STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE BOARD OF MEDICAL PRACTICE

STIPULATION AND
ORDER

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

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 Universiry 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

F. Abuzzahab, Jr.
FARUK S. ABUZZAHAB, M.D.
Respondent

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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 14th day of July, 1998.

MINNESOTA BOARD OF
MEDICAL PRACTICE

Edward H Tuck

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