees to supervise Respondent. The supervisor must be willing and able to:

(1) meet with Respondent at least once a month;

(2) review Respondent's patient records at least once a month;

(3) report immediately to the Board if at any time the supervising physician is uncertain from the patient records whether controlled substances have been correctly prescribed for a patient, or whether a patient has been correctly diagnosed or whether a patient's care has been adequately monitored;

(4) review Respondent's log of prescriptions for controlled substances and copies of the prescriptions at least once a month to assure that each one was either co-signed or reported to the Board.

The Board, with the assistance of Board staff, agrees to act promptly to attempt to find a supervising physician and to take into consideration the proposals made by Respondent.

i. Respondent agrees to see clinical patients and to maintain his clinical practice primarily at his group/clinic office. All patient records must also be maintained and available for review at Respondent's group/clinic office. To the extent Respondent sees patients on a limited basis in his home office, these patients must be disclosed to the supervising physician and these patient records must be maintained at his group/clinic office and also be available for review by the supervising physician. Should Respondent become employed at a hospital, regional treatment center or similar institution, all patient records will

be maintained at the institution in the manner that records of other physicians' records are, provided however, that they are available for review for compliance with this Stipulation and Order, and provided further, that nothing in this provision shall relieve Respondent of any of his other obligations under this Stipulation and Order should he become employed by such an institution.

j. Respondent meets with the supervising psychiatrist at least once a month and pays any costs associated with the supervision.

k. The supervising physician shall meet regularly with the Complaint Review Committee at their request and submit quarterly reports to the Board;

l. Respondent shall meet on a quarterly basis with a designated Board member. Such meetings shall take place at a time mutually convenient to Respondent and the designated Board member. It shall be Respondent's obligation to contact the designated Board member to arrange each of the quarterly meetings. The purpose of such meetings shall be to review Respondent's compliance with the terms of this Stipulation and Order;

m. The Board or its designee will determine whether the conditions are met for the purposes of signing a stay of the suspension as provided herein.

n. Respondent shall not engage in any conduct constituting a violation for which disciplinary action may be imposed under Minn. Stat. § 147.091 (1996).

o. Respondent shall pay to the Board a civil penalty of $50,000.00 in partial reimbursement for the costs of this investigation and proceeding.

p. Any and all pending complaints and/or investigations that are not now part of the contested case being settled by this Stipulation and Order, including but not limited to investigations into the sertindole study in which Patient #35 participated, the Fen-Phen study in which Patient #45 participated, any further investigation of the treatment of any patient referred to by number in any version of the Notice of Conference or the Notice of and Order for Hearing in this case, and any investigation of the patient whose chart was subpoenaed at the same time as Patient #46's chart, and any investigation of Respondent's personal and

professional finances, are hereby closed. The Board will not take further action on these closed matters unless complaints arise and/or conduct by Respondent occurs subsequent to the date of the Stipulation and Order that warrant an investigation and further action.

2. The Stipulation and Order will remain in effect for a minimum of two (2) years from the date of this Order. At the end of this period, Respondent may petition for reinstatement of an unconditional license upon proof satisfactory to the Board that he has complied with the terms of this Stipulation and Order. Upon hearing the petition the Board may continue, modify or remove the conditions set out herein.

3. Within ten days of the date of this order, Respondent shall provide the Board with a list of all hospitals and skilled nursing facilities at which Respondent currently has medical privileges and a list of all states in which Respondent is licensed or has applied for licensure. The information shall be sent to Robert Leach, Board of Medical Practice, Suite 400, 2829 University Avenue S.E., Minneapolis, Minnesota 55414.

4. If Respondent shall fail, neglect, or refuse to fully comply with each of the terms, provisions, and conditions herein, the Committee shall schedule a hearing before the Board. The Committee shall mail Respondent a notice of the violations alleged by the Committee and of the time and place of the hearing. Respondent shall submit a response to the allegations at least three days prior to the hearing. If Respondent does not submit a timely response to the Board, the allegations may be deemed admitted. At the hearing before the Board, the Committee and Respondent may submit affidavits made on personal knowledge and argument based on the record in support of their positions. The evidentiary record before the Board shall be limited to such affidavits and this Stipulation and Order. At this hearing, the Board will determine whether to impose additional disciplinary action, including additional conditions or limitations on Respondent's practice or revocation of Respondent's license.

5. In the event the Board in its discretion does not approve this settlement, this stipulation is withdrawn and shall be of no evidentiary value and shall not be relied upon nor introduced in any disciplinary action by either party hereto except that Respondent agrees that

should the Board reject this stipulation and if this case proceeds to hearing, Respondent will assert no claim that the Board was prejudiced by its review and discussion of this stipulation or of any records relating hereto.

6. In the event Respondent should leave Minnesota to reside or practice outside the state, Respondent shall promptly notify the Board in writing of the new location as well as the dates of departure and return. Periods of residency or practice outside of Minnesota will not apply to the reduction of any period of Respondent's suspended, limited, or conditioned license in Minnesota unless Respondent demonstrates that practice in another state conforms completely with Respondent's Minnesota license to practice medicine.

7. Respondent has been advised by Board representatives that he may choose to be represented by legal counsel in this matter and has chosen to be represented by Marcy S. Wallace, Esq.

8. Respondent waives any further hearings on this matter before the Board to which Respondent may be entitled by Minnesota or United States constitutions, statutes, or rules and agrees that the order to be entered pursuant to the stipulation shall be the final order herein.

9. Respondent hereby acknowledges that he has read and understands this stipulation and has voluntarily entered into the stipulation without threat or promise by the Board or any

of its members, employees, or agents. This stipulation contains the entire agreement between the parties, there being no other agreement of any kind, verbal or otherwise, which varies the terms of this stipulation.

Dated: 6-10-98

FARUK S. ABUZZAHAB, M.D.
Respondent

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For the Committee

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6/11/98

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ORDER

Upon consideration of this stipulation and all the files, records, and proceedings herein,

IT IS HEREBY ORDERED that the terms of this stipulation are adopted and implemented by the Board this 11th day of July, 1998.

MINNESOTA BOARD OF
MEDICAL PRACTICE

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STATE OF MINNESOTA

BOARD OF MEDICAL PRACTICE

In the Matter of the
Medical License of
Faruk S. Abuzzahab, M.D.
License Number: 17,068

TEMPORARY SUSPENSION ORDER

On November 15, 1997, the above-entitled matter came on for consideration by the Board of Medical Practice ("Board"). Sharon A. Lewis, Assistant Attorney General, was present as counsel to the Complaint Review Committee. Respondent was present and represented by Marcy Wallace, Esq. Beverly Jones Heydinger, Deputy Attorney General, was present as counsel to the Board. Following the hearing, additional materials were submitted, and deliberations continued in closed session on December 13, 1997. The following members were present and took part in the deliberations: Doris C. Brooker, M.D., Adrienne Breiner, James Gaviser, M.D., David C. Herman, M.D., Patricia A. Jilk, Barbara LeTourneau, M.D., Mary Mika, Craig Stone, Elliott V. Troup, M.D., Joseph Willett, D.O.

The Complaint Review Committee ("Committee" or "CRC") requested a Temporary Suspension Order of Dr. Abuzzahab's license based on a pattern of substandard and dangerous prescribing practices. The CRC contends that these practices fall below the minimum acceptable level of care, show a reckless disregard for the patients' welfare, leading to significant deterioration in their lives. The CRC contends that these practices have continued for many years. A contested case proceeding is currently in progress where the CRC is presenting evidence in support of its request for disciplinary action because of these practices. Copies of the transcript of the hearing through November 12, 1997, and for November 20 and 21, 1997, have

EXHIBIT

A

been provided to the Board and reviewed by it. The hearing is scheduled to reconvene January 5, 1998.

The CRC contends that recent events justify the unusual step of seeking a temporary suspension while the contested case is in progress. It believes that these recent events demonstrate that Dr. Abuzzahab continues to engage in substandard and dangerous prescribing practices, fails to appropriately monitor patients and respond to changes in their condition, even though he is on notice that the CRC believes that his practices are deficient, and even though as an expert in the field, he is well aware of the appropriate standard of care.

Dr. Abuzzahab vehemently denies that his prescribing practices fall below the standard of care. He believes that those practices must be reviewed in the context of the type of cases he handles, that he takes on many patients with complex problems, and that he has years of experience to back up his prescribing practices. He has submitted many affidavits to the Board from colleagues attesting to his years of experience treating persons with serious mental illness, his knowledge of the field, and his willingness to accept referrals of difficult cases. Dr. Abuzzahab strenuously opposes the suspension because he believes that his practices meet the standard of care and the CRC will not be able to prove its case to the contrary. He has provided the Board with an expert report which he believes demonstrates that the standard of care has been met.

Based on the evidence before it, the Board makes the following:

FINDINGS OF FACT

1. Faruk S. Abuzzahab, M.D. ("Respondent") has been licensed to practice medicine and psychiatry in the State of Minnesota during all times material herein and is subject to the jurisdiction of the Minnesota Board of Medical Practice ("Board").

2. The Board is authorized pursuant to Minn. Stat. §§ 147.01 through 147.22 (1996) ("Medical Practices Act") to license, regulate and discipline persons who apply for a petition or hold licenses to practice medicine and psychiatry in the State of Minnesota and is further authorized pursuant to Minn. Stat. § 214.103 (1996) to review complaints against physicians, to

refer such complaints to the Attorney General's Office and to initiate appropriate disciplinary action.

3. The Board may consider a Temporary Suspension Order pursuant to Minn. Stat. § 147.091, subd. 4 (1996) where the licensee violates a provision of the Medical Practices Act and poses a serious risk of harm to the public.

4. The Complaint Review Committee of the Board initiated a contested case proceeding in July, 1996, seeking disciplinary action against Dr. Abuzzahab's license because of his substandard and dangerous practices with respect to approximately 43 patients over a period of more than 15 years. The CRC alleges that these practices contributed, if not caused, severe deterioration of the patients' conditions and, in some cases, their deaths.

5. This contested case proceeding was initiated because the Committee found on the basis of its extensive review of the medical records and the opinion of its expert, Dr. Morris Goldman, that Dr. Abuzzahab's care of these patients fell markedly below the minimum standard of care, showed a careless, if not willful, disregard of the patients' welfare and created an unnecessary risk of harm in violation of Minn. Stat. § 147.091, subds. 1(g)(k)(s)(o) and (p). See Notice of Hearing; Transcript (hereinafter "Tr.") at p. 102; Goldman's Reports.

6. Dr. Goldman testified that the minimum standard of care required of a physician prescribing psychoactive drugs mandates that he establish a diagnosis, identify the relevant symptoms that will be targeted with treatment, choose medications that are appropriate to the diagnosis and symptoms, and monitor the patients' response to assess whether the desired effects are occurring and that the adverse effects do not outweigh the benefits of the medication. He further testified that a physician's obligation to comply with these minimum standards is even more rigorous when there are indications that the patients is or is becoming dependent upon drugs. See Tr. at pp. 105-107. This is so because there is an inherent risk of harm in prescribing

any drugs, controlled or uncontrolled, which becomes even greater in a patient with a history of substance abuse. Id.[1]

7. The CRC alleges that the pattern that emerges from Respondent's treatment of the patients identified in the Notice of Hearing is that he uniformly fails to substantiate his diagnoses, monitor whether the combination of drugs is appropriate for the symptoms being treated and is having the desired effect, and evaluate whether the benefit outweighs the adverse effects noted in the chart. This fundamental failure shows a reckless, if not willful, disregard of the patients' welfare, exposes the patients to an unnecessary risk of harm and contributes to their deterioration while under his care.

8. The CRC alleges that patient #44 is a recovering alcoholic and cocaine addict who sought expert help from Dr. Abuzzahab in 1996 to treat his anxiety. The CRC contends that at Patient #44's initial visit, Dr. Abuzzahab prescribed more than double the dose of Xanax (a benzodiazepine) prescribed by patient #44's family physician; he told patient #44 to use the Xanax as a "hamburger helper".

9. A partner of the Dr. Abuzzahab's, Dr. Simon, reviewed the charts and submitted a letter to the Board. He acknowledged that the patient was prescribed 1 mg. three times a day of Xanax, but 2 mg. tablets were prescribed because the tablets were scored, which could aid tapering the amount. Dr. Abuzzahab represcribed 100 more tablets two weeks later over the

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[1] Dr. Goldman testified that this standard of care is the same standard described by Respondent in his writings and teaching materials. Tr. at pp. 113-14. In his deposition testimony and in numerous writings from 1973 through 1996, Respondent agrees that the minimum standard of care requires that the prescribing of controlled substances must be closely monitored and well-documented to ensure that they are having the desired effect, are treating the underlying disorder and not drug interactions, that the benefit of the drug outweighs their risks and that they do not contribute to or create drug dependency or abuse. Excerpts from Respondent's deposition at pp. 132-136; 147 and 374-78; see also Kollmorgen v. State Bd. of Med. Exam'rs, 416 N.W.2d 485 (Minn. App. 1987). In Kollmorgen, the Court of Appeals affirmed the Board's disciplinary action against a psychiatrist for overprescribing controlled substances based in part on Respondent's expert testimony that the standard of care required that controlled substances be cautiously dispensed in limited quantities under close supervision without any automatic refills. 416 N.W.2d at 489.

phone without seeing the patient or documenting the reasons for the patient's high use. Dr. Simon does not comment on Dr. Abuzzahab's decision to refill by phone.

10. Apparently patient #44 called Dr. Abuzzahab on or about April 30. 1996, to tell him he had stopped taking the Xanax. and was concerned about symptoms. Dr. Abuzzahab told the patient he had the flu and should see his family physician. Patient #44 was then admitted to a hospital emergency room. He was dizzy, shaking and agitated, and was diagnosed with drug withdrawal.

11. It is the CRC's contention that, while taking the medication prescribed by Dr. Abuzzahab, patient #44 experienced significant physical and emotional harm. that he had several auto accidents: fell repeatedly, chipping his teeth: required hospitalization after cutting himself accidentally with a sheet rock knife; alienated his family; and lost his job due to drug-induced behaviors such as slurred speech. Tr. IV, pp. 441-45, 465-66, 571-72, 574. He considers himself "lucky to be alive" after seeking treatment from Dr. Abuzzahab. Id. at 574. Transcript IV, pp. 44. 561-62, 564. 566. 574.

12. Based on the evidence provided to the Board, it does not appear that Dr. Abuzzahab monitored patient #44 sufficiently. The patient was referred by a family physician who was requesting expert help because he saw signs of addictive behavior. Tr. IV. pp. 470. 557-58. It does not appear that Dr. Abuzzahab carefully monitored the number of pills taken. that he adequately documented the reasons for the dosages. dealt with the documented side effects, or responded appropriately when told that the patient had stopped taking the medication. He apparently failed to see the patient or recognize the withdrawal symptoms. Tr. IV, pp. 448-53, 567-568.

13. The CRC also contends that Dr. Abuzzahab created a serious risk of harm to the public and to patient #45. a 33-year-old man who had been twice placed on involuntary holds at Hennepin County Medical Center ("HCMC") while acutely psychotic, and who was committed to Anoka Metro Regional Treatment Center ("AMRTC") as mentally ill and a danger to himself or others after a May 1997 psychotic episode in which he was shooting guns.

14. Based on the evidence presented by the CRC, it appears that Dr. Abuzzahab prescribed high doses of benzodiazepines for a long period of time without adequately monitoring the patient. The CRC contends that, although Dr. Abuzzahab may be aware of the appropriate standards for prescribing such medications, he did not adequately monitor the patient or the patient's behavior or indicate in his records why his course of treatment was justified.

15. It appears that Dr. Abuzzahab prescribed long-term, continuous controlled substances (benzodiazepines and narcotic analgesics) to patient #45 even though data indicated that patient #45 exhibited drug seeking behavior and might be chemically dependent. He documents that he told the patient to decrease the dose but he continued to prescribe large amounts, and there is no documentation of a tapering plan.

16. The CRC submitted evidence that patient #45 was chemically dependent and that Dr. Abuzzahab should have known and monitored the patient accordingly. It claims:

i. On June 8, 1988, patient #45 was placed on an involuntary 72-hour hold order at HCMC in an acutely psychotic state. He tested positive for methamphetamines and later discharged against medical advice with a diagnosis of schizophreniform disorder and acute confusional state, possibly secondary to methamphetamine toxicity. While Dr. Abuzzahab's medical records note the HCMC admission, there is no evidence Dr. Abuzzahab made any effort to obtain any information regarding the admission. AMRTC records indicate that Dr. Abuzzahab erroneously informed AMRTC this past August that patient #45 had never been psychotic. (AMRTC chart note dated 8/29/97).

ii On October 29, 1991, Dr. Abuzzahab documented that he warned another physician that patient #45 "may be having dependence problems and should go to the chronic pain program and/or lose weight and not go on controlled substances for pain."

iii. On November 30, 1991, Dr. Abuzzahab gave patient #45 thirty (30) samples of alprazolam (Xanax) 2 mg. hs after noting that the patient "rejected non-addictive hypnotics."

iv. In a letter, dated May 15, 1992, to another physician, Dr. Abuzzahab stated, "It is my recommendation that all avenues for treatment should be exhausted for his lower back before any consideration is made about giving him any type of pain medication, especially the opiate derivatives or controlled substances." Despite this documentation, Dr. Abuzzahab continued to maintain patient #45 on high doses of benzodiazepines and later prescribed narcotic analgesics of the opiate class with no explanation.

v. On November 18, 1992, Dr. Abuzzahab noted discussing "possible dependence" with patient #45, but proceeded to prescribe diazepam (Valium) 10 mg. on an "as needed" basis on this date. There is no documentation of any plan discussed with the patient to taper the medication use.

17. Dr. F.O. Anderson, one of Dr. Abuzzahab's partners, disagrees with the CRC's interpretation of the record, but his own report filed with the Board suggests that the patient regularly lied and minimized the facts of his present and past medical history, that the patient was repeatedly referred to chronic pain specialists, and had a pervasive mental disturbance. He contends that Dr. Abuzzahab was the only psychiatrist to be able to develop a lasting relationship with the patient. Further, he contends that the records show that the patient's problems were not primarily chemical dependency, contrary to the CRC's claim that Dr. Abuzzahab should have recognized the patient's dependency and drug-seeking behavior.

18. Between September 15, 1994 and July 5, 1996, Dr. Abuzzahab's charting repeatedly indicates that patient #45 was seeking and/or receiving methadone for pain control from a methadone clinic. Dr. Abuzzahab apparently relied solely on what the patient told him and made no effort to check with the methadone clinic, believing the patient's statement that the methadone was for pain control.

19. In addition, it appears that on two separate occasions (June 8, 1988 and March 25, 1997) while being treated by Dr. Abuzzahab, patient #45 experienced psychotic episodes and was hospitalized on 72-hour hold orders at Hennepin County Medical Center. In both instances, patient #45 was diagnosed with a schizophreniform disorder as well as psychoses or confusional

state secondary to medication abuse. Dr. Abuzzahab was aware of both hospitalizations; but, in both cases, it appears that he relied solely on the patient's explanation and failed to obtain any follow-up information regarding why the patient was hospitalized against his will and what type of treatment the patient received while hospitalized.

20. In March 1997, Dr. Abuzzahab received notification that patient #45 was "psychotic" and "shooting guns" and was in HCMC crisis center after being arrested and "tear gassed." HCMC medical records indicate that patient #45 was brought to HCMC by the Bloomington police after flooding his apartment and shooting at his landlord and the police. Patient #45 was described as "grossly psychotic" and "delusional" insisting that he was the second coming of Christ and that hospital staff was going to kill him.

21. Patient #45 was admitted under a 72-hour hold. A petition for commitment was subsequently filed and patient #45 was placed under a district court hold and committed to Anoka Metro Regional Treatment Center as mentally ill. Apparently, the petition for commitment as chemically dependent was dismissed.

22. Thus, although acknowledging Dr. Anderson's view, it would seem that there is substantial evidence offered at this stage of the proceeding that, even in 1997, Dr. Abuzzahab did not exercise the necessary level of care in monitoring this patient who, by all accounts, was very difficult and presented a complex set of problems with signs of drug dependency or drug-seeking. The need to check with other caregivers and coordinate care would seem to be required.

23. Patient #46 was a young adult male diagnosed with schizoaffective depressive disorder. The CRC alleges that Dr. Abuzzahab showed a reckless disregard for Patient #46's welfare and exposed him to a significant risk of harm in that Dr. Abuzzahab abruptly changed patient #46's antipsychotic medication and failed to assess signs of possible decompensation or otherwise respond appropriately to the patient's complaints of lip tremors, nausea, increased anxiety and body pain. It contends that Dr. Abuzzahab experimented with frequent dosage changes in the anti-psychotics and added high doses of an antidepressant and an analgesic.

24. On May 29, 1997, patient #46 was hospitalized. He was discharged on June 17, 1997. Although the CRC alleges there was no follow-up appointment scheduled, Dr. Abuzzahab claims he saw the patient the same afternoon. Less than three weeks after discharge, on July 2, 1997, the patient attempted suicide by jumping in the river and was rehospitalized. The CRC contends that indications on July 8 and 9 were that patient #46 was still paranoid and delusional and that he needed a structured treatment environment. Dr. Abuzzahab discharged patient #46 on July 10 to his apartment with a 10-day supply of medications. Patient #46 may have committed suicide. He drowned in the river on July 29, 1997.

25. Dr. W. A. Callahan, another of Dr. Abuzzahab's partners, reviewed some of the medical records for Patient #46. He notes that the patient suffered from a serious and persistent mental illness "frequently punctuated by suicidal ideation and or behavior." He believes the medication changes were made in conjunction with the patient and family, and that there was no evidence that the patient lacked capacity to consent to the medications. He believes that allegations that Dr. Abuzzahab's prescribing practices were reckless, substandard or dangerous, or showed willful disregard for the patient are unfounded.

26. The records provided to the Board do not adequately document the reasons for the frequent medication changes made for patient #46. The parties dispute whether the records demonstrate his familiarity with the patient's prior suicide attempts.

27. Although Dr. Callahan reviewed the records, he does not indicate whether there was adequate documentation to explain the medication changes or to show that Dr. Abuzzahab fully appreciated the patient's history of suicidal ideation and attempts.

28. Dr. Abuzzahab has been aware for several years that the Board has been concerned with his patient monitoring and prescribing practices. The committee contends that this, supported by the evidence presented at the contested case hearing, demonstrates an entrenched and continuing pattern of prescribing and monitoring practices which falls markedly below the standard of care, amounting to a reckless disregard of the patients' welfare, causing serious harm and, in three cases, possibly death.

29. Psychiatry is not an exact science. It is acknowledged that Dr. Abuzzahab has received advanced training, has years of experience, and is considered by some to be the "expert's expert". His own testimony in the contested case proceeding shows that he is aware of the steps to take when setting an initial medication dosage, that coordination of care is the best approach, that controlled substances must be cautiously dispensed under close supervision, that one must be alert to signs of drug dependency and addiction and respond to them, and obtain prior medical records. T. Vol. 5, pp. 80, 146, 173, 201 and 208 (uncertified rough draft).

30. Physicians who take on very difficult patients and prescribe medications such as the benzodiazepines must carefully document each step, the reasons for them, and closely monitor the results. When the patient's situation changes, the physician should promptly assess the changes to determine the necessary response.

31. Dr. Abuzzahab has presented many affidavits from his colleagues attesting to his knowledge. Many state that they have referred difficult patients to him or conferred with him, and that they value his expertise. They believe he is skilled in prescribing medications.

32. The more difficult and complex the case presented, the greater the physician's duty to carefully diagnose the patient, document the diagnosis, describe the selected treatment, carefully monitor and document the results, and explain changes in treatment. Where patients have a history of abusing drugs, or lying to get drugs, close monitoring is especially necessary. Based on the evidence presented, there is probable cause to conclude that Dr. Abuzzahab did not exercise an appropriate level of vigilance and responsiveness in the care of patients #44, #45 and #46, and that such lack of vigilance and responsiveness has occurred from time to time for several years.

33. At the time the Committee became aware in November, 1996 of Dr. Abuzzahab's treatment of patient #44, it did not seek a temporary suspension because a contested case hearing was scheduled to begin in May, 1997. The CRC expected that the disciplinary proceeding would be concluded and a final Board Order issued within a timely manner.

34. There have been several delays in the continuation of the hearing, and given the number of the complaints covered by the Notice of Hearing, the soonest it is likely to conclude is in January, 1998. The ALJ must then issue a report before the matter will come to the Board for final review and order.

35. Dr. Abuzzahab has offered to have his prescriptions co-signed by a partner until the contested case proceeding is completed. This does not assure that Dr. Abuzzahab will carefully review patient histories to establish a diagnosis and document his basis for it, that he will carefully monitor seriously ill patients, respond to changes in their condition, see them regularly and as needed, check with other providers and coordinate care with them, and document his care with sufficient detail.

36. A temporary suspension is necessary to prevent Dr. Abuzzahab's practices which expose patients to a serious risk of harm.

CONCLUSION

1. There has been substantial evidence presented that Dr. Abuzzahab falls below the minimum standard of care, shows a careless if not willful disregard of some patients' welfare, and creates an unnecessary risk of harm to patients in violation of Minn. Stat. § 147.091, subd. 1(g)(k) and (o)(1996). Based on the preliminary evidence provided, it appears that there is probable cause to find that substandard and dangerous practices are continuing, and the Board finds that his continued practice of medicine and psychiatry creates a serious risk of harm to the public.

2. A temporary suspension is necessary to protect the public pending the final outcome in this proceeding.

ORDER

Based upon its consideration of this matter, the Board makes the following Order:

1. Dr. Abuzzahab's license to practice medicine and psychiatry in the State of Minnesota is temporarily SUSPENDED pursuant to Minn. Stat. § 147.091, subd. 4 (1996).

2. During the period of temporary suspension, Respondent shall not in any manner practice medicine or psychiatry in the State of Minnesota.

This Order for a temporary suspension shall take effect immediately upon notice to the Respondent and remain in effect until such time as modified by the Board or the Board issues a final Order in this matter. This Order was adopted by the Board on December 13, 1997, one member dissenting.

Dated: December 19, 1997

MINNESOTA BOARD OF MEDICAL PRACTICE

By: [signature]
Doris C. Brooker, M.D., President

MEMORANDUM

The Board is aware that in considering a request for temporary suspension, it does not have a full record before it. The CRC has raised many allegations and provided medical records and the opinion of an expert in support of its claims. Most of the charges have been known to the Respondent for some time; a few are relatively recent. His expert disagrees that the standard of care has been violated. Dr. Abuzzahab asserts that when all the facts are known, he will have demonstrated that his care for the patients who are the subject of this proceeding fully meets the standard of care and has not violated the Medical Practices Act.

The Board does not prejudge the final outcome. It is clear that both sides expect to prevail. However, at this stage, the Board is asked to determine whether, based on the information it has, there is probable cause to believe that Dr. Abuzzahab has violated the Medical Practices Act and presents a serious danger to the public. The Board believes there has been such a showing.

The Board is concerned that the evidence shows that Dr. Abuzzahab focuses on the question of whether he prescribed the proper medications in the proper doses. The Board's analysis is that he has ignored what seems to be at the heart of the complaint against him. He may be technically expert, and the evidence shows he is very knowledgeable, but there is strong evidence that he does not closely monitor and respond to the changing needs of the very sick individuals he treats to be sure that each successive prescription is justified and its rationale carefully documented. It appears that Dr. Abuzzahab is sometimes careless in applying the standards that he knows well and helps teach to others. When he monitors carefully, it may well be that he attains excellent results, but there is strong evidence that a sufficiently high degree of care is not exercised consistently, thus exposing some patients to great risk.

Examples of this are set out in the findings of fact for patients #44, #45, and #46. These instances suggest that, at least in some cases, adequate care was not taken to fully evaluate the full circumstances in deciding upon and carrying out a course of treatment. Such complex cases

call for detailed documentation and explanation of treatment decisions and those do not appear to have been consistently provided.

It is because Dr. Abuzzahab holds himself out as an expert and frequently treats people with serious and complex mental illness that the risk of allowing such lapses to continue is so great. Such a caseload demands extra care and vigilance. When such patients have problems, they require immediate response and treatment must be carefully documented. Lapses in monitoring and failure to respond appropriately may have very serious consequences. A good physician will occasionally have bad outcomes, and it is not the results in these cases that compel the Board to act. It is the apparent laxness in monitoring and responding to the changing needs of the patients, and inattentiveness to all of the information about the patients that justify the temporary suspension.

Based on the information presented, there is probable cause to believe, and strong evidence to support the CRC's claims that Minn. Stat. § 147.091, subd. 1(g)(k) and (o) have been violated, in particular, that Dr. Abuzzahab has: shown a careless disregard for the health, welfare or safety of some patients, and may have placed patients at unnecessary risk; failed to conform to the minimal standards of acceptable and prevailing medical practice by not carefully documenting diagnosis, not documenting the rationale for the chosen course of treatment and changes to it, not responding immediately to changes in the patient, not verifying information provided by possibly unreliable patients, and reviewing prior treatment records; and by failing to maintain adequate medical records.

The CRC has alleged a violation of Minn. Stat. § 147.091, subd. 1(s), which covers improper prescribing. Given the apparent dispute among the experts about the proper use of the drugs at issue, and the lack of expertise on the Board to evaluate specific drugs and dosages for these patients, or the medication changes, the Board declines to find that the record is sufficiently developed to find that this provision has been violated. The CRC has also alleged a violation of Minn. Stat. § 147.091, subd. 1(p) which prohibits fee splitting, arising out of the conduct of the Respondent's research. As with subdivision 1(s), the Board declines to find that the record has

been sufficiently developed to address it. The Board takes no position at this time on these violations and awaits further development of the record.

Dated: December 19, 1997

MINNESOTA BOARD OF MEDICAL PRACTICE

By: [signature]
Doris C. Brooker, M.D., President

CONTAINS NOT PUBLIC DATA

STATE OF MINNESOTA
BOARD OF MEDICAL PRACTICE

In the Matter of the Temporary Suspension
of the Medical License of Faruk S. Abuzzahab, M.D.
Date of Birth: 10-12-32
License Number: 17,068

ORDER CONTINUING TEMPORARY SUSPENSION

On April 18, 1998, the Board of Medical Practice met to consider the report of Administrative Law Judge George A. Beck (ALJ) and determine whether the Temporary Suspension of Dr. Abuzzahab's medical license should continue pending resolution of the contested case which is currently in progress. Sharon A. Lewis, Assistant Attorney General, appeared for the Complaint Review Committee (CRC). CRC members, Dr. Janet Lindquist and Dr. Peter Smyth, were also present. Dr. Abuzzahab was present and represented by Marcy Wallace, Cox, Goudy, McNulty & Wallace, P.L.L.P. The following Board members were present to hear oral argument from the parties and to deliberate: Adrienne Breiner, David C. Herman, M.D., Rebecca Hafner, M.D., Patricia A. Jilk, Barbara LeTourneau, M.D., Mary Mika, C. Randall Nelms, Jr., M.D., Burton S. Schwartz, M.D., Craig Stone, J.D., Elliott V. Troup, M.D. and Joseph Willett, D.O. Beverly Jones Heydinger, Deputy Attorney General, was present to advise the Board.

The Board met on November 15, 1997 and December 13, 1997 to consider the CRC's request to temporarily suspend Dr. Abuzzahab's license. The Temporary Suspension Order was issued on December 19, 1997. As required by statute, a contested case hearing was commenced within thirty days to consider the matters which served as the basis for the Temporary Suspension Order. Minn. Stat. § 147.091, subd. 4 (1996). The contested case on the Temporary Suspension was held and on March 12, 1998, the ALJ issued Findings of Fact, Conclusions of Law and Recommendation. Pursuant to Minn. Stat. § 14.61 (1996) the parties were given the opportunity to file exceptions and responses to the ALJ report. The exceptions and responses, and the record were copied and distributed to the Board for review prior to its deliberations on April 18, 1997.

The ALJ found that Dr. Abuzzahab had violated Minn. Stat. § 147.091, subd. 1, but that he was willing to accept limitations on his practice which would protect the public pending the outcome of the underlying contested case.

The CRC contends that the ALJ's report supports its view that Dr. Abuzzahab has violated Minn. Stat. § 147.091, subd. 1, and that his unrestricted practice of medicine creates a serious risk of harm to the public. It asks the Board to continue the Temporary Suspension. Dr. Abuzzahab disagrees that violations have occurred or that his practice presents a serious risk

EXHIBIT

of harm to the public and requests that the Temporary Suspension Order be vacated.

At this point the Board must decide whether the Temporary Suspension Order shall remain in effect or be lifted, pending completion of the underlying full contested case on the issues set forth in the CRC's Third Amended Notice of Hearing.

Based on the record before it, the Board makes the following:

FINDINGS OF FACT

Procedural Background

1. The Board is authorized pursuant to Minn. Stat. §§ 147.01 through 147.22 (1996) ("the Medical Practices Act") to regulate and discipline persons who hold licenses to practice medicine and psychiatry in the State of Minnesota and is further authorized pursuant to Minn. Stat. § 214.103 (1996), to review complaints against physicians, to refer such complaints to the Attorney General's Office, and to initiate appropriate disciplinary action.

2. This temporary suspension proceeding arises out of a contested case which the Committee initiated in July 1996, seeking disciplinary action against Dr. Abuzzahab's license with respect to approximately 43 patients treated over a period of more than 15 years. See July 31, 1996 Notice of Hearing; *see also* Committee's proposed Temporary Suspension Order TSO Vol. I: Tab 1.

3. In March 1997, the Committee amended the contested case Notice of Hearing to add Patient No. 44. In the fall of 1997, the Committee similarly amended the Notice of Hearing, over Dr. Abuzzahab's objection, to add Patient No. 45. On November 5, 1997, the Committee submitted a request to the Board for a temporary suspension of Dr. Abuzzahab's license. Patient No. 46 first came into the proceedings at that time.

4. The Board considered the Committee's request and Dr. Abuzzahab's responses on November 15, 1997. The Board tabled the decision on the temporary suspension until December 13, 1997, in order to permit the parties to make additional written submissions to the Board. The Board issued an order on December 19, 1997, temporarily suspending Dr. Abuzzahab's license pending the resolution of the contested case proceeding. Dr. Abuzzahab petitioned the Board to stay his temporary suspension on the condition that he practice under the supervision of Donald Mayberg, M.D. On January 15, 1998, the Board denied this petition. TSOR[1] Vol. II:Tabs A-24-27, A-30, A-33, A-35-36, A-38.

5. The Temporary Suspension Order was issued pursuant to Minn. Stat. § 147.091, subd. 4 (1996), which authorizes the Board to temporarily suspend a license where a licensee violates the Medical Practices Act and the licensee's practice poses a serious risk of harm to the public. Pursuant to statute, an evidentiary hearing was commenced on January 19, 1998, on an expedited basis in an attempt to assure prompt post deprivation review of the temporary suspension.

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[1] TSOR refers to the record submitted to the Board in December of 1997 in regard to the temporary suspension.

Dr. Abuzzahab

6. Faruk S. Abuzzahab, M.D. ("Respondent" or "Dr. Abuzzahab") has been licensed to practice medicine and psychiatry in the State of Minnesota during all times material herein and is subject to the jurisdiction of the Minnesota Board of Medical Practice ("Board").

7. Dr. Abuzzahab was born in Beirut, Lebanon. His first language is Arabic. He became a naturalized citizen of the United States sometime in the 1970s. C.C.[2] Tr. Vol. VII:17-18. He received his M.D. degree from the American University of Beirut, Lebanon in 1959 and completed a one-year rotating internship there. Thereafter, he took a three-year residency program at Johns Hopkins in Baltimore, Maryland from 1959 to 1962. C.C. Tr. Vol. V:639; C.C. Tr. Vol. VII:18-19. He earned a Ph.D. in pharmacology from the University of Minnesota in 1966. He was board certified in psychiatry in 1966. C.C. Tr. Vol. V:639-40; Exh. Z. Dr. Abuzzahab is also certified by the American Society of Addiction Medicine. C.C. Tr. Vol. V:756. Exh. Z. He is also board certified in clinical pharmacology, a specialty which deals with all drugs, not just psychiatric drugs. C.C. Tr. Vol. V:675-76. He is also a diplomat of the American Board of Quality Assurance and Utilization Review Physicians, Inc. Exh. Z.

8. Dr. Abuzzahab has been engaged in the private practice of psychiatry since 1973 under the name of Clinical Psychopharmacology Consultants. C.C. Tr. Vol. V:682-85. He was employed full time at the University of Minnesota from 1962 to 1972 and has continued to teach there part time ever since. C.C. Tr. Vol. V:686-90. He was chief of the Department of Psychiatry at St. Mary's Hospital. Chair of the Minnesota Psychiatric Society Ethics Committee and President of the Minnesota Psychiatric Society. Exh. Z. He has been the principal investigator in many psychotropic drug studies over the years and has published extensively regarding them. Exh. Z.

Applicable Standard of Care

9. The minimum standard of care required of a physician prescribing psychoactive drugs mandates that he or she establish a diagnosis, identify the relevant symptoms that will be targeted with treatment, choose medications that are appropriate to the diagnosis and symptoms, and monitor the patients' response to assess whether the desired effects are occurring and whether the adverse effects outweigh the benefits of the medication. A physician's obligation to comply with these minimum standards is even more rigorous when there are indications that the patients is or is becoming dependent upon drugs. See C.C. Tr. Vol. I:105-07.[3]

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[2] C.C. Tr. refers to the transcript of the original contested case hearing in this matter which began in July of 1997, OAH File No. 1-0903-10687-2.

[3] This standard of care is the same standard described by Respondent in his writings and teaching materials. C.C. Tr. at pp. 113-14.; see also *Kollmorgen v. State. Bd. of Med. Exam'rs*, 416 N.W.2d 485 (Minn. App. 1987. In *Kollmorgen*, the Court of Appeals affirmed the Board's disciplinary action against a psychiatrist for overprescribing controlled substances based in part on Respondent's expert testimony that the standard of care required that controlled substances be cautiously dispensed in limited quantities under close supervision without any automatic refills. 416 N.W.2d at 489.

10. This standard of care is one that Dr. Abuzzahab acknowledges. He acknowledged in the underlying contested case that he is aware of the steps to take when setting an initial medication dosage, that coordination of care is the best approach, that controlled substances must be cautiously dispensed under close supervision, that one must be alert to signs of drug dependency and addiction and respond to them, and obtain prior medical records. C.C. Tr. Vol. VII:77, 139-140, 173, 201-208.

11. This standard of care is also recognized by Dr. Abuzzahab's experts, Dr. Lewis and Dr. Anderson. TSO[4] Tr. Vol. VI:1126-27 (Dr. Lewis); Vol. X:1965-67 (Dr. Anderson).

Expert Witnesses

12. Dr. Morris Goldman is a board certified psychiatrist who is an associate professor at the University of Chicago. C.C. Tr. Vol. XII:59-60, Exh. 42. He has treated patients with anxiety disorders, major depression, bipolar or manic depression, schizophrenia, and schizoaffective disorders. Since 1993, Dr. Goldman has had supervisory responsibility to review and evaluate treatment provided by other psychiatrists and residents. C.C. Tr. Vol. I:17-47. In Dr. Goldman's clinical practice, he currently sees approximately 40 patients (with 150 his career high), personally treats approximately 8 inpatients at the 25 bed hospital where he is on staff, and consults monthly on about 5 to 10 patients at the state hospital. C.C. Vol. XII:11-20. At present, he is Chief of the Psychiatric Institute in the University of Chicago Research Program, Chief of the Psychotic Disorder Center at the University of Chicago, and a consulting psychiatrist at the Elgin Mental Health Center. Exh. 42. He spends about 40 percent of his time in the clinical care of patients, 20 percent in teaching and 40 percent in research. C.C. Tr. Vol. I:31. At the present time, Dr. Goldman is directly responsible for the approximately 300 patients treated by the residents he supervises. C.C. Tr. Vol. XII:17-18.

13. Dr. Glenn Lewis is a board certified psychiatrist who is in the private practice of psychiatry in Minneapolis and has approximately 700 to 800 outpatients. TSO Tr. Vol. VI:932-33. From 1974 to 1991, he was Director of the Abbott-Northwestern Mental Health Center which included a 92 bed inpatient service. He was Executive Director of successor organizations from 1991 to 1995. Exh. MM. Dr. Lewis was president and founder of the Minneapolis Psychiatric Institute, a practice group of 20 psychiatrists, psychologists and nurse clinicians from 1985 to 1995. Exh. MM. He is a Life Fellow of the American Psychiatric Association. TSO Tr. Vol. VI:930. Dr. Lewis served from 1993 to 1995 as a representative of the American Hospital Association on the Mental Health Professional Technical Advisory Council of the Joint Commission on Accreditation of Health Organizations. In this capacity, he was responsible for ensuring that hospitals met Joint Commission standards for mental health inpatient programs in order to maintain their accreditation. TSO Tr. Vol. VI:940-41.

Patient No. 44

14. Patient No. 44 first became a patient of Daniel Smith, M.D., at the Quello Clinic on November 18, 1994. Exh. R:16. He is a recovering alcoholic and former cocaine addict.

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[4] TSO Tr. refers to the transcript of the contested case hearing on the Temporary Suspension Order which began in January of 1998.

C.C. Tr. IV:558; Exhs. 48A. 48B. By June 6. 1995, he was complaining of not sleeping and being anxious due to stress at work. Dr. Smith gave him a trial on Paxil, an antidepressant. On July 18, 1995, he was changed to Zoloft, another antidepressant. Exh. R:12. On July 21, 1995, the dosage was increased without much effect. On September 8. 1995, Patient No. 44 advised Dr. Smith of his recent slip from his chemical dependency recovery. He continued to be treated with Zoloft. Exh. R:9-11.

15. On October 26. 1995, Patient No. 44 saw Dr. Amra, also at the Quello Clinic, complaining of injuries sustained in a fall from a ladder on October 20th. Dr. Amra gave him 24 tablets of Vicodin, a narcotic analgesic. Exh. R:50-51.

16. On December 8, 1995, Patient No. 44 had been on Zoloft for four months but had not been helped. Exh. R:8; TSO Tr. Vol. VI:1037-38, TSO Tr. Vol. V:914. On January 19, 1996, Dr. Smith formally diagnosed him as depressed and noted his anxiety attacks. He discontinued the Zoloft and put Patient No. 44 on .25 milligrams of Xanax (a benzodiazepine) twice a day. He charted that he hoped he could taper the patient off Xanax starting in about a month. Exh. R:7.

17. On February 13. 1996, Patient No. 44 telephoned saying that he had doubled his dose of Xanax on his own and that it was not helping his anxiety attacks. Dr. McCutcheon, covering for Dr. Smith, added Ativan, another benzodiazepine. .5 milligrams three times a day and, by phone, prescribed 30 tablets. Exh. R:6. Seven days later on February 20, 1996, Dr. Smith increased the Xanax (Alprazolam) to one milligram, three times a day, noting that the Ativan had not helped the panic attacks. Dr. Smith charted that he planned to wean Patient No. 44 off slowly when the time was right. Exh. R:5. Seven days later on February 27, 1996, Patient No. 44 reported by phone that Xanax one milligram three times a day helped only on the first day. Exh. R:4. Dr. Smith approved, by phone, increasing to 1.5 milligrams three times a day. He phoned in a prescription for 150 Xanax tablets.

18. Dr. Smith charted that on March 11. 1996, Patient No. 44 reported that Xanax 1.5 milligrams three times a day was not helping at all and requested help to feel better. Dr. Smith then referred him to Dr. Simon. Dr. Abuzzahab's colleague. Exh. R:4. Dr. Smith charted nothing specific regarding potential dependency or the need to discontinue the benzodiazepines.

19. On March 14. 1996, Patient No. 44 requested another refill of Xanax from Dr. Smith by telephone claiming that he had taken his previous prescription. Exh. R:3. The 150 tablets prescribed on February 27 should have lasted fifty days. C.C. Vol. IV:584; Exh. R:3.

20. On March 15. 1996, Patient No. 44 telephoned Dr. Smith's office again to report that he had been crying at work. and was not coping well. He requested immediate psychiatric help and was referred to the Fairview Hospital Emergency Room. Exh. R:3.

21. On April 3. 1996, Dr. Smith authorized six more Xanax tablets for Patient No. 44. Exh. R:64. The family physicians who treated Patient No. 44 recognized their inability to control his use of Xanax and referred Patient No. 44 for expert help in treating his anxiety. Treatment by other physicians. particularly family physicians, is irrelevant to whether Dr. Abuzzahab's treatment of Patient No. 44 fell below minimum standards, created an unnecessary risk of harm and showed a careless disregard of his welfare.

22. On April 5, 1996. Patient No. 44 had his only visit with Dr. Abuzzahab. He advised Dr. Abuzzahab of his history of alcoholism and cocaine use as well as his slip from sobriety. Exh. 48b: 1-4. He also provided an extensive history regarding his symptoms, including his anxiety attacks and weeping. Dr. Abuzzahab diagnosed Patient No. 44 as suffering from Bipolar II Disorder, Rapid Cycling Variety, non-seasonal, with anxiety. Exh. 48b: 1-6. He also gave the patient an Axis II diagnosis, a differential diagnosis, of antisocial personality disorder versus obsessive compulsive personality disorder.

23. Patient No. 44 told Dr. Abuzzahab that he had used Xanax one milligram three times a day on and off for a few months with excellent results. TSO Tr. Vol. VIII:1445, Exh. 48b:6. Dr. Abuzzahab had no reason to believe the patient was not telling him the truth. TSO Tr. Vol. V:917. At the April 5 visit, Dr. Abuzzahab had the patient sign a release to obtain information from Dr. Smith. The release was sent to Dr. Smith on the same day. Exh. 48b:9-10; Exh. R:46-48. Dr. Smith, however, apparently did not forward the requested information to Dr. Abuzzahab since it does not appear in the medical record. The chart does not indicate any attempt at follow-up by Dr. Abuzzahab. TSO Vol. V:909-12, TSO Tr. VI:1043-5.

24. Dr. Abuzzahab prescribed Serzone for Patient No. 44 on April 5th, an antidepressant that also has anti-anxiety effects. It typically takes three to six weeks to take effect. TSO Tr. Vol. VI:1040, Exh. 48b:7. He continued the patient on Xanax and explained to the patient that the Xanax would assist him with his anxiety until the Serzone took effect and that thereafter he would gradually taper off Xanax. TSO Tr. Vol. VI:1041-47; Exh. 48b:7. Dr. Abuzzahab wrote a prescription for the Xanax for 100 of the two milligram tablets. These tablets are scored to allow the patient to take a half or a quarter of the tablet and would be convenient for the later tapering. TSO Tr. Vol. VIII:1448-49. There is no indication in Dr. Abuzzahab's records that he explained to Patient No. 44 that the tablets were scored or that he instructed him how much to take. Patient No. 44 testified that Dr. Abuzzahab simply told him to use the Xanax as a "hamburger helper." CC Tr. Vol. IV: 561-3. Exh. 48b:7.

Dr. Abuzzahab scheduled the patient for an appointment six weeks later on May 16, 1996. TSO Tr. Vol. VIII:1448. On April 5th, Dr. Abuzzahab also gave the patient an MMPI to complete to assist in diagnosis. The patient failed to complete and return it. TSO Tr. Vol. VIII:1446.

25. Although Dr. Abuzzahab's chart indicates that he intended that the patient take three milligrams of Xanax per day, his written prescription states that the patient is to take "one" three times a day, but does not explicitly state whether the "one" refers to a milligram or a tablet of the medication. Exh. 48b:7, Exh. 48c. The instructions which appeared on the patient's bottle of medication are not in evidence. If the patient took three tablets per day (6 mg.) the Xanax prescription should have lasted until May 5th or so.

26. In Dr. Goldman's opinion, Dr. Abuzzahab failed to select a treatment appropriate to his diagnosis in a patient like No. 44, who is also a drug abuser. Rather than prescribing a mood stabilizer, he prescribed Serzone, a drug that produces the side effect of mania. C.C. Tr. Vol. IX:134-35 and failed to reduce the dose of Xanax. See Exh. 48b:7; Exh. GG. According to Dr. Goldman, this combination of drugs created an unnecessary risk of harm to this patient. C.C.

Tr. Vol. IX:135, see also TSO Tr. Vol. I:22. 55. Moreover, Dr. Goldman believes that in prescribing these drugs, particularly the Xanax. Dr. Abuzzahab failed to recognize that given the patient's alcoholism and the cross-tolerance of Xanax with alcohol. he had a duty to taper Patient No. 44 off the Xanax. C.C. Tr. Vol. IX: 131-35 (Dr. Goldman).

27. Dr. Goldman testified that it is a marked departure from the minimum standard of care to provide a substance abuser a larger amount of the substance than the physician had prescribed with the explanation that that would somehow facilitate a gradual reduction because of the size of the pill or the ease with which it could be divided into smaller amounts. See TSO Tr. Vol. I:34. It is also a departure from the minimum standard of care to prescribe a two-month prescription of a benzodiazepine (in this case Xanax) to a patient who abused a substance (alcohol) that is cross-tolerant to the benzodiazepine without a follow-up visit for six weeks. TSO Tr. Vol. I:41.

28. In Dr. Lewis' opinion. Dr. Abuzzahab's prescription of Serzone to Patient No. 44 without concomitantly prescribing a mood stabilizer was not unusual. TSO Vol. VI:1037-38. The patient previously had received an antidepressant (Zoloft) without a mood stabilizer and had not reported any problems with induction of manic episodes. TSO Vol. VI:1038. There is no evidence in the record that Zoloft produces the same adverse side effect of mania as Serzone.

The risk of induction of a manic episode from the administration of Serzone without a mood stabilizer is quite low according to Dr. Lewis. TSO Tr. Vol. VI:1038-39; see also TSO Tr. Vol. VIII:1442-43 (Dr. Abuzzahab). The Physicians Desk Reference (PDR) does not suggest that a patient be warned of a high risk of induction of a manic episode. TSO Vol. VI:1038-39.

Dr. Lewis was familiar with the admonition in the PDR that if Xanax is prescribed concomitantly with Serzone, the Xanax dose should be reduced by one-half. TSO Tr. Vol. IX:1756-57.

Dr. Goldman's contention that the risk is sufficiently high in a patient with Bipolar II Rapid Cycling Variety, that Dr. Abuzzahab was required to warn the patient of it. document the reason for not prescribing a mood stabilizer and see the patient within a few days, is not supported by the PDR or other literature, according to Dr. Lewis. In fact, since Serzone takes three to six weeks to take effect. no manic episode could have been induced prior to that time frame in Dr. Lewis' opinion. TSO Tr. Vol. VI:1038-40. Dr. Lewis also believes that it was not appropriate to begin to taper the Xanax on April 5th, but rather to wait until the antidepressant took effect. TSO Tr. Vol. VI:1041-42.

29. On April 5th, Dr. Abuzzahab gave the patient the manufacturer's package insert for Serzone which contains plain language information for patients. TSO Tr. VI:1039-40; TSO Tr. Vol. VIII:1444. He also provided the package insert for Xanax. TSO Vol. VIII:1449. On April 8. 1996, Patient No. 44 called and spoke to a staff member at Dr. Abuzzahab's office. He complained of dizziness and vertigo. Dr. Abuzzahab had the staff member call him back and tell him to discontinue the Serzone and restart it at a lower dosage when the symptoms disappeared. Exh. 48b:7. At the time in question, the manufacturers of Serzone recommended an excessive starting dosage which caused such symptoms in many persons. TSO Tr. Vol. VI:1046-47.

30. On April 19, 1996, Dr. Abuzzahab authorized his staff to call in a telephone prescription for 100 one-milligram tablets of the Xanax for Patient No. 44. The charting was done by a staff member. Exh. 48b:7. The prescription was written for 90 1-mg. tablets. Ex:48c. The patient should not have been out of Xanax on April 19. Patient No. 44 understood he was to use the Xanax as his "hamburger helper" as needed, and he could have consumed 100 2-mg. tablets plus 90 1-mg. tablets in a three-week period based upon the prescriptions written by Dr. Abuzzahab. C.C. Tr. Vol. IV:561-2. In Dr. Goldman's opinion, Dr. Abuzzahab's failure to monitor the number of pills he had prescribed to Patient No. 44 and be alert to the fact that the patient had escalated the dose he was taking is substandard. TSO Tr. Vol. I:36-40. Dr. Lewis acknowledged that the April 19th prescription was an "anomaly". TSO Tr. Vol. VI:1049. Dr. Abuzzahab admitted that this was a "plain mistake" and that he has not been able to determine why he authorized that refill. TSO Tr. Vol. VIII:1457-59.

31. Dr. Abuzzahab's office policy for handling telephone calls is that a staff member charts the pertinent conversation at the time of the call on a call slip, then pulls the chart and presents the slip and chart to Dr. Abuzzahab for his review and decision-making. After Dr. Abuzzahab makes a decision and instructs the staff, the staff member is then responsible for charting it. The message slips themselves are then routinely destroyed. TSO Tr. Vol. VII:1161-4. In this instance, however, the staff member did not chart who had telephoned and requested the prescription refill nor the reason it was given. TSO Tr. Vol. VI:1048. At that time, Dr. Abuzzahab's practice was to not give any benzodiazepine refills over the telephone, particularly early refills, with exceptions only in the case of an emergency where the patient would be at risk of severe withdrawal symptoms. In those instances, Dr. Abuzzahab would give the patient enough to tide him or her over until he could see the patient. Dr. Abuzzahab's prescription pad states on it that there will be no refills without the patient being seen. TSO Tr. Vol. VII:1165-66; Exh. 48c.

32. Patients who abuse benzodiazepines or other controlled substances are known to con their physicians, especially after only one visit, in order to obtain these medications. TSO Tr. Vol. VII:1261; Vol. IX:1754-5.

33. There is no indication that Patient No. 44 ever complained of any other problems or side effects from his medications other than severe vertigo and dizziness to Dr. Abuzzahab while under his care. TSO Tr. Vol. VIII:1451-52.

34. On April 30, 1996, at 9:30 a.m., Patient No. 44 called Dr. Smith's office to report that he had discontinued all of his medications abruptly the previous Thursday. The package insert which Dr. Abuzzahab gave Patient No. 44 warns in plain language against abruptly discontinuing Xanax. TSO Tr. Vol. VIII:1448-52, Exh. GG. He reported flu-like symptoms, an inability to get out of bed and stated that he had not eaten for three days. He also told Dr. Smith's staff that he had been taking four milligrams of Xanax per day. He was advised to contact Dr. Abuzzahab regarding potential withdrawal symptoms. Exh. R:1.

35. At about 8:00 p.m. on April 30, 1996, Patient No. 44 spoke to Dr. Abuzzahab by phone. He reported that he had discontinued his medications the previous week, that he was shaky, not eating, and had a fever. C.C. Tr. IV 446-47; Exh. 48b:8. TSO Tr. Vol. VIII:1461-62. Respondent told Patient No. 44 that the drugs were "out of his body" and that he had "the flu"

and that he should see his family physician. Dr. Abuzzahab's chart does not indicate that he gave Patient No. 44 notice that his complaints were possible withdrawal symptoms. C.C. Tr. IV:447, 567, 569; TSO Tr. Vol. VIII:1463-64; Exh. 48b:8.

36. Earlier that day (at 12:30 p.m. April 30, 1996), Patient No. 44 called Dr. Smith's office again and reported that he had spoken to Dr. Abuzzahab's office and had been offered an appointment because Dr. Abuzzahab would give no medications over the phone but the patient did not feel well enough to drive himself. He claimed that his wife would drive him to an appointment there the next day. TSO Tr. Vol. VIII:1462-3, Exh. R:1.

Dr. Abuzzahab did not learn of Patient No. 44's telephone call to Dr. Smith's office until early 1997 when the Quello Clinic records were produced as part of discovery in the contested case proceeding. TSO Tr. Vol. X:1857-58.

37. In Dr. Goldman's opinion, given the amount of Xanax Dr. Abuzzahab had prescribed to this patient in the preceding four weeks, Dr. Abuzzahab should have anticipated that the patient was going through benzodiazepine withdrawal from the abrupt discontinuation of Xanax. C.C. Tr. IX:135-36: see also Exh. GG:1, 3.

His failure to recognize the patient's symptoms as possible signs of benzodiazapine withdrawal fell below the minimum standard of care. TSO Tr. Vol. I:38-39.

Dr. Abuzzahab's expert. Dr. Lewis, agreed that the symptoms reported by Patient No. 44 on April 30, 1996, could have been signs of early Xanax withdrawal and that it would have been important to know how much Xanax the patient had actually been taking and when he had stopped abruptly. TSO Tr. Vol. IX:1748-56. Moreover, Dr. Lewis testified that had he known that Patient No. 44 had taken 10 mg. or more of Xanax a day up until the time he stopped abruptly, he would have wanted Patient No. 44 in or near a hospital in case he had a seizure. See. id. and TSO Tr. Vol. IX:1773-74.

38. Patient No. 44 did not follow Dr. Abuzzahab's telephone advice on April 30, 1996, and went to the emergency room the next day. He was dizzy, shaking, faint, unable to walk, agitated, and convinced that his heart was racing and that he was dying. C.C. Tr. IV:448-50, 567-68; Exh. 48d:5. The emergency room doctor, Dr. Puff, diagnosed drug withdrawal and prescribed a tapered dose of Lorazepam, which immediately helped the symptoms. C.C. Tr. IV:567-68, Exh. 48d. Even after emergency room treatment for withdrawal symptoms, Patient No. 44 hallucinated, with decreasing severity, for approximately ten days. C.C. Tr. IV 452-454.

39. Dr. Puff also gave the patient 4 milligrams of Ativan, a benzodiazepine, and prescribed Librium, another benzodiazepine, 50 milligrams three times a day. Exh. R:27. Apparently, the patient was placed on a tapering schedule, but that schedule is not available. TSO Tr. Vol. VI:1055-58.

40. How much Xanax Patient No. 44 had actually been taking prior to discontinuing it is unclear. According to Patient No. 44, he took the two milligram tablets by the handful. If he had filled the second prescription and had taken all of the tablets, this would be an average daily dose of approximately 11 milligrams a day, TSO Tr. Vol. IX:1773) which is in excess of the 10 milligrams per day maximum dosage recommended by PDR. Even at that dosage, the

medications prescribed by Dr. Puff might have been sufficient to prevent any withdrawal symptoms, if the tapering was properly done. TSO Tr. Vol. VI:1051-58; TSO Tr. Vol. IX:1774-75.

41. In Dr. Goldman's opinion, these withdrawal symptoms are consistent with abrupt discontinuance of Xanax in the amounts prescribed by Dr. Abuzzahab to Patient No. 44. C.C. Tr. Vol. XII:163, 166-67 (Dr. Goldman); TSO Tr. Vol. IX:1755 (Dr. Lewis). Dr. Goldman believes that Dr. Abuzzahab's failure to respond appropriately to signs of withdrawal reported to him by Patient No. 44 on April 30, 1996, was below the minimal standard of care, showed a careless disregard for the patient's welfare and contributed, if not caused, unnecessary harm. C.C. Tr. IX:136-37. While brief, Dr. Goldman believes that Dr. Abuzzahab's treatment of Patient No. 44 demonstrates a marked failure to adequately document a diagnosis and select the appropriate treatment for the targeted symptoms, to adequately monitor the effects of the medication and respond appropriately to adverse events and to use appropriate caution in prescribing addicting substances to a patient with a high risk of abusing the prescribed drugs. See C.C. Tr. IX:139-40; TSO Tr. Vol. I:23-24; Exh. 43d:2.

Patient No. 45

42. Patient No. 45 was a 33 year-old man whom Dr. Abuzzahab treated for depression on and off over a nine-year period. See Exh. 49c-1:26-69. He was first seen by Dr. Abuzzahab on November 21, 1987. He had herniated a disc on the job the previous October and, except for a six-week job as a janitor, had not worked since. His chief complaint was that he had been depressed and anxious for the last year. Dr. Abuzzahab did an extensive intake work-up, after which he gave Patient No. 45 the Axis I diagnosis of recurrent unipolar depression. Dr. Abuzzahab felt he met all the diagnostic criteria for depression as he had sleep disturbance, loss of interest, guilt relating to his injury, difficulty with his employer, loss of energy, problems in concentration, appetite disturbance, nervous eating at night, psychomotor agitation (meaning anxiety) and had thought of suicide in the past. Dr. Abuzzahab considered the illness recurrent, as there is a recurrence rate of almost 90 percent in any case of depression and in this instance the patient had previously been treated by two different psychiatrists with antidepressants. TSO Tr. Vol. VIII:1340-43; Exh. 49c-1:26-38. Patient No. 45 brought with him an MMPI administered in the Spring of 1987, which showed moderately severe depression and an above average risk to develop chemical dependency problems. Exh. 49c-1:25. Dr. Abuzzahab also gave an Axis II diagnosis of suspected passive dependent personality disorder. Exh. 49c-1:38.

43. Dr. Goldman felt that Dr. Abuzzahab did not have support for his diagnosis and that the patient's response did not support Dr. Abuzzahab's actions thereby placing the patient at undue risk of harm. TSO Tr. I:74; *but see* TSO Tr. II:291. In Dr. Lewis' opinion, Dr. Abuzzahab's diagnosis was justified. TSO Tr. Vol. VI:1012-16. The fact that the patient later failed to fully respond to various antidepressants does not mean that the diagnosis was wrong or should have been reevaluated, but only means the proper treatment has not been found as yet, according to Dr. Lewis. TSO Tr. Vol. VI:1016. Some depressed people do not respond to antidepressants. TSO Tr. Vol. IX:1743-44.

44. Patient No. 45 came to Dr. Abuzzahab taking Valium, ten milligrams twice a day.

Dr. Abuzzahab placed him in a drug study for Buproprion. (Wellbutrin), and increased the Valium from ten milligrams twice a day to ten milligrams three times a day. He also gave him ten samples of triazolam (Halcion), of the smallest size manufactured. .125 milligram tablets. Dr. Abuzzahab increased the Valium to 30 mg daily because Wellbutrin, the antidepressant Dr. Abuzzahab was prescribing, had been on the market the year before but taken off because it produced seizures at a rate four times that of other antidepressants. Dr. Abuzzahab put Patient No. 45 on a trial to see if Wellbutrin would help him without producing seizures. Valium is a potent anticonvulsant and as part of this protocol, the FDA allowed the use of benzodiazepines to suppress seizures. Because the patient was 5' 8" and weighed 246 lbs., the twenty milligrams of Valium a day he was taking was insufficient for this purpose in Dr. Abuzzahab's opinion. In addition. Wellbutrin does not help anxiety or insomnia. Halcion, a hypnotic, was given because Wellbutrin can produce insomnia which can worsen depression and increase the risk of seizure. TSO Tr. Vol. VIII:1343-45. The above reasons for prescribing Wellbutrin, Valium and Halcion were not charted at the November appointment. Dr. Abuzzahab did chart the patient's inability to sleep at his December 1987 visits. Exh. 49b:4; Exh. 49c-1:38-39; TSO Tr. Vol. II:251-54; TSO Tr. Vol. I:80.

Dr. Goldman testified that the addition of a benzodiazepine (in this case, Valium) is not a routine treatment for unipolar depression and that it is below the minimum standard of care to prescribe Valium, a prophylactic measure to prevent seizures as Dr. Abuzzahab claimed he did in this case. TSO Tr. Vol. I:79, 89 and 96 (Dr. Goldman); *accord* TSO Tr. Vol. V:765 (Dr. Erdmann).

45. From November 21, 1987, until January of 1988, Dr. Abuzzahab saw the patient every two weeks because he was on the Wellbutrin drug study. The patient used the benzodiazepines he had been given judiciously during that time and seldom used the sleeping medications. When Dr. Abuzzahab decreased the patient's Wellbutrin, he also decreased the patient's Valium. TSO Tr. Vol. VIII:1345-49. On January 28, 1988. Dr. Abuzzahab increased the Valium to 30 milligrams a day because the patient was having headaches and Valium had helped with headaches in the past. He was also having a twitch in the left eye, which Valium is effective in treating. He was also transitioning from Wellbutrin to another antidepressant, Prozac. and Valium was to help ease the transition. TSO Tr. Vol. VIII:1349.

Dr. Abuzzahab has given several reasons for prescribing these benzodiazepines such as to prevent seizures from the antidepressants. to treat anxiety, headaches, nausea or the eye tick the patient developed. *See* TSO Tr. Vol. VIII:1347-49. None of these reasons support prescribing the benzodiazepines for the period of time or in the doses prescribed to Patient No. 45 and may indeed be drug induced symptoms. TSO Tr. Vol. I:79, 89, 92-97 (Dr. Goldman); Vol. V:765 (Dr. Erdmann). Dr. Erdmann testified that he believed patient No. 45's psychosis was induced at least in part by the benzodiazepines and Fastin Dr. Abuzzahab had been prescribing; he also testified that he found no medical justification for the benzodiazepines because Patient No. 45 showed no signs of anxiety, panic attacks or major depression once tapered off the benzodiazepines. TSO Tr. Vol. V:714-16.

46. In February, 1988, Dr. Abuzzahab changed the patient to another antidepressant, Asendin. as his insurance would not pay for Prozac. As of this date, the patient had received a

total of only twenty Halcion pills. TSO Tr. Vol. VIII:1349-50

47. In March of 1988, Patient No. 45 telephoned Dr. Abuzzahab's office on the 14th and the 15th and sought a refill of Halcion and an early refill of Valium by phone. Dr. Abuzzahab denied these refills pursuant to his office policy not to grant controlled substances over the phone without a face to face interview and examination of the patient. TSO Tr. Vol. VIII:1350-51; TSO Tr. Vol. I:81; TSO Tr. Vol. II:263.

48. On May 3, 1988, Dr. Abuzzahab reduced the patient's Valium to 20 milligrams a day, as he was not then taking Welbutrin. On May 30th, the patient ran out of Valium and was given 10-15 pills at the emergency room to tide him over until his next appointment. This was predictable, as had the patient taken the medication as prescribed, he would have been out of them on that date. TSO Tr. Vol. VIII:1352-53; Exh. 49b:5-6.

49. On June 4, 1988, Dr. Abuzzahab increased the Valium to 30 milligrams a day and gave the patient ten more Halcion tablets, a total of thirty over seven months. Dr. Abuzzahab also gave him a package insert, with the section on abuse underlined. He read it to the patient to help educate him, a practice that he generally follows to try to teach patients that these drugs can produce dependence and should not be relied on routinely for sleep. At this point, the patient had been taking either 20 or 30 milligrams of Valium a day, which is a low dose in a patient weighing between 220 and 250 lbs. The manufacturer's recommendation is up to 40 milligrams a day for an average size person of 150 to 170 pounds. TSO Tr. Vol. VIII:1354-55.

50. On June 9, 1988, Patient No. 45 was placed on a 72-hour hold at Hennepin County Medical Center, a fact that was charted by one of Dr. Abuzzahab's staff members. The HCMC records show that this patient was in a disorganized paranoid state on admission, and that his urine was positive for amphetamines. The diagnosis was schizophreniform disorder vs. drug-induced psychosis. See Exh. 49c-2:2-11. There is no indication in Dr. Abuzzahab's outpatient notes that he inquired either of Patient No. 45 or of HCMC about the circumstances of Patient No. 45's admission.

51. In Dr. Goldman's opinion, at this point the minimum standard of care required that Dr. Abuzzahab inquire about the circumstances of Patient No. 45's 72-hour hold because this information would have provided additional evidence of Patient No. 45's substance abuse as well as evidence of a possible different diagnosis and would require a reevaluation of Dr. Abuzzahab's treatment choice. See TSO Tr. Vol. I:83-84 (Dr. Goldman); TSO Tr. Vol. V:706-09 (Dr. Erdmann). Dr. Lewis felt that the records were not essential because Dr. Abuzzahab knew the patient well. TSO Tr. Vol. VI:998. Dr. Anderson, who reviewed the patient's record, agreed that information about this 72-hour hold as well as numerous other signs of impaired functioning and psychiatric symptoms was important to consider. TSO Tr. Vol. X:1948, 1968-73.

52. On July 8, 1988, Patient No. 45 phoned again seeking a refill of Valium which was refused. The request was not an early refill, however, as he should have run out of his pills if he was taking them as prescribed. TSO Tr. Vol. VIII:1356; TSO Tr. Vol. II:265.

53. Dr. Abuzzahab saw Patient No. 45 on July 12, 1988, continued him on the Asendin, gave him fifty Valium tablets and twenty samples of the sleeping pill, plus a motrin-like analgesic for his back pain. At that time, Dr. Abuzzahab set another appointment for August

of 1988. TSO Tr. Vol. VIII:1356-57.

54. When a patient has been hospitalized, the medical protocol is for the physicians at the hospital to obtain a release and forward the discharge summary to the treating physician, a process which can take a month. TSO Tr. Vol. VI:998-1000. There is no such release in the HCMC chart for this admission. TSO Tr. Vol. X:1948-49; Exh. 49c-2:1-46. Normally, Dr. Abuzzahab's practice in a situation where there had been a 72-hour hold would have been to follow up and request a release from the patient if the discharge summary was not sent to him so that he could either obtain it or talk to the treating physician. TSO Tr. Vol. VIII:1357-58 The chart does not indicate that Dr. Abuzzahab requested the discharge summary from HCMC during August or September. Exh. 49b:6. However, when Patient No. 45 failed his September 13, 1988 appointment, Dr. Abuzzahab apparently saw no need to try to obtain information about the hold. TSO Tr. Vol. VIII:1357.

55. In Dr. Lewis' opinion, the fact that the patient had been hospitalized with psychotic symptoms in the summer of 1988. does not affect the validity of Dr. Abuzzahab's diagnosis of depression. A person can have more than one mental illness. TSO Tr. Vol. VIII:1360-61. Depression can also have psychotic features. TSO Tr. Vol. V:740-46. Dr. Goldman believes the hospitalization should have led to a reassessment in order to comply with the minimum standard of care. TSO Tr. Vol. I:85-86.

56. Patient No. 45 also had another hold or hospitalization at HCMC in July of 1988 after his appointment with Dr. Abuzzahab. Exh. 49E. Dr. Abuzzahab did not know of this until it surfaced during the hearing. TSO Tr. Vol. VIII:1358.

57. Patient No. 45 stopped seeing Dr. Abuzzahab for approximately 2 1/2 years following his missed appointment, returning in March of 1991. By that time, Patient No. 45 was on disability and had been receiving a combination of an antidepressant and antipsychotic from another treating psychiatrist. Exh. 49c-2:44. Dr. Abuzzahab's chart does not show any attempt to obtain information from the prior psychiatrist, however. Exh. 49b.

58. On March 29. 1991, Patient No. 45 returned to Dr. Abuzzahab's care. At that time, Dr. Abuzzahab reassessed his diagnosis. His impression of depression was reinforced, but he did not specifically chart this reassessment. During the two and one half year interval the patient had been treated with Prozac. He also had treatment with Elavil and had also received Trilafon. Trilafon is commonly prescribed with Elavil, with FDA approval, to enhance the Elavil blood level and protect from the agitation and insomnia, which can be side effects of Elavil. TSO Tr. Vol. VIII:1358-60. In Dr. Lewis' opinion, these antidepressants, like the one the patient had received prior to entering Dr. Abuzzahab's care in 1988, were given in the usual dosages for treating depression, and inferring a diagnosis of depression from them is proper. TSO Tr. Vol. VI:1015-16. Dr. Goldman's opinion is that a reassessment of the diagnosis in the chart was required to comport with the minimum standard of care. TSO Tr. Vol. I:88.

59. When Patient No. 45 returned to Dr. Abuzzahab in the Spring of 1991, Dr. Abuzzahab put him on an antidepressant study drug, paroxetine, which has subsequently been marketed as Paxil. Dr. Abuzzahab was comparing it with Prozac or a placebo. Dr. Abuzzahab did this because the patient had had a good response to Wellbutrin, but had had a problem with the side effect of headaches and had a good response to Prozac which his insurance would not

pay for and had gained weight when he took Elavil. TSO Tr. Vol. VIII:1361-62. He did not chart these reasons, however.

60. On April 23, 1991, Dr. Abuzzahab took Patient No. 45 off the study medications because of side effects and restarted him on Wellbutrin. Two days later, a prescription for thirty Halcion tablets was called to the pharmacy (contrary to Dr. Abuzzahab's usual policy) because Dr. Abuzzahab had forgotten to give them to him two days earlier when he had placed him on Wellbutrin, which causes insomnia. TSO Tr. Vol. VIII:1363-64. The reason for this prescription was not charted. Exh. 49b:7.

61. When Dr. Abuzzahab saw the patient in May of 1991, he had self-discontinued his Welbutrin because of its side effects, severe headaches and insomnia. Dr. Abuzzahab prescribed Xanax, a benzodiazepine, because it helps headaches, anxiety and insomnia, and gave him thirty samples, along with the package insert. He also gave him Doral, for sleep, twenty samples with a package insert, and authorized fifty Valium if the other medications did not work. The reasons for the prescriptions were not charted. Dr. Abuzzahab emphasized the dependence liability of the benzodiazepines at the May visit, and documented in his June 6 note that the patient reported that the Xanax was more helpful than Valium in controlling headache, neck tightness and back pain. The anxiety, headaches and insomnia were under control, allowing the patient to be restarted on Wellbutrin on June 6, 1991. TSO Tr. Vol. VIII:1365-66. Again, Dr. Abuzzahab was seeing the patient every two weeks because of medication changes. TSO Tr. Vol. VIII:1366.

62. By June of 1991, Patient No. 45 had become a volunteer at The Lighthouse, a shelter for the homeless, something which is positive because community involvement and volunteer activity help depression. TSO Tr. Vol. VIII:1367-68.

63. By July of 1991, Patient No. 45 had received only thirty sleeping pills over a two month period, leading Dr. Abuzzahab to believe that Patient No. 45 was not abusing it, but using it only to counteract the insomnia from Wellbutrin. TSO Tr. Vol. VIII:1368-69. Dr. Abuzzahab's belief that there were no signs that Patient No. 45 was dependent upon abusing drugs is contradicted by Dr. Goldman (TSO Tr. Vol. I:81, 84, 90) and by Dr. Anderson (TSO Tr. Vol. X:1973) as well as by the documentation in Patient No. 45's chart which notes many of the signs of dependency and abuse that Dr. Abuzzahab teaches his students. *See* Exh. 45.

64. By August of 1991, Dr. Abuzzahab reduced Patient No. 45's antidepressant because he was getting a little too energized, perhaps hypomanic. TSO Tr. Vol. VIII:1369. Similarly, in September, 1991, the patient was less depressed. TSO Tr. Vol. VIII:1369.

65. Through August, September and October of 1991, Dr. Abuzzahab generally reduced the Valium when he reduced the Wellbutrin and increased it when he increased the Wellbutrin because he was using the Valium to assist the patient in accepting the Wellbutrin. TSO Tr. Vol. VIII:1369-71. Dr. Abuzzahab gave Patient No. 45 ten more of the Doral in August, but then discontinued them in September because the patient reported being too sleepy in the morning. TSO Tr. Vol. VIII:1370-71.

66. On October 29, 1991, Dr. Abuzzahab had a conversation with Michael Pleasants, M.D., a family practice doctor treating the patient and Dr. Abuzzahab warned him that the patient might be having dependence problems and should not go on controlled substances for his

back pain. At that point Dr. Abuzzahab had not diagnosed the patient as chemically dependent. TSO Tr. Vol. VIII:1372. In spite of this documentation, Dr. Abuzzahab continued to maintain Patient No. 45 on diazepam (Valium), a controlled substance. Exh. 49c-1:50. The chart does not indicate any plan to taper the patient off benzodiazepines. TSO Tr. Vol. I:90-91.

67. On November 30, 1991, Dr. Abuzzahab encouraged the patient to decrease his Valium which was still at 30 milligrams a day, gave him a pamphlet outlining sleep hygiene to try to educate him how to sleep without controlled substances and encouraged him to try non-addicting hypnotics, such as Benadryl and Vistaral. Unfortunately, those had not worked for him before. Because the Prosom, which Dr. Abuzzahab had given the patient on November 4 had lost its effect in five days, Dr. Abuzzahab gave him 30 2-mg tablets of Xanax, and continued the Valium at 30 mg per day. Exh. 49c-1:51. Dr. Abuzzahab's chart does not explicitly justify the Xanax prescription. TSO Tr. Vol. I:93-94.

68. On December 28, 1991, Dr. Abuzzahab again prescribed 30 mg of Valium per day, but advised the patient to reduce the Valium to twenty milligrams a day. Dr. Abuzzahab prescribed 60 tablets of Xanax and reduced the dose to one milligram at night. Dr. Abuzzahab documented that he explained to the patient the goal of getting off benzodiazepines, even though they stopped the ticks in his eyes. TSO Tr. Vol. VIII:1373-6.

69. On the next visit in February of 1992, Dr. Abuzzahab again gave Patient No. 45 the package insert from Xanax. He continued the Xanax for sleep. Dr. Abuzzahab at this point allowed the patient to increase the Valium to 30 milligrams a day because he added a new antidepressant, Zoloft, which can cause anxiety and insomnia. It had just been released for general use and Dr. Abuzzahab wanted to find out if it would help him. TSO Tr. Vol. VIII:1376-7. The reason for increasing the Valium was not charted. Exh. 49b:9.

70. Dr. Abuzzahab next saw him in April, 1992. At this point, he continued the patient on 30 mg of Valium but gave him only 30 tablets of Xanax at .5 mg. On April 29, 1992, Respondent documented that Patient No. 45 was willing to go to a chronic pain program with oxycodone and acetaminophen (Percocet). Exh. 49c-1:52. Dr. Abuzzahab also coordinated care with Dr. Biewen, Patient No. 45's orthopedist, regarding his back pain. Dr. Biewen sent Dr. Abuzzahab a spine care center progress note, which documented by a positive MRI that the patient had a degenerative disc at L5-S1, with posterior disc protrusion. On May 15, 1992, Dr. Abuzzahab wrote Dr. Biewen a letter stating other options for treatment should be exhausted for Patient No. 45's lower back before giving him opiate derivatives or controlled substances for the pain. TSO Tr. Vol. VIII:1377-9; Exh. 49c-1:12. Despite this, Dr. Abuzzahab continued to maintain Patient No. 45 on diazepam 30 milligrams a day.

71. On June 23, 1992, Dr. Abuzzahab denied an early telephone request by Patient No. 45 for Valium. The patient then sought Valium and Wellbutrin at a crisis center on June 30, 1992. Exh. 49b:10.

72. Subsequently, the patient's back deteriorated. In July, 1992 he reported that neurosurgery was possible. By this point the patient was back on Wellbutrin and Dr. Abuzzahab continued him on Valium to prevent seizures from the Wellbutrin. TSO Tr. Vol. VIII:1379-80. This reason was documented. Exh. 49b:10; TSO Tr. Vol. I:95-96. Dr. Abuzzahab encouraged the patient to get a second opinion about his back when he was reluctant

to have a myelogram. and gave him twelve samples of Xanax, sending him home again with a package insert. TSO Tr. Vol. VIII:1380-1; Exh. 49b:10.

73. When Dr. Abuzzahab saw the patient on September 5, 1992. his depression was worse and he was seeking a second opinion from William Brauer, M.D. at Abbott Northwestern Hospital. He was also planning to see a psychotherapist, which Dr. Abuzzahab saw as a positive sign. TSO Tr. Vol. VIII:1381-2.

74. On October 12, 1992, the patient reported that Zoloft helped him better than Wellbutrin and that he was feeling like doing things, a positive sign. TSO Tr. Vol. VIII:1382. The Valium was continued at 30 mg per day.

75. On October 21, 1992, Patient No. 45 fell and reinjured his back. The Zoloft also began losing its effect, a predictable resistance phenomenon that frequently occurs. He was spending a lot of time in bed and planning to see another psychotherapist. TSO Tr. Vol. VIII:1382-84.

76. By April of 1993, the patient remained on 30 milligrams a day of Valium. Dr. Abuzzahab believes that because the 30 mg was not increased. the patient did not acquire tolerance which is the first sign that the patient is moving into dependency. TSO Tr. Vol. VIII:1386-87. The patient continued on Wellbutrin and Paxil. Exh. 49b:11.

77. On June 1, 1993, the patient reported, and Dr. Abuzzahab documented, that he had had severe back pain for two weeks and had had a nerve block without benefit. Dr. Abuzzahab gave him fifteen oxycodone to help his severe back pain. TSO Tr. Vol. VIII:1387-88; Exh. 49b:12. Apart from noting the back pain. Dr. Abuzzahab did not explain why this prescription was appropriate for this patient. TSO Tr. Vol. I:96. Dr. Abuzzahab continued to give Patient No. 45 ten to fifteen of these per month or similar pain pills until approximately March of 1995. TSO Tr. Vol. VIII:1406. He was not concerned about the patient becoming addicted to the pain pills because of the small amount and the fact that the patient took them in a conservative manner. TSO Tr. Vol. VIII:1407; TSO Tr. Vol. III:395.

78. Dr. Abuzzahab attempted to refer Patient No. 45 into a chronic pain program at the University of Minnesota, which unfortunately, refused services, apparently because of the patient's economic situation. TSO Tr. Vol. VIII:1404-6. Dr. Abuzzahab did not know that in 1993, Patient No. 45 had been consulting with Dr. Belgrade at the HCMC chronic pain program and that Dr. Belgrade had been refusing him narcotic analgesics. Exh. 49f. He learned of this for the first time during the hearing. TSO Tr. Vol. VIII:1390-91.

79. On October 18, 1993, Dr. Abuzzahab continued the same amount of Valium that he had been prescribing to the patient all along, and then charted "or Xanax" because the two medications were not going to be taken simultaneously. TSO Tr. Vol. VIII:1392. The patient reported that things were disappearing from his apartment. Exh. 49b:12. For the next 10 months, Patient No. 45 was continued on Wellbutrin. Valium and Oxycodone. Exh. 49b:12-14.

80. In December of 1994, Dr. Abuzzahab suggested a new antidepressant, SMS 181101, still under study, because Patient No. 45 continued to suffer from side effects of the antidepressant he was taking. TSO Tr. Vol. VIII:1403.

81. March 25, 1995 was the last time Dr. Abuzzahab prescribed any controlled

substances to the patient during this course of treatment because Patient No. 45 had decided to go to a methadone clinic for his chronic back pain. TSO Tr. Vol. VIII:1407-08. Dr. Abuzzahab had recommended that he explore a chronic pain program first. Dr. Abuzzahab told Patient No. 45 that all of his care had to be coordinated in that clinic and that he would not prescribe for him or treat him while he was being treated at the clinic. TSO Tr. Vol. VIII:1407-10. The methadone clinic faxed Dr. Abuzzahab a release and he sent all of the records to the clinic. TSO Tr. Vol. VIII:1409. Records of the Crisis Interventions' Center for Patient No. 45 dated September 13, 1995, show that Dr. Tichey spoke with Dr. Abuzzahab who reported that he would no longer prescribe Xanax to Patient No. 45 because he believed Patient No. 45 had lied about heroin addiction to get into a methadone program for his pain. TSO Tr. Vol. V:763-64.

82. According to Dr. Erdman, a physician should have known or at least been alert to the fact that a methadone treatment facility may only prescribe methadone for narcotic addition. TSO Tr. Vol. V:762; Exh. 53 and 21 C.F.R. pt. 291.505(d)(1)(i).

As demonstrated in Findings No. 58-82, Dr. Abuzzahab continued to place Patient No. 45 at undue risk of harm in that he continued to prescribe controlled substances without a diagnosis or clinical response that would justify their use to this patient who showed numerous signs of dependency or abuse. *See* TSO Tr. Vol. I:104-08 (Dr. Goldman); *see also* TSO Tr. Vol. V:714-16 (Dr. Erdmann); Vol. X:1968-73 (Dr. Anderson).

83. In July 5, 1996, Patient No. 45 returned to Dr. Abuzzahab's care and reported he had been off methadone for three weeks with no back pain for five weeks. Dr. Abuzzahab's records do not show that he made any effort to obtain information from Patient No. 45 or the methadone treatment clinic to verify the circumstances of Patient No. 45's treatment. The patient had gained weight and his blood pressure had gone up to a dangerous level. Dr. Abuzzahab started him on "Phen-Fen" and gave the patient a prescription for two milligrams of Xanax at bedtime, as "Phen-Fen" can produce insomnia. TSO Tr. Vol. VIII:1410-1413. The reason for prescribing Xanax was not documented in the chart. Exh. 49c-1:65. Throughout the course of treatment with "Phen-Fen," Dr. Abuzzahab monitored the patient for symptoms and signs of pulmonary hypertension which was reported as a side effect of phenfluramine TSO Tr. Vol. VIII:1413-14.

84. Ultimately, Dr. Abuzzahab discontinued the phenfluramine and continued the patient on phentermine (Fastin) alone. TSO Tr. Vol. VIII:1413, 1418. In August of 1996, Dr. Abuzzahab gave this patient 100 10 mg tablets of Valium without documenting a reason. Patient No. 45 used them sparingly, taking five to ten milligrams a day. TSO Tr. Vol. VIII:1420-1421. This is a small dose for a person his size. TSO Tr. Vol. VIII:1417. By this time, the patient's blood pressure was normal and he had lost a significant amount of weight. TSO Tr. Vol. VIII:1419-20. Phentermine (Fastin) is an amphetamine-like drug that has a high potential for abuse should be used cautiously in a patient with a chemical dependency history. TSO Tr. Vol. V:711-16.

85. On December 26, 1996, Dr. Abuzzahab gave this patient his last Xanax prescription, 100 tablets. By the patient's February 28, 1997 appointment, he would have still had enough Xanax to last a month and would have been about to run out of the Valium prescribed in August. TSO Tr. Vol. VIII:1423-24. He no longer felt depressed and was

functioning without antidepressants. TSO Tr. Vol. VIII:1420. On February 28, 1997, Dr. Abuzzahab had no concerns that he was abusing the benzodiazepines because of the small dosage. TSO Tr. Vol. VIII:1424. Dr. Abuzzahab saw the patient's treatment at that time, as a success, as the patient had lost 61 lbs. and his blood pressure had dropped to normal. As a result, the patient's mood was positive and he felt like dating again. TSO Tr. Vol. VIII:1424-25.

86. On March 25, 1997, Patient No. 45 was placed on a 72-hour hold at Hennepin County Medical Center after discharging a firearm in his apartment. He was arrested and tear gassed after flooding his apartment and shooting at his landlord and the police. He was admitted to the HCMC Crisis Center where he was wildly agitated and combative, insisting that he was the second coming of Christ and that the hospital staff was going to kill him. Exh. 49c-2:59-60. Dr. Abuzzahab learned of this three days after the admission when Patient No. 45 called to ask that his March 28th appointment be canceled because of his detention at Hennepin County. TSO Tr. Vol. VIII:1425.

87. During his hospitalization at HCMC, Patient No. 45 tapered off all benzodiazepines. Dr. Dallas Erdmann, the psychiatrist who treated him, found that Patient No. 45 displayed no evidence of anxiety disorder or panic attacks, he ambulated without difficulty and did not appear to be suffering from pain. TSO Tr. Vol. V:716-17; Exh. 49c-2:51. Within two days of admission, the patient was no longer floridly psychotic according to Dr. Erdmann's progress notes. TSO Tr. Vol. V:743-44.

88. Patient No. 45 reported on admission to Hennepin County that he had been taking Vicodin, a schedule IV narcotic analgesic. TSO Tr. Vol. V:733-34. He refused to reveal his primary care physician or physicians from whom he had received any pain medications including the Vicodin. TSO Tr. Vol. V:738-39. Dr. Abuzzahab's last prescription of any scheduled analgesic had been approximately two years earlier. TSO Tr. Vol. VIII:1405-08.

89. The admission diagnosis at HCMC was psychosis n.o.s., schizoaffective disorder vs. psychosis secondary to prescription drug abuse and prescription drug abuse/dependence. Exh. 49c-2:49. Dr. Erdmann was unable to rule out the patient's having had major depression in the past. TSO Tr. Vol. V:739-40.

90. On discharge, the diagnosis was psychosis secondary to prescription drug abuse, prescription narcotic dependence and personality disorder n.o.s. with schizoid personality features. Exh. 49c-2:49. By the time of the patient's discharge on May 1, 1997, Dr. Erdmann understood that in the past, depression with psychotic features had been a differential diagnosis for this patient. TSO Tr. Vol. V:746. The HCMC chart indicated that various physicians whom the patient had seen at the crisis intervention center diagnosed him with depression. TSO Tr. Vol. V:749-55.
Prior to Patient No. 45's transfer to Anoka Metro Regional Treatment Center, his discharge diagnosis included psychosis secondary to prescription drug use, prescription narcotic dependence and personality disorder not otherwise specified. On his discharge summary Dr. Erdmann made reference to the patient's history of schizophreniform disorder vs. depression with psychotic features. Exh. 49c-2:49-52.

91. Although Dr. Erdman diagnosed the patient as being dependent on narcotics at the time of discharge, he admitted at the hearing that only two of the DSM-IV diagnostic criteria

were met. TSO Tr. Vol. V:756-63.

92. Patient No. 45 told Dr. Abuzzahab that the Vicodin he was taking upon admission to HCMC had been prescribed by a dentist. Dr. Abuzzahab blames Patient No. 45's crisis on sleep deprivation, the stressful environment he was living in and the Vicodin. Dr. Goldman also thought Vicodin was the culprit and felt that the medications that Dr. Abuzzahab prescribed, the benzodiazepines and the phentermine, (Fastin), were not the likely cause. TSO Tr. Vol. III:359-60. Dr. Goldman was positive about Dr. Abuzzahab's course of treatment of Patient No. 45 in regard to the weight and blood pressure reduction which were important clinical problems which he treated with desired effects. He does not believe it is clear that Dr. Abuzzahab was accountable for the patient's HCMC crisis. TSO Tr. Vol. III:359-64.

93. Dr. Erdman inferred that Fastin in combination with benzodiazepines was responsible for the crisis, at least in part. However, a tox screen taken on admission was negative for amphetamines, meaning that Patient No. 45 had no Fastin in his system at the time the tox screen was taken. TSO Tr. Vol. V:737-38. The possibility that the Fastin had metabolized by the time of the tox screen cannot be ruled out. TSO Tr. Vol. V:774-75.

94. Patient No. 45 was then committed to Anoka Metro Regional Treatment Center as mentally ill and dangerous. At the time of his transfer to AMRTC, Patient No. 45's differential diagnoses included psychosis not otherwise specified, schizophreniform reaction, drug induced psychosis now in remission, and paranoid personality disorder. Exh. 49c-3:6. The application to commit him as chemically dependent as well was denied by the court for lack of clear and convincing evidence. Exh. 49c-3:243. According to the Court of Appeals decision regarding the commitment, the Court appointed examiner, Dr. Chris Meadows, also diagnosed Patient No. 45 as suffering from "major depression" with paranoid thinking. TSOR Vol. II, Tab A-14, Exh. J.

95. The patient remained at Anoka until discharge on October 21, 1997. While there, he was treated by Ken Kuhn, M.D. and Bruce Field, M.D. Dr. Kuhn is internationally known in the chemical dependency field. Dr. Field is also widely respected. TSO Tr. Vol. X:1941-43; TSO Tr. Vol. VI:1031. Patent No. 45's discharge summaries at Anoka did not include any variety of chemical dependency. Rather, his Axis I diagnoses were brief psychotic disorder, anxiety NOS and history of depression NOS. TSO Tr. Vol. VI:1030-32; Exh. 49c-3:24-25. Dr. Field discontinued the patient's olanzapine as he had been off it two months without decompensation. Exh.49c-3: 24, 61.

96. Dr. Field charted that he was willing to try the patient on Wellbutrin and a benzodiazepine. Exh. 49c-3:24,61. He referred the patient to another physician to be put back on Fastin. Exh. 49c-3:52. Patient No. 45 was discharged from AMRTC in October of 1997 against medical advice. Exh. 49c-3:24-25. Although the treating psychiatrist at AMRTC was willing to follow Dr. Abuzzahab's course of treatment with this patient, he did so as an interim measure to establish a therapeutic relationship with this patient and appropriately address his psychiatric symptoms both with a trial of antipsychotics and a structured living environment. *Id.*

97. In Dr. Goldman's opinion, Dr. Abuzzahab's failure to respond to signs of Patient No. 45's substance abuse, to reevaluate his diagnosis and treatment, to adequately monitor the patient, to check with other caregivers, and to initiate and continue the controlled substances without a clear documented rationale fell below the minimum standard of care and created an

unnecessary risk in this patient. TSO Tr. Vol. I:75-77, 91, 101, 105 (Dr. Goldman); TSO Tr. Vol. III:352. Dr. Goldman's opinion is that inferring prior history from medications that were prescribed to a patient is below the minimum standard of care.

98. In Dr. Lewis' opinion, the minimum standard of care does not require that a physician document his clinical judgment or risk/benefit analysis for the use of controlled substances. TSO Tr. Vol. VI:991-92. He does not believe that it is possible to write down every reassessment in a busy clinical practice. TSO Tr. Vol. VI:994. In his opinion, the prescription of Halcion and Valium was done for obvious reasons which do not require charting. TSO Tr. Vol. VI:1002-03; 1017. Dr. Lewis states that it is standard practice not to record a reassessment that results in the same diagnosis. TSO Tr. Vol. VI:1029.

99. There is evidence in the record suggesting that unipolar depression was not the only possible diagnosis for Patient No. 45. Other psychiatrists who dealt with this patient, including Dr. Anderson, found that the patient's condition suggested a personality disorder and/or schizoaffective disorder warranting a course, or at least a trial, of an antipsychotic drug and not an antidepressant. TSO Tr. Vol. X:1990-91, 94; Exh. 49E; Exh. 49c-2:49-52.

<u>Patient No. 46</u>

100. Patient No. 46 was first seen by Dr. Abuzzahab on March 31, 1987, at age 17, for a second opinion. Dr. Abuzzahab did a thorough work-up, obtained all of the patient's psychiatric records from Group Health, and gave the patient a differential diagnosis of schizo-affective depression with paranoid psychosis vs. recurrent unipolar depression. TSO Tr. Vol. VII:1178-1181; Exh. 50c-1:76-86.

101. After this single session in 1987, Patient No. 46 remained continuously under other psychiatric care until he returned to Dr. Abuzzahab on August 28, 1996. During this period, Patient No. 46 was treated by numerous psychiatrists. As he had grown older, his various treating doctors ultimately settled on diagnoses of schizophrenia or schizo-affective disorder. TSO Tr. Vol. III:413.

102. Between 1987 and 1992, Patient No. 46 had approximately nine hospitalizations, approximately four of which were for suicidal gestures or attempts, and the balance of which were for suicidal ideation. TSO Tr. Vol. II:159-62. This history was not recorded in Dr. Abuzzahab's chart in 1996.

103. Schizophrenia and schizo-affective disorder are very impairing and tend to have a downhill course over time. They are characterized by a number of so-called "positive" symptoms such as thought disorder, anxiety, paranoia, and depression, and by negative symptoms, including social-withdrawal, pathological shyness and social isolation. TSO Tr. Vol. IV:614-20; TSO Tr. Vol. VII:1180. Suicidality is a major concern with these disorders. Fifty percent of schizophrenics attempt suicide and ten percent succeed. TSO Tr. Vol. IV:640; TSO Tr. Vol. VII:1187-88.

104. Until approximately 1990 or 1991, the standard neuroleptics available to treat these disorders left most patients with the negative symptoms of schizophrenia and did not fully relieve the positive symptoms in all patients. These medications also had severe side effects, including extrapyramidal side effects such as tardive dyskinesia. TSO Tr. Vol. IV:621-22.

Tardive dyskinesia involves involuntary movements, sometimes of the mouth or face, at other times other portions of the body. Tardive dyskinesia may be permanent. TSO Tr. Vol. VII:1194-5.

105. Clozaril is one of four new atypical neuroleptics used to treat schizophrenia. In the Spring of 1992, it was the only such atypical neuroleptic, having come on the market approximately a year previously. From the time of its release on to the market until currently, Clozaril has been a second-line neuroleptic. TSO Tr. Vol. VI:954.1135-36, Vol. IX:1764-5. It is approved for use only when someone has failed at least two trials of a standard first-line neuroleptic either because they do not improve on these medications, or because they cannot tolerate them due to side effects. TSO Tr. Vol. IV:624. Clozaril presents a minimal risk of extrapyramidal side effects such as tardive dyskinesia. TSO Tr. Vol. IV:622-23. Nonetheless, approval of Clozaril by the FDA was quite controversial because of its potentially great toxicity and numerous serious and/or unpleasant side effects. TSO Tr. Vol. IV:628. Clozaril can cause a fatal blood abnormality, agranulocytosis. As a result, every patient who takes Clozaril is part of a national registry and can obtain a supply of the medication only by having weekly blood draws and weekly white blood counts. TSO Tr. Vol. III:480-82; TSO Tr. Vol..IV: 624-26. Even with this system in place there have been fatalities. The patients must endure the discomfort and inconvenience of the blood draws as well as live with the fear of death. TSO Tr. Vol. IV:623-28. Most patients on Clozaril continue to suffer the negative symptoms of schizophrenia.

106. In addition, Clozaril can cause seizures and the makers of Clozaril recommend (as with many medications) that one not drive an automobile at any time while taking it. TSO Tr. Vol. III:482-84. Clozaril can also cause fatal cardiopulmonary collapse, but rarely. It causes constipation, which can progress to fecal impaction and iliac paralysis. TSO Tr. Vol. III:486-87. Clozaril also causes a very high rate of sedation and weight gain. Drooling while sleeping is another unpleasant side effect of Clozaril which affects nearly a third of the patients. TSO Tr. Vol. III:488; TSO Tr. Vol. V:818-19. The drooling is so severe that typically the patient's pillow will be soaked in the morning. TSO Tr. Vol. IV:630; TSO Tr. Vol. V:818-19. Extreme weight gain is another common side effect of Clozaril. TSO Tr. Vol. III:491-92. It is typical for patients to dislike being on Clozaril and to seek other alternatives TSO Tr. Vol. VI:984; TSO Tr. Vol. VII:1179-82 and to abruptly quit taking Clozaril or reduce dosages on their own. TSO Tr. Vol. VII:1235. Nonetheless, in Dr. Goldman's opinion, Clozaril is the one antipsychotic medicine that has been clearly shown to be superior to standard treatment in its effects. TSO Tr. Vol. II:170.

Despite Clozaril's shortcomings, it is recognized as the "gold standard" for treating schizophrenia. TSO Tr. Vol. II:170 (Dr. Goldman); TSO Tr. Vol. IV:628 (Dr. Abuzzahab); TSO Tr. Vol. IX:1761-62 (Dr. Lewis).

107. In March of 1992, Patient No. 46 was hospitalized after attempting suicide and subsequently committed to Anoka Metro Regional Treatment Center where he came under the care of Floyd Anderson, M.D., also one of the members of Dr. Abuzzahab's practice group. He was committed under Dr. Anderson's care from March 3, 1992 to April 20, 1992. Exh. 50c-2:203; TSO Tr. Vol. VII:1176-7. Dr. Anderson noted that Patient No. 46 had been tried on various antipsychotic medications with only partial success because most of these courses of

treatment were cut short when the patient complained of side effects or become angry and sullen and self-discontinued his medications. Exh. 50c-2:203-05, 237. During the hospitalization, Dr. Anderson, at the patient's request, began a trial of Clozaril. Exh. 50c-2:240; TSO Tr. Vol. VII:1177.

108. Dr. Anderson discharged Patient No. 46 on 400 milligrams of Clozaril a day in April of 1992. Thereafter, he was seen as an outpatient by Alex Uspensky, M.D., until he returned to Dr. Abuzzahab's care in the summer of 1996. TSO Tr. Vol. IV:518; TSO Tr. Vol. VII:1176-77, Exh. 50c-2:203. By this time, Patient No. 46 was on 800 milligrams of Clozaril a day, almost the maximum dose. TSO Tr. Vol. X:1922.
Patient No. 46 was discharged to a Rule 36 facility (Oasis) where he remained until 1994. At that time, his schizophrenia was sufficiently controlled to allow him to move into an apartment in an assisted living facility and ultimately take a job in a sheltered workshop. TSO Tr. Vol. IV:513-18 (Patient No. 46's mother).

109. Dr. Uspensky kept the patient on Clozaril as well as prescribing various other medications. Although the first year and half of Dr. Uspensky's office chart is missing, the balance of the chart reflects that Patient No. 46 continued to have positive as well as negative symptoms of schizophrenia under Dr. Uspensky's care, including paranoia, fears and depression. TSO Tr. Vol. X:1922. At one point it was charted that the patient was wearing sunglasses so that people would not see his paranoid eyes. Dr. Uspensky gave the patient Stelazine, another antipsychotic drug, indicating that Clozaril alone was not sufficient. TSO Tr. Vol. IX:1765-67. Dr. Uspensky had also given Patient No. 46 electroconvulsive treatment with minimum benefit. TSO Tr. Vol. VII:1185-86. Although he had no further suicide attempts or hospitalizations during these years, Patient No. 46 was, in 1996, living on disability, in supervised housing, working at a sheltered workshop, socially isolated, withdrawn and shy. He was able to maintain a car and did socialize with his family and a friend. TSO Tr. Vol. II:174; TSO Tr. Vol. IV:513-18; TSO Tr. Vol. VII:1180.

110. Patient No. 46 desired to start dating and perhaps marry and have a family. He was troubled by the side effects of Clozaril, especially weight gain and constipation. TSO Tr. Vol. IV:517-19. He wanted to go off Clozaril and try a new medication. TSO Tr. Vol. VII:1179-80.

111. Dr. Abuzzahab saw Patient No. 46 on August 28, 1996. He advised Dr. Abuzzahab that he had been paranoid since age 16 (TSO Tr. Vol. VII:1180-81) and sometimes felt that people are plotting to harm him. He also gave a history of depression. He complained of constipation so severe that laxatives were necessary every other day, of not feeling rested, although sleeping nine hours most days and twelve hours on weekends. He also complained of weight gain, from 150 lbs. to 220 lbs. Dr. Abuzzahab charted that the patient's family history was "positive", with depression and suicide in two maternal uncles, one of whom was possibly also schizophrenic. Patient No. 46 reported numerous hospitalizations and electro-convulsive therapy. Dr. Abuzzahab's intake note contains no mention of prior suicide attempts or suicidal ideation. TSO Tr. Vol. VII:1180; Exh. 50b:4-5, Exh. 50c-1:88-94.

112. According to Dr. Abuzzahab, it is his practice to question patients about suicidality, but if the answer is negative, in other words, if the patient denies suicidal ideation or

attempts. he does not always chart it. According to Dr. Lewis. this is consistent with the practice of most physicians who chart positive symptoms or signs. and do not chart negative data. TSO Tr. Vol. VI:1028-9; TSO Tr. Vol. VIII:1476-77 (Dr. Abuzzahab). In Dr. Goldman's opinion, it is a marked departure from the standard of care to fail to document suicidality whether it was denied or not because understanding the course of a patient's schizophrenia is critical to the decision to switch medications. TSO Tr. Vol. II:165-69; TSO Tr. Vol. III:469.

113. Dr. Abuzzahab did not obtain Dr. Uspensky's outpatient records. It is Dr. Abuzzahab's practice to obtain data from the prior treating physician when there is a referral. In cases where the patient self-refers, however, he defers to the patient's decision as to whether to release those prior records. Patient No. 46 did not give Dr. Abuzzahab a release for the prior records. Dr. Abuzzahab was willing to proceed without these records because Patient No. 46 was able to tell Dr. Abuzzahab quite specifically what medications he was currently taking. TSO Tr. Vol. IX:1577-86. Had he obtained Patient No. 46's chart, however, Dr. Abuzzahab would not have learned of these prior suicide attempts as there is no mention of them in Dr. Uspensky's chart. Exh. 50c-4: TSO Tr. Vol. V:802-4. He would have learned of the patient's relative stability for several years and that Dr. Uspensky was unwilling to take Patient No. 46 off Clozaril. TSO Tr. Vol. IV:519. Dr. Abuzzahab would have learned of prior suicide attempts in the patient's hospital records.

It was essential that Dr. Abuzzahab obtain this information to make an informed choice about the risks to patients who were taken off Clozaril. TSO Tr. Vol. II:153. 165, 170-73 (Dr. Goldman). Dr. Abuzzahab's failure to obtain this information as necessary to do a risk-benefit analysis in deciding whether to take Patient No. 46 off Clozaril placed him at an undue risk of harm and at a "huge risk" of regression to suicidal preoccupation. *Id.: see also* TSO Tr. Vol. II:167-68. First. Dr. Abuzzahab acknowledged that schizophrenic patients like Patient No. 46 present a high risk of suicide. and that this risk increases with every prior suicide attempt. TSO Tr. Vol. IX:1574-76. As an expert with considerable experience treating schizophrenic patients. Dr. Abuzzahab knew that Clozaril was the "gold standard" for treating treatment-resistant schizophrenics and that because of the "hard lessons" associated with taking patients off Clozaril and putting them on Risperidone. he needed to exercise extreme caution transferring the patient from one medication to another. TSO Tr. Vol VII:1182-83; Vol. IX:1761-62. Dr. Abuzzahab knew at this time that while promising, Risperidone and the recently introduced Zyprexa/Olanzepine were as yet untested as a substitute for patients like Patient No. 46 who were already on Clozaril. TSO Tr. Vol. IV:628-32; Vol. VIII:1520; *see also* Exhs. 57-60.

Also. Dr. Abuzzahab's testimony suggests a careless disregard of his obligation to get information about the patient's condition pre- and post-Clozaril, including his suicidality. He said that apparently it wasn't important to note what medications Patient No. 46 was on or what his course was between the time he stopped Lithium and started Clozaril because that was not his chief complaint. TSO Tr. Vol. IX:1557-65.

114. By the summer of 1996, there was another atypical neuroleptic on the market, risperadone (Risperdal). Risperdal is safer. has fewer side effects and may bring schizophrenic patients closer to a normal existence. On Clozaril, patients may avoid hospitalizations, but lead impaired marginal existences. TSO Tr. Vol. VI:952-58. Although there are not extensive controlled double blind studies. pilot studies shows that Risperdal is at least as effective as

Clozaril. Exs. 57, 58, 59, 60. Patients must be slowly tapered off Clozaril and on to Risperdal. When Risperdal first came on the market in approximately 1994 or 1995, this was unknown, causing problems for some patients.

115. Dr. Abuzzahab, at Patient No. 46's first visit, began to slowly taper Patient No. 46 off Clozaril and on to Risperdal, a process he continued until January 7, 1997. TSO Tr. Vol. VII:1184. Patient No. 46 initially did well after the tapering from Clozaril to Risperdal and was able to travel to Arizona by himself to visit his family in January of 1997. TSO Tr. Vol. VII:1183-4. Dr. Abuzzahab saw Patient No. 46 approximately monthly during this period, TSO Tr. Vol. VII:1183 a practice which he continued throughout the course of treatment. Subsequently, Patient No. 46's psychiatric symptoms increased. He began to report more depression, fear, sadness and anxiety. See Exh. 50c-1:87, 95-99.

116. In Dr. Goldman's opinion, Dr. Abuzzahab's failure to obtain the records from Dr. Uspensky for Patient No. 46 is a departure from minimum standards. TSO Tr. Vol. II:167-69. Dr. Abuzzahab acknowledges that schizophrenic patients like Patient No. 46 present a high risk of suicide. TSO Tr. Vol. IX:1574-76. Dr. Abuzzahab knew that taking patients off Clozaril and putting them on Risperidone, had to be done very slowly with close monitoring. TSO Tr. Vol. VII:1182-83. In Dr. Goldman's opinion, information about the patient's course pre- and post-Clozaril was essential for Dr. Abuzzahab to make a risk recommendation on changing medications and failure to do so was below minimum standards and placed him at a "huge risk." TSO Tr. Vol. II:153, 165, 170-73. He also feels that Dr. Abuzzahab's failure to document why he took the patient off Clozaril to try a new medication was below the minimum standard. TSO Tr. Vol. II:171-72.

117. On February 6, 1997, the patient reported that his anxiety continued despite the fact that Dr. Abuzzahab restarted him on Buspar, an anti-anxiety agent. TSO Tr. Vol. VII:1188-89. At this point, Dr. Abuzzahab decided to gradually reduce and phase out the Risperdal and give the patient a trial on olanzapine (Zyprexa) which had come on the market in November, 1996. TSO Tr. Vol. VII:1188.

118. Olanzapine (Zyprexa) is another new atypical neuroleptic which had been approved by the FDA in the fall of 1996. Like Risperdal, it is substantially less toxic than Clozaril and was approved as a first-line neuroleptic. Olanzapine, like Clozaril, presents less risk of tardive dyskinesia than does Risperdal. TSO Tr. Vol. VI:953-54. Olanzapine has many fewer side effects and is quite effective on the negative symptoms of schizophrenia. With Zyprexa, some patients find that their schizophrenia becomes undetectable, giving them more normal lives. TSO Tr. Vol. VI:952-58.

119. Dr. Abuzzahab had substantial experience doing drug studies with olanzapine before it went on the market and was familiar with the good results obtained with the medication. TSO Tr. Vol. VIII:1531. Although Dr. Abuzzahab has never seen another patient develop tardive dyskinesia from olanzapine, on March 11, 1997, Patient No. 46 complained of uncontrollable mouth movements, causing Dr. Abuzzahab to decrease the dose. TSO Tr. Vol. VII:1191-92.

120. On April 3, 1997, Dr. Abuzzahab examined the patient and found no tongue movements on the lower dosage, nor did the patient report a history of mouth movements on the

lower dosage. Romberg's sign was also negative. TSO Tr. Vol. VII:1193-94. Like Dr. Uspensky, Dr. Abuzzahab had also prescribed various antidepressants to Patient No. 46. On that same date, he prescribed Serzone, an antidepressant. TSO Tr. Vol. VII:1193. On April 3, 1997, Patient No. 46 complained of a lot of physical pain all over his body. Dr. Abuzzahab charted that it started before he began taking the Serzone, because Serzone can cause joint discomfort. Dr. Abuzzahab prescribed Ultram, a nonscheduled analgesic, which does not cause psychiatric side effects. TSO Tr. Vol. VI:1008; TSO Tr. Vol. VII:1197. When Ultram and Motrin were not relieving the pain and the patient phoned on April 18, 1997, Dr. Abuzzahab suggested a family physician or arthritis specialist to rule out a physical source, given the patient's history of athletic injuries. TSO Tr. Vol. VII:1198.

121. On April 28, 1997 and April 29, 1997, Patient No. 46's mother called stating that the patient had insomnia, nausea, anxiety, and racing thoughts. TSO Tr. Vol. VII:1199-1200. Dr. Abuzzahab originally advised increasing the Zyprexa to 20 milligrams as a way of dealing with all of these symptoms. TSO Tr. Vol. VII:1201-4; TSO Tr. Vol. IX:1681-85. When this did not work, on the 29th, he ordered Compazine for the nausea and Benadryl for sleep. Patient No. 46 did not follow Dr. Abuzzahab's advice to increase the Zyprexa. TSO Tr. Vol. IV:532.

122. In Dr. Goldman's opinion, Patient No. 46 immediately developed symptoms that should have alerted Dr. Abuzzahab to the possibility that either the Zyprexa was not working, that it was producing adverse drug effects, or that Patient No. 46 had stopped taking the drug and was decompensating. These symptoms included anxiety, insomnia, depression, paranoia, body pain, and uncontrollable mouth movements.

123. Based on his belief that these new drugs should work and not produce these types of adverse symptoms, Dr. Abuzzahab surmised that these symptoms were either attributable to the inevitable course of schizophrenia regardless of the drug regimen, or to a cause separate and distinct from the illness or the drugs. TSO Tr. Vol. IX:1682-85. These Findings illustrate that Dr. Abuzzahab based critical decisions about this patient on generalized assumptions causing him to ignore or disregard the patient's dire condition. As a consequence, he failed to respond appropriately to the patient's rapidly deteriorating condition, thereby placing him at great risk of harm.

124. Dr. Abuzzahab scheduled an appointment on May 5, 1997 to accommodate Patient No. 46's parents so they could also attend the session. TSO Tr. Vol. VII:1200. Two days previously, the patient had been to the Fairview University Medical Center emergency room where the physician, in telephone consultation with Dr. Abuzzahab, prescribed Ativan for the patient. TSO Tr. Vol. VII:1206-07. He was seen at the hospital due to extreme anxiety and depression. His family reported that he had been doing well until a week earlier. Exh. 50c-2:186. At that time, the parents refused continued hospitalization. During the May 5, 1997 visit, Dr. Abuzzahab learned that the patient had self-discontinued his Zyprexa the previous week because of lip movements. TSO Tr. Vol. VII:1200; 1208. Dr. Abuzzahab made no effort at this appointment to question Patient No. 46 about the symptoms he had been reporting by phone during the preceding weeks. His notes do not reflect that he assessed the patient's current psychiatric state or that the patient was uncommunicative, kept his sunglasses on and wore no shoes because of pain. TSO Tr. Vol. IX:1687-91; Vol. IV:539.

125. The focus of the May 5th appointment, at least on the part of Dr. Abuzzahab, was to determine what antipsychotic medication the patient and the family wanted. Instead of recommending that the patient go back on Clozaril, a drug known to have worked for him in the past, Dr. Abuzzahab recommended, without documentation, that the family give Risperidone another try and also consider a new study drug, MDL 100, 907. Id.; TSO Tr. Vol. IV:539-43; Exh. 50c-1:98. Dr. Abuzzahab did not recommend Clozaril, a drug known to have worked for Patient No. 46 in the past because he thought the new drugs could help with less side effects and were cheaper. TSO Tr. Vol. VIII:1484-85, 1515-21, 1531. The patient was titrated on to Risperdal and by May 15, 1997, was better. On May 21, 1997, Patient No. 46 complained by phone of tremors in his leg and feet. Dr. Abuzzahab recommended decreasing the Risperdal dosage. TSO Tr. Vol. VII:1217.

126. In Dr. Goldman's opinion, Dr. Abuzzahab failed to document a risk benefit analysis in deciding to take Patient No. 46 off Clozaril and start him on a series of new medications which contributed to a fairly immediate deterioration in his condition. Dr. Goldman believes that this failure showed a careless disregard for the patient's welfare, and placed him at undue risk of harm. TSO Tr. Vol. II:153, 170-73. In Dr. Lewis' opinion, the history is not pertinent because Dr. Abuzzahab should have offered the newer, safer drugs to the patient, especially where the patient desires to be off of Clozaril. TSO Tr. Vol. VI:956-57. Dr. Lewis testified that a patient's preference should not override a physician's best judgment, but, at times, a patient will refuse the physician's advice. TSO Tr. Vol. IX:1725-26.

127. On two or three occasions during the course of treatment of Patient No. 46, in the spring of 1997, Dr. Abuzzahab offered the patient and his parents a chance to participate in drug studies of new neuroleptics. One of these was MDL-100, 907. The inclusion criteria for that study permits patients who have been on Clozaril to participate after a brief washout period unless they are taking Clozaril for documented neuroleptic resistance. Patient No. 46 did not have documented neuroleptic resistance. The exclusion criteria provide that patients who have more than moderate symptoms following the two most recent trials of neuroleptic drug therapy should be excluded. Patient No. 46 was partially responsive to numerous neuroleptics, including Clozaril, but had difficulty tolerating them because of their side effects. Thus, he met both the inclusion and exclusion criteria. TSO Tr. Vol. VIII:1494-98; TSO Tr. Vol. X:1914-16. MDL 100, 907 has none of Clozaril's toxicity or unpleasant side effects, it does not cause tardive dyskenesia, and it targets the negative symptoms of schizophrenia. TSO Tr. Vol. IV:634-36; TSO Tr. Vol. VII:1216. Dr. Abuzzahab admitted that there was no evidence of the efficacy of MDL vs. Clozaril, stating "sometimes the only way to find out if a drug study is effective is to put the patient on it." TSO Tr. Vol. IV:634-636.

128. Patient No. 46 was admitted to the emergency room of Fairview-University Medical Center (FUMC) on May 29, 1997. He was delusional, paranoid and suicidal. It was apparent that he may have stopped taking his anti-psychotic medication and was decompensating. Exh. 50c-2:96-97.

129. Patient No. 46 was immediately restarted on Clozaril at his parents' request by Dr. Callahan, a member of Dr. Abuzzahab's practice group who was covering for Dr. Abuzzahab. During the course of this hospitalization, the staff repeatedly addressed Patient No. 46's

psychiatric state and specifically his suicidality. Vol. VII:1217-20; See Exh. 50c-2:100-137. On June 12, 13, and 16, the patient is noted to be paranoid, delusional and feeling hopeless. On June 16, the day before discharge, Patient No. 46 states that he is still feeling depressed, sad and "wishes he would die." Exh. 50c-2:134.

130. Patient No. 46 remained hospitalized until June 17, 1997. TSO Tr. Vol. VII:1223-24. He complained of drooling and other side effects from the Clozaril. On June 17, Patient No. 46 was discharged to Whittier, a board and care facility, with staff trained to assist with medications and other activities. TSO Tr. Vol. VII:1223.

131. There is no indication from Dr. Abuzzahab's chart notes that he personally addressed the patient's psychiatric condition and his suicidality during his hospital course. TSO Tr. Vol. II:177-78.

132. Both the patient and his parents were concerned that he was being discharged too soon. TSO Tr. Vol. X:1840; Exh. 50c-2:136.. According to Dr. Abuzzahab, he had indeed taken into account the patient's psychiatric condition and concluded that he was despondent and hopeless but not suicidal. Dr. Abuzzahab decided to discharge Patient No. 46 to Whittier because a Rule 36 placement at Oasis was not available and because Patient No. 46 did not meet the criteria for continued hospitalization. TSO Tr. Vol. X:1837–40. Dr. Abuzzahab testified that there is a prodrome to suicide such as feelings of uselessness that are advance warnings of suicide and that a No Harm Contract does not mean a patient won't hurt himself. TSO Tr. Vol. VII:1273-75. Dr. Abuzzahab also testified that in discussions with parents or staff he mentioned the costs of continued hospitalizations and the entitlement mentality in seeking to keep Patient No. 46 in the hospital longer. TSO Tr. Vol. X:1840. Dr. Abuzzahab has expressed the view that if a patient is determined to kill himself, he can't be prevented from doing it and hospitalization postpones the event. TSO Tr. Vol. IV:641–42.

133. Patient No. 46 had a prescheduled regular appointment with Dr. Abuzzahab on June 17, 1997. TSO Tr. Vol. VII:1230. Hospital staff charted a hospitalization follow-up appointment for him on June 26, 1997. Exh. 50c-2:184.

134. On July 2, 1997, Patient No. 46 was readmitted to Fairview University Medical Center through the emergency room after he reported to his mother that he had gone into the Mississippi River attempting suicide, but changed his mind and swam back to shore. Patient No. 46 was assessed by Dr. Abuzzahab as suicidal on admission. TSO Tr. Vol. VII:1232-35. Again, there was an issue as to whether he had been compliant with his medications as he had previously spoken to Dr. Abuzzahab by phone and indicated a desire to go off Clozaril, a course that Dr. Abuzzahab recommended against. TSO Tr. Vol. VII:1235. Clozaril was resumed in the hospital and the patient improved with Dr. Abuzzahab having him sign a no-harm contract TSO Tr. Vol. V:833; Exh. 50c-2:12) and allowing him various passes in an attempt to assess his readiness to leave the hospital.

135. Dr. Abuzzahab saw the patient daily during the course of this hospitalization, including on the 4th of July, although the standard practice is to see a hospitalized patient approximately three times a week. TSO Tr. Vol. VI:987-8. Dr. Abuzzahab allowed the patient day passes to be with his parents and others outside the hospital which were successful in that the patient returned safely. Exh. 50c-2:51. Dr. Abuzzahab relied on the numerous entries in the

chart of other staff members regarding whether or not the patient was expressing suicidal ideation. TSO Tr. Vol. VI:961-62. The patient was talking openly about being suicidal up until the day of discharge. Dr. Abuzzahab, however, made no progress notes himself which addressed the patient's suicidality. TSO Tr. Vol. II:181-88; see Exh. 50c-2:12-13; 50-77.

136. In the discharge summary for the July 2-10, 1997 hospitalization, Dr. Abuzzahab reports that the patient denies any past suicide attempts; however, Dr. Abuzzahab does not indicate that the patient's reports are wrong. Nowhere in his progress notes nor in his discharge summary does Dr. Abuzzahab address the risk versus benefit of the discharge plans or the level of suicidality. TSO Tr. Vol. II:191-96; Exh. 50c-2:50-51.

137. While the patient did continue to express some suicidal ideation until the day prior to discharge, he also denied suicidal ideation and consistently denied it before and at the time of discharge. TSO Tr. Vol. V:868-69. Once the patient is no longer suicidal, third party payors, such as Medicare, which funded this patient's treatment, will not pay for additional hospitalization. TSO Tr. Vol. VII:1224-5; TSO Tr. Vol. IX:1734. Dr. Abuzzahab sought an outpatient placement for Patient No. 46. TSO Tr. Vol. VII:1221. The patient was placed on the waiting list of Oasis, a rule 36 facility. Waiting lists are a common problem with these facilities. TSO Tr. Vol. VII:1221; TSO Tr. Vol. VI:964-66. Pending placement at Oasis, Dr. Abuzzahab considered Whittier, a supervised living facility. However, Whittier refused to take Patient No. 46 back and gave no explanation for the refusal. TSO Tr. Vol. IX:1716. Thus, Dr. Abuzzahab discharged Patient No. 46 to his apartment with a day treatment program and authorized a home health nurse to visit Patient No. 46's apartment regularly. TSO Tr. Vol. VI:964-70.

138. At the time of discharge on July 10, 1997, Dr. Abuzzahab did not schedule an outpatient appointment with Patient No. 46. Dr. Abuzzahab sometimes calls his office to schedule such an appointment and sometimes does not, depending on the circumstances. TSO Tr. Vol. VII:1256. In this instance, since the patient was to participate in the day treatment program, he did not schedule such an appointment as the patient's schedule in those activities was not yet known. Thus, Dr. Abuzzahab planned for the patient to call him for an outpatient appointment as he had done in the past once his schedule was known and a non-conflicting appointment could be selected. TSO Tr. Vol. X:1853. The written discharge instructions prepared by the nurse includes a form, which contains a preprinted box that the patient is to call for a follow-up appointment. TSO Tr. Vol. VI:969-70.

139. In Dr. Goldman's opinion, Dr. Abuzzahab's failure to personally address the patient's suicidality in the chart throughout the course of the hospitalizations and his failure to institute appropriate measures to minimize this risk on discharge demonstrated Dr. Abuzzahab's careless disregard for this patient and placed him at undue risk of the harm that ultimately befell him. TSO Tr. Vol. II:153, 181-196.

140. In Dr. Lewis' opinion, Dr. Abuzzahab's charting during Patient No. 46's hospital stay complies with the standards of the Joint Commission on Accreditation of Hospitals. He believes documenting prior suicidality does not have much predictive value and may be in prior hospital records anyway. Dr. Lewis feels that Dr. Abuzzahab properly relied on staff notes and that his actions, such as allowing more freedom for the patient, is an assessment. TSO Tr. Vol. VI:960-962. His outpatient documentation is also adequate. TSO Tr. Vol. VI:963-64, 985. In

Dr. Lewis' view, Dr. Abuzzahab did chart the rationale for his treatment changes, except in instances where it would be self-evident to any psychiatrist in which cases, specific documentation is not required by any standards. The reasons for Dr. Abuzzahab's changes to Patient No. 46's neuroleptic medications are obvious from his chart, according to Dr. Lewis. TSO Tr. Vol. VI:985.
Whether charted or not Dr. Abuzzahab failed to appreciate the risks of taking Patient No. 46 off Clozaril, failed to respond appropriately to the patient's rapid deterioration, and virtually ignored this patient's suicidality. In his memorandum, the ALJ correctly points out that Dr. Lewis' opinions reflect the practicalities of a busy practice rather than focus on the patients' safety as do Dr. Goldman's. *See* Attached Memorandum at [p. 59].

141. Patient No. 46 participated only partially in the day treatment program. Exh. KK. The records of the home health nurse and the day treatment program. Exh. KK and LL, show that he consistently denied any suicidal ideation from the time of the July 10 discharge until the last time anyone spoke with him on the afternoon of July 24th. At that time, he told his social worker that he was safe, meaning that he did not have any suicidal ideation, but that he was upset with his mother for interfering in his affairs. TSO Tr. Vol. VI:970-78; Exh. LL:6, 12, 17; Exh. KK:10. Patient No. 46 had a long term ambivalent relationship with his parents. TSO Tr. Vol. VII:1210.

142. On July 21, 1997, the home healthcare nurse called Dr. Abuzzahab to advise that the patient was refusing to go to day treatment and wanted to decrease his Clozaril because of constipation. Dr. Abuzzahab did not schedule an appointment immediately, but told the nurse to make an appointment and to encourage the patient to keep it. TSO Tr. Vol. X:1847–48, 51; Exh. 50c-1:99, 103-105.

143. In Dr. Goldman's view, Dr. Abuzzahab's failure to schedule a prompt appointment for the patient shortly after discharge is below the minimum standard of care. TSO Tr. Vol. II:196-97. In Dr. Lewis' opinion, Dr. Abuzzahab's scheduling was an appropriate and reasonable choice as having the nurse schedule the appointment would assure that he could bring Patient No. 46 to the appointment. TSO Tr. Vol. VI:969-70, 982-84; Exh. LL. Whether the nurse made an appointment is unknown, as appointments are not necessarily charted when made. TSO Tr. Vol. VII:1160.

144. Four days later, Patient No. 46's mother called and said that Patient No. 46 had not been feeling well for two to three days according to the nurse. Dr. Abuzzahab scheduled an appointment for the next day. That same day, however, Patient No. 46 was missing. On July 28, 1997, he was found dead in the river. The Ramsey County Medical Examiners Office did not determine whether the death was by suicide, finding only that it was an apparent death by drowning. Exh. 50c-3.

145. After Patient No. 46's death, the hospital's peer review organization reviewed the treatment he had received under Dr. Abuzzahab, pursuant to a rule that provides for such review in cases of an untoward outcome shortly after a hospital discharge. These are blind reviews TSO Tr. Vol. X:2007; TSO Tr. Vol. VII:1319-25. The peer review committee upon review found no problem with either the documentation or the substance of care. TSOR Vol. II, Tab A-14; Exh. L. The Board gives little weight to the result of the peer review because Dr. Abuzzahab and

Fairview University Medical Center have asserted a peer review privilege preventing the peer review committee from evaluating the information relied upon by the peer review committee or any possible conflict of interest with the hospital's potential liability.

Dr. Abuzzahab's Current Practice and the Effect of the Temporary Suspension Order

146. Until the temporary suspension of his license, Dr. Abuzzahab maintained his private practice with several other physicians, most recently, John Simon, M.D., William Callahan, M.D., Karen Dickson, M.D., and Floyd Anderson, M.D. They are not partners, and each has his or her own patients. They share office space, share expenses and have a call coverage group. TSO Tr. Vol. IV:649-50.

147. Dr. Abuzzahab's practice focuses on those with advanced states of psychiatric disorders. These patients are usually Medicare patients and chronically and persistently mentally ill people. Other physicians refer patients to Dr. Abuzzahab because he will accept difficult patients. Since the temporary suspension order, other psychiatrists are making efforts to continue care for his patients, however, the need has apparently not been fully met. TSO Tr. Vol. IX:1757-59.

148. Paula Clayton, M.D. is one other person to whom the community can refer such refractory patients. TSO Tr. Vol. VI:1068-70. Since the temporary suspension, Dr. Clayton has received at least twenty phone calls from Dr. Abuzzahab's patients, but she cannot take any new patients and has been referring them to a clinic. TSO Tr. Vol. X:2009-13.

149. Dr. Glenn Lewis has treated some of these patients including a chronically depressed patient who has been crying because his doctor is gone.

150. Since the temporary suspension order, Floyd Anderson, M.D., formerly of Dr. Abuzzahab's practice group, has come back from a semi-retirement to help address the care of these patients. TSO Tr. Vol. X:1951. Dr. Anderson has examined approximately 250 of Dr. Abuzzahab's patients since the temporary suspension, including all of the patients who were on any controlled substances. He has reviewed the records of another 250 patients. TSO Tr. Vol. X:1952-53. Many of these patients have told Dr. Anderson that Dr. Abuzzahab saved their lives. Two thirds of them were referred by other psychiatrists whose treatment had failed. Many of these patients were doing very well with high levels of function and absence of side effects. The temporary suspension has caused significant anxiety and fears among at least sixty percent of these very ill patients. TSO Tr. Vol. X:1954-55. Lifting the temporary suspension order would benefit the public according to Dr. Anderson, based on his experience with these patients. TSO Tr. Vol. X:1960.

151. In five percent of the cases, Dr. Anderson would have treated Dr. Abuzzahab's patients differently if he had been their psychiatrist. TSO Tr. Vol. X:1955. This rate is consistent with the work of other colleagues with whom Dr. Anderson also occasionally disagrees. In Dr. Anderson's opinion, all physicians make mistakes, as does Dr. Abuzzahab, but Dr. Abuzzahab's mistakes do not endanger the public any more than those made by others. TSO Tr. Vol. X:1998-99. Dr. Abuzzahab's practice is also unique, according to Dr. Anderson, in that he takes problem patients and continues to try with them and never "fires" them as patients as other doctors do. TSO Tr. Vol. X:1999-2000.

152. According to Dr. Anderson, there are substantial difficulties in finding alternative care for Dr. Abuzzahab's patients. TSO Tr. Vol. X:1996. Many patients Dr. Abuzzahab sees are society's outcasts: unpopular, rude and discounting of professionals. Many doctors will not treat them long term as Dr. Abuzzahab has. TSO Tr. Vol. X:1995.

153. Many of Dr. Abuzzahab's colleagues and patients have submitted letters to the full board and as a part of this record. These persons highly praise his contributions to the medical community and his unique expertise. The Minnesota Psychiatric Society also submitted a petition. TSOR Vol. II, Tab A-7, Tab A-14; Exh. D, Tab A-35.

154. A former patient, Mr. S, also corroborated Dr. Abuzzahab's care in monitoring and attending difficult patients such as Mr. S. himself. He was depressed and suicidal and presented to Dr. Abuzzahab with a history of chemical dependency and recovery. Dr. Abuzzahab's interventions, including his psychotherapy and prescribing of medications, helped Mr. S. recover. Dr. Abuzzahab's treatment regimen included Xanax which he carefully monitored in this recovering chemically dependent person. TSO Tr. Vol. VII:1241-62.
Dr. Abuzzahab's good reputation and good practices with some patients are irrelevant to whether Dr. Abuzzahab engaged in substandard and dangerous practices with respect to Patients No. 44, 45 and 46 or any of the other 43 patients subject to the underlying contested case. Dr. Abuzzahab's reputation and expertise did not mitigate his errors but rather imposed a higher duty on him to treat his vulnerable patients safely.

155. Dr. Abuzzahab has attempted to address the Board's concerns. He voluntarily began on December 1, 1997, having all of his controlled substance prescriptions countersigned by one of his colleagues prior to dispensing them. TSO Tr. Vol. VII:1167-68. He also voluntarily offered to be supervised by Donald Mayberg, M.D., and to alleviate any concerns that the Board might have pending the final outcome of this matter. TSOR Vol. II, Tab A-35.
Although Dr. Abuzzahab has proposed a "gentlemen's agreement," he has not negotiated a Stipulation and Order imposing enforceable restrictions on his license.

CONCLUSIONS OF LAW

1. The Board of Medical Practice and the Administrative Law Judge have jurisdiction in this matter pursuant to Minn. Stat. §§ 147.091 and 14.50 (1996).

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. R. 1400.7300, subp. 5 (1996). *See also*, *In Re Wang*, 441 N.W.2d 488, 492 (Minn. 1989).

4. Minn. Stat. § 147.091, subd. 4, provides as follows:

Temporary suspension of license. In addition to any other remedy provided by law, the board may, without a hearing, temporarily suspend the license of a physician if the board finds that the physician has violated a statute or rule which the board is empowered to enforce and continued practice by the physician would create a serious risk of harm to the public. The suspension shall

take effect upon written notice to the physician, specifying the statute or rule violated. The suspension shall remain in effect until the board issues a final order in the matter after a hearing. At the time it issues the suspension notice, the board shall schedule a disciplinary hearing to be held pursuant to the administrative procedure act. The physician shall be provided with at least 20 days notice of any hearing held pursuant to this subdivision. The hearing shall be scheduled to begin no later than 30 days after the issuance of the suspension order.

5. Minn. Stat. § 147.091, subd. 1, provides, in part, as follows:

Grounds listed. The board may refuse to grant a license or may impose disciplinary action as described in section 147.141 against any physician. The following conduct is prohibited and is grounds for disciplinary action:

. . .

(g) Engaging in any unethical conduct: conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare or safety of a patient; or medical practice which is professionally incompetent, in that it may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established.

. . .

(k) Engaging in unprofessional conduct. Unprofessional conduct shall include any departure from or the failure to conform to the minimal standards of acceptable and prevailing medical practice in which proceeding actual injury to a patient need not be established.

. . .

(o) Improper management of medical records, including failure to maintain adequate medical records, to comply with a patient's request made pursuant to section 144.335 or to furnish a medical record or report required by law.

6. The Temporary Suspension Order issued by the Board on December 19, 1997, states at p. 14 that the grounds for the temporary suspension were that there was probable cause to believe that Minn. Stat. § 147.091, subd. 1(g)(k) and (o) had been violated in that the Respondent had not carefully documented his diagnosis, had not documented the rationale for the chosen course of treatment and changes to it, did not respond immediately to changes in the patient, did not verify information provided by possibly unreliable patients, and did not review prior treatment records.

7. The Board has not considered the issues of improper prescribing by the Respondent or the Respondent's drug studies as a part of the Temporary Suspension Order.[5]

8. The Letter-Order of the Administrative Law Judge dated January 5, 1998, limited the issues in this proceeding to those described in Conclusion No. 6 above.

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[5] Some of the foregoing Findings of Fact relate to the issue of prescribing because that issue is so closely linked to the issues relied upon by the Board in its Temporary Suspension Order that the Findings had to be made to provide a context.

9. The Committee has proved by a preponderance of the evidence that the Respondent failed to review prior treatment records (Findings of Fact Nos. 23, 57, 97, 102, 113, and 116), document the rationale for treatment and changes in the patient's treatment (Findings of Fact Nos. 27, 31, 44, 58, 59, 60, 67, 69, 77, 83, 97, 116, 125, and 126, monitor and respond immediately to changes in the patient (Findings of Fact Nos. 30, 37, 41, 51, 54, 139, and 143), and verify information from patients (Findings of Fact No. 23), and thereby has shown a careless disregard for the health, welfare, or safety of some patients and may have created unnecessary danger to a patient's life, health or safety standards of acceptable and prevailing medical practice in violation of Minn. Stat. § 147.091, subd. 1(k); and has failed to maintain adequate medical records contrary to Minn. Stat. § 147.091, subd. 1(o).

10. The Committee has proved by a preponderance of the evidence that continued practice by the Respondent would create a serious risk of harm to the public and that temporary suspension of his unrestricted license to practice is warranted. Dr. Abuzzahab's license to practice medicine and surgery is hereby SUSPENDED, pending the outcome of the contested case.

11. The Board agrees to stay the temporary suspension order pending the outcome of the contested case if all of the following conditions are met:

a) The Board receives a signed agreement from one of Dr. Abuzzahab's partners to review each of Dr. Abuzzahab's prescriptions for a controlled substance and:

(1) co-sign when the prescription is appropriate:

(2) retain copies of each prescription written by Dr. Abuzzahab which is co-signed: and

(3) report to the Board once a month each prescription which was not co-signed and explain the reason it was not co-signed.

b) Dr. Abuzzahab submits each prescription for a controlled substance to one partner for co-signature, log each prescription and provide a copy of the log to the Board upon request.

c) Dr. Abuzzahab completes a records management course approved by the Board.

d) Dr. Abuzzahab enrolls in a medical ethics course specifically designed for physicians engaged in research. Enrollment is effective upon payment of the tuition. The course must be successfully completed and the Board must receive written notice of successful completion from the training program by July 31, 1998 or any stay in effect at that time will be revoked.

e) Dr. Abuzzahab neither directs nor assists with any drug study.

f) The Board is able to find a psychiatrist who has the skill and time needed and agrees to supervise Dr. Abuzzahab until the contested case is completed and the Board issues its final order in this matter. The supervisor must be willing and able to:

(1) meet with Dr. Abuzzahab at least once a month;

(2) review Dr. Abuzzahab's patient records at least once a month:

(3) report immediately to the Board if at any time the supervising physician is uncertain from the patient records whether controlled substances have been correctly prescribed for a patient, or whether a patient has been correctly diagnosed or whether a patient's care has been adequately monitored;

(4) review Dr. Abuzzahab's log of prescriptions for controlled substances and copies of the prescriptions at least once a month to assure that each one was either co-signed or reported to the Board.

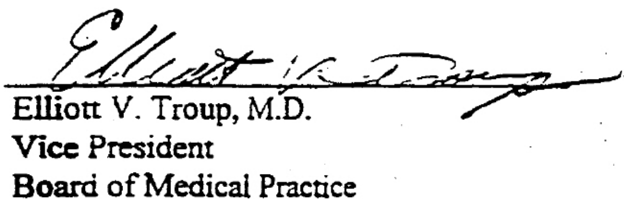
(g) Dr. Abuzzahab meets with the supervising psychiatrist at least once a month and pays any costs associated with the supervision.

(h) Dr. Abuzzahab signs a Stipulation and Order to Stay Suspension incorporating the terms of the Stay.

12. In the event that a stay is issued and the Board or CRC obtains information that any of the terms of the stay have been violated, the Board may revoke the stay upon written notice to Dr. Abuzzahab of its basis and the Temporary Suspension Order will be reinstated pending the outcome of the contested case hearing. There will be no separate hearing on the revocation of the stay since the Board has determined that a Temporary Suspension is warranted, and a full contested case is in progress.

13. This Order was approved by vote of the Board members participating in the deliberation; Craig Stone, J.D. dissented. The following members dissented to Conclusion 11 only: Adrienne Breiner, Patricia A. Jilk, and Mary Mika.

May 15, 1998



Elliott V. Troup, M.D.
Vice President
Board of Medical Practice

MEMORANDUM

The Board has fully considered the ALJ's report and exceptions filed by the parties, as well as the record. The Board is well aware of its obligation to reach its own conclusions about whether the evidence supports the factual findings and whether the findings support the conclusions of law. In this case, the ALJ did a thorough job reviewing the evidence and wrote an excellent report. To a great degree, the Board agrees with the ALJ and has accepted his findings and conclusions. However, the Board is appointed because of its special expertise regarding the

standards of the medical profession and has the duty and responsibility by statute to determine whether violations occurred and whether Dr. Abuzzahab presents a serious risk of harm to the public. Thus, while giving great deference to the ALJ. it has carefully examined the record and applied its expertise to conclude that continued unrestricted practice by Dr. Abuzzahab would pose a serious risk of harm to the public.

The following portion of the ALJ's Memorandum is adopted by the Board:

This contested case proceeding arises out of a Temporary Suspension Order issued by the Board of Medical Practice on December 19, 1997. That Order temporarily suspended the medical license of Dr. Abuzzahab based upon the Board's finding that his treatment of three patients fell below the minimum standard of care. The violations relied upon by the Board to support its Order included Dr. Abuzzahab's alleged failure to carefully document his diagnosis. his alleged failure to document the rationale for his chosen course of treatment and changes to that course of treatment. his alleged failure to respond immediately to changes in the condition of the patient. his alleged failure to verify information provided by possibly unreliable patients. and his alleged failure to review prior treatment records. In its Order, the Board found that the record was not sufficiently developed to make a determination on allegations of improper prescribing by the Respondent or as to allegations of improprieties in the conduct of drug studies by the Respondent.

Under Minn. Stat. § 147.091, subd. 4. the Board may temporarily suspend a license without a hearing and its order remains in effect until the Board issues a final order after a hearing. The Board is required to hold that hearing under the Administrative Procedure Act and is directed to schedule a hearing no later than 30 days after issuance of the suspension order. The hearing in this matter began on January 19, 1998, and concluded after two weeks of testimony.

<u>Burden of Proof/Standard of Proof</u>

In its post-hearing submission. the Complaint Review Committee argues that the issue in this proceeding is whether there is evidence to support the Board's conclusion that there was substantial evidence in the record before it to demonstrate that the Respondent's treatment of the three patients in question was substandard and dangerous and whether there is substantial evidence to establish probable cause to believe that the practices at issue pose a serious risk of harm to the public. Committee's Post Hearing Brief, p. 3. The Committee does not cite any legal authority for its view of its burden of proof or of the standard of proof. Neither "substantial evidence" or (sic) "probable cause" are mentioned in the Medical Practice Act. The "substantial evidence" standard is typically used by an appellate court in reviewing agency decisions, but not by the finder of fact in a contested case proceeding. See Minn. Stat. § 14.69(e). In its Temporary Suspension Order, the Board did conceptualize its duty, in considering whether or not to issue a Temporary Suspension Order, to be to determine whether there was substantial evidence to indicate a violation by Dr. Abuzzahab and whether there was probable cause to find that his continued practice created a serious risk of harm to the public. These observations by the Board. however, appear to be a recognition that its final decision in the matter will be made after a contested case hearing during which a full record will be developed in the usual trial-type manner which will then lead to a redetermination of this matter by the Board without reference to

its preliminary determinations at the time of the Temporary Suspension Order.

Under the Administrative Procedure Act and the Rules of the Office of Administrative Hearings, the party proposing that certain action be taken must prove the facts at issue by a preponderance of the evidence, unless the substantive law provides a different burden or standard. Minn. Rule 1400.7300, subp. 5. In this case, the Committee has not pointed to any different standard set out in the statute or case law.

There is nothing in Minn. Stat. § 147.091, subd. 4, to support the Committee's view that the issue in this full contested case proceeding is whether or not the evidence presented to the Board to support the temporary suspension is substantial. Rather, the statute's reference to a disciplinary hearing held pursuant to the Administrative Procedure Act compels a full trial-type proceeding under a preponderance of the evidence standard. The Committee's interpretation would mean that a physician's license could be suspended upon evidence that was less than a preponderance or by a determination that there was only probable cause to believe that a serious risk of harm to the public existed. That does not appear to be the legislative intent. Likewise, the Committee's brief seems to assume that the Board's determinations in its Temporary Suspension Order are entitled to some weight in this contested case proceeding. However, the Board is obligated to redetermine this matter based upon the evidence now compiled in this record.

The Respondent argues that the appropriate standard of proof in this proceeding is proof by clear and convincing evidence. This is apparently the standard in health care professional discipline cases in a few other states. It is the standard employed in attorney and judicial discipline cases in Minnesota. *In Re Gillard*, 271 N.W.2d 785-805 note 3 (Minn. 1978). However, in Minnesota the appropriate standard for health care professional discipline cases has been clear since the Supreme Court handed down its decision in *In Re Wang*, 441 N.W.2d 488, 492 note 5 (Minn. 1989). In that case, the court adopted the preponderance of the evidence standard for health care professional discipline cases. As the Respondent points out, it also went a step further in observing that "We trust that in all professional disciplinary matters the finder of fact, bearing in mind the gravity of the decision to be made, will be persuaded only by evidence with heft." 441 N.W.2d at 492. The preponderance standard was most recently applied in a medical license proceeding in the case of *In Re Medical License of Harvey B. Friedenson*, ___N.W.2d___ (Minn. Ct. App. February 24, 1998). In that case the Court of Appeals rejected the licensee's argument that a clear and convincing standard is appropriate and affirmed its prior rulings that preponderance of the evidence was the appropriate standard in professional disciplinary proceedings in Minnesota.

Due Process

The Respondent raises two other issues related to due process. The first is whether or not each alleged violation of a standard of conduct must be supported by expert testimony in the record. The Committee has presented the expert testimony of Dr. Goldman in support of its allegations. The Respondent's contention is that some of the allegations were not supported by Dr. Goldman's testimony.

In Wisconsin, the State Medical Examining Board cannot rely on the expert knowledge of its members, but must base its actions upon the record before it. It may not substitute its knowledge for evidence which is lacking in the record. *Gilbert v. State Medical Examining Board*, 349

N.W.2d 68, 84 (Wisc. 1984). Likewise, in South Dakota with a couple of exceptions, expert testimony is required to establish the proper "competency standards" and whether or not they are met. *In Re Appeal of Schramm*, 414 N.W.2d 31, 36 (S.D. 1987). The South Dakota court noted that this holding is the majority rule in the United States and is supported by three reasons, namely, due process rights of confrontation and cross-examination, the fact that many boards are comprised of lay members as well as professionals, and the necessity to have expert testimony in the record to allow for judicial review. In some states, however, findings of incompetence without expert testimony may still be based solely on the expertise of board members. *See, e.g. Davidson v. State*, 33 Wash. App. 783, 657 P.2d 810 (1983); *Sillery v. Board of Medicine*, 145 Mich. App. 681, 378 N.W.2d 570 (1985). In Minnesota, while the Supreme Court has made it clear that "unprofessional" conduct is that conduct which fails to conform to the standards of professional behavior recognized by a consensus of expert opinion. *Reyburn v. State Board of Optometry*, 78 N.W.2d 351 (Minn. 1956), the Minnesota court has yet to announce a rule requiring expert testimony in the record.

In this case, each of the violations of statute found by the Administrative Law Judge is supported by expert testimony in the record. Accordingly, whatever the present state of the law in Minnesota as to whether a violation of minimum standards can be found without expert testimony to that point in the record, this recommended decision should be found to be consistent with either the majority or minority rule in this country.

The Respondent also argues that he has not received sufficient notice of the charges against him. Under Minn. Rule 1400.5600, subp. 2D., the agency must provide a statement of the allegations or issues to be determined in its Notice of Hearing. The Administrative Procedure Act itself provides that parties must be afforded reasonable notice and if the issues cannot be fully stated in advance of the hearing, they must be fully stated as soon as practical. Minn. Stat. § 14.58. Generally, the details of specific incidents or events need not be described, but sufficient facts must be presented to apprise the Respondent of the grounds on which the charges are based. *Hughes v. Department of Public Safety*, 200 Minn. 16, 21, 273 N.W. 618, 621 (1937); *Schmidt v. I.S.D. No. 1*, 349 N.W.2d 563, 567 (Minn. Ct. App. 1984). The usual remedy for a lack of notice is a motion for a more definite statement. However, if, as the Respondent contends, allegations of misconduct are raised for the first time in post-hearing submissions, a due process problem would be presented.

The Committee did cite to some allegations in its final brief that arguably were not within the Notice of Hearing. However, each of the violations found by the Administrative Law Judge was based upon allegations set out in the Third Amended Notice of Hearing.

Expert Witnesses

Each party argues that the other's expert witness should be disregarded based upon his qualifications, knowledge or bias. The record supports the conclusion that both Dr. Goldman and Dr. Lewis are qualified to render an expert opinion in this case. Each reviewed a large amount of data in this case, mastered it, and offered a logical coherent opinion based upon the facts reviewed. Dr. Goldman is a board certified psychiatrist who maintains a clinical practice along with teaching and research. He has had supervisory responsibility for reviewing and evaluating the treatment provided by other psychiatrists and residents. He has experience in

treating the mental disorders and the corresponding medications at issue in this proceeding. He is familiar with the minimum standards of care for psychiatrists as enunciated by the Respondent himself in his lectures to students.

Likewise, Dr. Lewis is a psychiatrist of considerable experience in this community. He has clinical experience with the medications and disorders at issue. He also has experience supervising psychiatrists and in reviewing hospitals against accreditation standards. Although the Committee suggests that Dr. Lewis has a bias due to his awareness of Dr. Abuzzahab's good reputation in the community, it does not appear that there is any social or professional relationship between Dr. Lewis and Dr. Abuzzahab that would preclude an objective opinion.

The Respondent points out that Dr. Goldman does not have a Ph.D. in pharmacology as the Respondent does and has a small clinical practice. These factors do not disqualify Dr. Goldman, however, and the hearing record supports a conclusion that he is well acquainted both with psychiatric medications and clinical practice. As the Respondent has pointed out, Dr. Goldman did make a number of factual mistakes in his initial assessment of the patients in question. Exh. EE. It is, of course, understandable that some mistakes would be made in the interpretation of the handwritten portions of the record and due to the volume of material involved. However, the factual mistakes have been corrected in the record and the conclusions arrived at are based upon the corrected data. The Respondent contends that Dr. Goldman has inappropriately criticized a number of psychiatrists in the course of this proceeding in reviewing their charts, and that he has also failed to criticize some practitioners for alleged mistakes that he held Dr. Abuzzahab accountable for. Whatever the situation in that regard, the focus of this proceeding is on whether or not the Respondent complied with the minimum standard of care in his treatment of the three patients in question. While Dr. Goldman's views on other practitioners may be informative, they do not negate his opinion as to the Respondent's conduct.

With some exceptions, the foregoing Conclusions of Law credit the expert testimony of Dr. Goldman over that of Dr. Lewis. Ultimately, of course, the Board of Medical Practice must determine what constitutes the minimum standard of care in the state of Minnesota. However, from the prospective of the Administrative Law Judge, Dr. Goldman's opinions seem to follow logically from the standard of care subscribed to by all of the psychiatrists involved in this proceeding. Findings of Fact Nos. 9-11. Dr. Goldman's determination of what is required to comply with the minimum standard of care seems to comport with what is required to ensure the health, safety and welfare of patients as required by Minn. Stat. § 147.091, subd. 1. While Dr. Lewis' opinions have a ring of practicality to them in the context of a busy clinical practice, Dr. Goldman's opinions seemed to focus more on the safety of the individual patient, a standard reflected in the Medical Practice Act.

Statutory Violations

Each party submitted proposed Findings of Fact in this case. The proposed findings contained a good deal of argument and an effort has been made to ensure that the foregoing Findings of Fact are not conclusory with the exception of the expert opinions expressed by Dr. Goldman and Dr. Lewis. Additionally, the Board should be aware that because of the press of time in dealing with this case, a large number of the cites to the transcript and exhibits in the proposed Findings of Fact are inaccurate. An effort has been made to ensure to accuracy of the cites in this

recommended decision.

The Complaint Committee has proved by a preponderance of the evidence, through evidence with heft, that on a number of occasions in his treatment of Patients No. 44, 45 and 46 the Respondent did not document the reasons for his treatment and did not carefully monitor and respond to the patients' changing conditions.

Dr. Abuzzahab's treatment of Patient No. 44 was brief; however, it included three departures from the minimum standard of care. Although the Respondent requested the patient's medical chart from Dr. Smith, it was not provided for some reason and the Respondent did not follow up to secure it. With a review of the chart, Dr. Abuzzahab would have realized that Patient No. 44 had not been candid with him concerning his use of Xanax while a patient of Dr. Smith. The Respondent also failed to adequately monitor the patient, who was a chemically dependent person, when he provided the patient with a large amount of a controlled substance, a two-month prescription, without a follow-up visit scheduled for six weeks. The initial prescription of the Xanax was followed by an early telephone refill on April 19, 1996. This early refill should have alerted the Respondent to possible abuse of the benzodiazepine by Patient No. 44. Finally, the Respondent failed to respond to the patient's withdrawal symptoms which he should have recognized and instead advised him that the Xanax was out of his system and that the patient probably had the flu.

The Respondent treated Patient No. 45 on and off over a nine-year period. He prescribed the patient a number of antidepressants as well as Valium, Xanax and Halcion, which are benzodiazepines and controlled substances. As the Findings of Fact and Conclusion No. 9 indicate, the Respondent repeatedly failed to document his rationale for the treatment of this patient in the record. For example, on a first visit with this patient in November of 1987, the patient's Valium was increased, he was placed on Wellbutrin and given 10 samples of Halcion without any explanation in the chart as to why this was being done. Although Dr. Abuzzahab explained his reasons at the hearing, the standard of care requires that these reasons be documented in the chart. The Respondent's additional failures to document and justify his treatment and prescriptions are set out at Findings of Fact Nos. 59, 60, 67, 69, 77, and 83.

The Respondent also fell below the minimum standard of care in regard to this patient by failing to obtain his treatment records, such as the record of his 72-hour hold at Hennepin County Medical Center in June of 1988. This record would have provided crucial information to the Respondent, possibly leading to a reassessment of the diagnosis. Although Dr. Abuzzahab argues that he abandoned his effort to obtain the information after the patient failed a September 1988 appointment, it appears that the record of the June 9, 1998 hospitalization should have been obtained prior to that time.

Although Dr. Abuzzahab and his expert witness argue that it is not possible to document the reasons for all initial prescriptions in a busy practice, it is difficult to see how adequate care can be given to a patient when the physician does not note what symptom he is attempting to treat, and what the medication is expected to accomplish. Without this information it is not possible to monitor and document results. In a busy clinical practice, even where the psychiatrist has extensive expertise, it cannot be expected that all of this information will be retained by the psychiatrist without being written in the chart. Adequate documentation is directly related to

patient safety.

The Respondent cared for Patient No. 46 from 1991 to 1997. Again, he failed to obtain the patient's prior psychiatric records from his previous psychiatrist. He stated that Patient No. 46 did not give him a release for prior records. The Respondent could, of course, insist that the patient do so before treatment. If he had had the prior record Dr. Abuzzahab would have learned of the condition of the patient while on Clozaril for several years and would have learned that Dr. Uspensky was unwilling to take the patient off of Clozaril. In fact, the patient came to the Respondent because of his desire to get off Clozaril. Additionally, the Respondent did not obtain prior hospital records, such as discharge summaries for the patient which would have provided him crucial information concerning the patient's nine hospitalizations, including four suicidal gestures or attempts. All of this information would have been important to him in determining a course of treatment. Additionally, the Respondent failed to document in his chart why he took the patient off Clozaril to try a new medication, and as he changed the patient from this new medication to others he also failed to document the reasons. This documentation seems particularly crucial to this patient since he was a difficult and fragile patient who had done better on Clozaril than he had previously.

Finally, the Respondent fell short of the minimum standard in his monitoring of Patient No. 46 after his discharge from the hospital in July of 1997. Although the patient had visits from a psychiatric nurse and was supposed to participate in day treatment, Dr. Goldman's opinion that the Respondent should have scheduled a prompt appointment for the patient shortly after discharge, or at least scheduled an appointment when the nurse brought problems to his attention on July 21, 1997. This opinion is reasonable and is consistent with the physician's obligation to monitor a patient's response to assess whether the desired effects of treatment are occurring. Dr. Abuzzahab was aware of the patient's suicidality during his hospitalization and should have been aware that this patient needed to be closely monitored upon release.

* * *

(End of ALJ's Memorandum)

The Board supplements the ALJ's Memorandum as follows:

Expertise of the Board

In his discussion of due process, the ALJ states that the Minnesota courts have not announced a rule requiring expert testimony in the record. Supra, p. [55]. Members' expertise may be used to evaluate the evidence. They may assess the expert testimony and determine its proper weight. The Board may also apply its expertise to determine if a set of facts constitutes a violation of the law. The Board cannot rely on its members to provide the factual basis for a violation which is unsupported by the record. Kollmorgen v. Bd. of Medical Examiners, 416 N.W.2d 485 (Minn. Ct. App. 1988).

Serious Risk of Harm to the Public

The ALJ concluded that the CRC had proven that Dr. Abuzzahab failed to adequately document the reason for his treatment of patients in his chart and that he has failed to adequately monitor and respond to changes in the conditions of Patients #44, #45 and #46. He was not convinced that continued practice would present a serious risk of harm to the public or that the

violations place the public at risk. In reaching this conclusion, the ALJ relied on the Respondent's voluntary agreement to have his prescriptions counter-signed by another physician and accept supervision. However, such voluntary agreements are insufficient to protect the public. The ALJ believed that with appropriate review and conditions imposed by the Board, the public could be adequately protected.

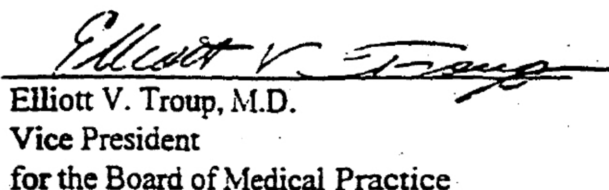
The Board's duty is to determine whether a physician with an unrestricted license can safely practice so that there is no serious harm to the public. The Board is convinced that Dr. Abuzzahab presents a serious risk of harm to such a degree that temporary suspension of his license is required. Since voluntary agreements by the physician are unenforceable, and Dr. Abuzzahab has had several opportunities to enter into a stipulation with the CRC, the Board will not accept that such voluntary offers are sufficient to protect the public.

It is clear that many psychiatrists familiar with Dr. Abuzzahab are concerned that his patients are difficult to treat and cannot be easily accepted into other practices. Many have expressed great confidence in Dr. Abuzzahab and have encouraged the Board to reconsider its Temporary Suspension Order. The CRC argues that the evidence of Dr. Abuzzahab's reputation should have been disregarded. As stated in its initial order, the Board agrees with the CRC that Dr. Abuzzahab's reputation is not relevant to whether his care for specific patients fell below the accepted minimum. However, it is evidence that Dr. Abuzzahab's peers have confidence in him and believe that patients can benefit from his expertise. He is, apparently, an important resource for some patients and other physicians. Under these circumstances, a capable psychiatrist who is fully informed about the types of violations which have been proven, and additional ones alleged by the CRC may be willing to oversee Dr. Abuzzahab while the contested case continues.

The Board has balanced the high level of confidence many of Dr. Abuzzahab's peers have in his skill with evidence that his care falls below minimally acceptable standards in some cases. The Board has decided that the public cannot be adequately protected unless Dr. Abuzzahab's patient care is closely supervised and he receives some additional training while the contested case process is completed. If Dr. Abuzzahab is willing to accept the conditions set forth in the Order and the Board can identify a supervisor who has the skill, time and willingness to oversee Dr. Abuzzahab's work, and keep in close contact with the CRC, the public can be adequately protected.

The Board will direct its staff to promptly review any documents submitted by Dr. Abuzzahab to fulfill the conditions imposed, and to seek a suitable supervisor. The Vice-Chair of the Board will to determine if the conditions are met and is authorized to sign the Stay on behalf of the Board.

May 15, 1998



Elliott V. Troup, M.D.
Vice President
for the Board of Medical Practice

AG:126490 v1

AFFIDAVIT OF SERVICE BY MAIL

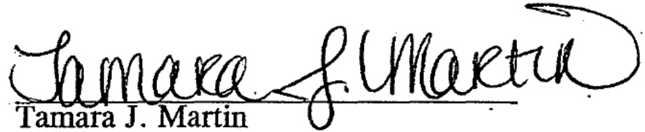
Re: In the Matter of the Medical License of Faruk Abuzzahab, M.D.
License No. 17,068

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

Tamara J. Martin, being first duly sworn, deposes and says:

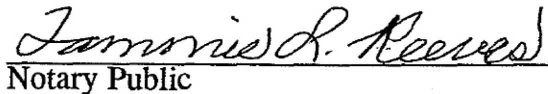
That at the City of St. Paul, County of Ramsey and State of Minnesota, on July 13, 1998, she served the attached STIPULATION AND ORDER by depositing in the United States mail at said city and state, a true and correct copy thereof, properly enveloped, with first class postage prepaid, and addressed to:

Marcy S. Wallace
Cox, Goudy, McNulty & Wallace
676A Butler Square
100 North Sixth Street
Minneapolis, MN 55403

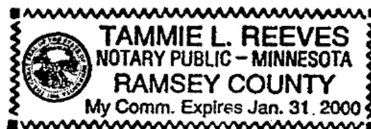


Tamara J. Martin

Subscribed and sworn to before me
This 13th day of July, 1998.



Notary Public



MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza 2829 University Avenue SE Suite 400 Minneapolis, MN 55414-3246
**Telephone (612) 617-2130 *Fax (612) 617-2166*
MN Relay Service for Hearing Impaired (800) 627-3529

July 29, 1998

TRUE AND EXACT COPY OF ORIGINAL

Faruk Abuzzahab, M.D.
Riverside Park Plaza
701 25th Avenue South, Suite 303
Minneapolis, MN 55454

Dear Dr. Abuzzahab:

Pursuant to your signed Stipulation and Order approved by the Board of Medical Practice on July 11, 1998, the Board has accepted your prescription monitoring agreement and approved your supervising psychiatrist.

Therefore, under the terms of the July 11, 1998 Order, the suspension of your medical license is hereby stayed as of today's date, July 29, 1998.

Sincerely,

Robert A. Leach
Executive Director

AN EQUAL OPPORTUNITY EMPLOYER
PRINTED ON RECYCLED PAPER

AFFIDAVIT OF PERSONAL SERVICE

RE: In the Matter of the License of Faruk S. Abuzzahab, M.D.
License No. 17,068

STATE OF MINNESOTA)
)ss.
COUNTY OF HENNEPIN)

Mary K. Erickson, being first duly sworn, hereby deposes and says:

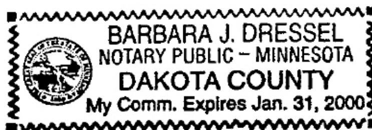
That at the City of Minneapolis on July 30, 1998, she personally served a true and correct copy of the attached letter to Dr. Abuzzahab. This letter was personally served to Dr. Abuzzahab at the office of the Board of Medical Practice at the following address:

2829 University Avenue SE, Suite 400
Minneapolis, MN 55414-2166

Mary K. Erickson
Mary K. Erickson

Subscribed and Sworn to before me
this 31st day of July, 1998.

Barbara J. Dressel
NOTARY PUBLIC



TRUE AND EXACT
COPY OF ORIGINAL

BEFORE THE MINNESOTA

BOARD OF MEDICAL PRACTICE

In the Matter of the
Medical License of
Faruk S. Abuzzahab, M.D.
Date of Birth: 10/12/32
License Number: 17,068

**ORDER OF
UNCONDITIONAL LICENSE**

The Minnesota Board of Medical Practice ("Board") having convened on September 9, 2000, to review the petition of Faruk S. Abuzzahab, M.D. ("Respondent"), for reinstatement of an unconditional license to practice medicine and surgery makes the following:

FINDINGS OF FACT

1. Respondent has been subject to Board monitoring pursuant to a Stipulation and Order dated July 11, 1998. This Order was based on Respondent's substandard care of patients, inappropriate prescribing and improper management of medical records.

2. The Board has received periodic reports from Respondent's supervising physician and designated Board member. The Board received verification that Respondent successfully completed the required coursework. The reports support Respondent's compliance with the terms and conditions of the Order and support his petition for reinstatement of an unconditional license.

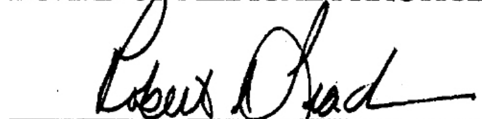
Based on the foregoing, the Board concludes that Respondent has complied with and fulfilled the Order issued by the Board on July 11, 1998, and hereby issues the following:

ORDER

IT IS HEREBY ORDERED that an unconditional license to practice medicine and surgery in the State of Minnesota be conferred upon Respondent, such license to carry all duties, benefits, responsibilities, and privileges inherent therein through Minnesota statute and rule.

Dated: September 9, 2000

STATE OF MINNESOTA
BOARD OF MEDICAL PRACTICE



AG: 413114,v. 01

AFFIDAVIT OF SERVICE BY MAIL

Re: In the Matter of the Medical License of Faruk S. Abuzzahab, M.D.
License No. 17,068

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

Susan Stafne, being first duly sworn, deposes and says:

That at the City of St. Paul, County of Ramsey and State of Minnesota, on September 11, 2000, she served the attached ORDER OF UNCONDITIONAL LICENSE by depositing in the United States mail at said city and state, a true and correct copy thereof, properly enveloped, with first-class postage prepaid, and addressed to:

Faruk S. Abuzzahab, M.D.
Riverside Park Plaza
701 - 25th Avenue South #303
Minneapolis, MN 55454

Sue Stafne
Susan Stafne

Subscribed and sworn to before me
this 11th day of September, 2000.

Sandra R. Thieling
Notary Public

SANDRA R. THIELING
NOTARY PUBLIC - MINNESOTA
MY COMMISSION EXPIRES
JANUARY 31, 2005

indicated that patient #38 was a substance abuser and was unable to function adequately on the medications.

d. On October 22, 1982, patient #38 underwent a chemical dependency evaluation after losing custody of her children (she was required to undergo an evaluation in order to regain custody). During this evaluation, another physician diagnosed patient #38 with "chemical abuse and dependency." It appears that the recommended 3-day evaluation could not be funded, however, so Respondent discharged the patient on this same date. In his discharge summary, Respondent failed to list chemical abuse/dependency as one of the patient's diagnoses. Respondent discharged patient #38 on the same medications which she had been taking on admission (including pentazocine 300 mg., diazepam 30 mg. daily, and chloral hydrate 2 gm daily) despite being told by consultants that these drugs should be stopped.

e. On February 11, 1982, August 4, 1982 and August 29, 1983, Respondent complied with patient #38's request for early renewal of controlled substances when told that the previous prescription had been lost or stolen.

f. On more than one occasion, Respondent renewed prescriptions with large supply of potentially lethal medications shortly after a serious suicide attempt. For example, on June 10, 1982, patient #38 was admitted to the hospital after overdosing on amitriptyline. Respondent discharged patient #38 on June 13, 1982, with the following medications: amitriptyline 100 mg. HS #10 (5 refills); chloral hydrate 1 gm HS + 1x repeat #25 (5 refills); pentazocine 50 mg. prn up to t.i.d. #25 (5 refills); and diazepam 10 mg. t.i.d. #25 (5 refills). Then, approximately two weeks later, on June 29, 1982, he prescribed patient #38 75 tablets of 150 mg. of Amitriptyline, a highly lethal supply.

g. On or about November 2, 1983, patient #38 committed suicide on an overdose of medication.

16. Patient #40 was a psychiatrically vulnerable patient diagnosed with paranoid schizophrenia whom Respondent placed into an investigational drug study without ensuring