BEFORE THE MINNESOTA
BOARD OF MEDICAL PRACTICE

In the Matter of the
Medical License of
Martin C. Hinz, M.D.
Date of Birth: 1/15/54
License Number: 31,670

STIPULATION
AND ORDER

IT IS HEREBY STIPULATED AND AGREED, by and between Martin C. Hinz, M.D.,
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.

2. Respondent has been advised by Board representatives that he may choose to be
represented by legal counsel in this matter. Respondent has chosen to be represented by David
P. Bunde, Fredrikson & Byron, P.A., 1100 International Center, 900 Second Avenue South,
Minneapolis, MN 55402-3397, (612) 347-7000. The Committee was represented by Paul R.
Kempainen, Assistant Attorney General, 1400 NCL Tower, 445 Minnesota Street, St. Paul,
Minnesota 55101, (651) 296-7575.

Background

3. Respondent's history with the Board includes the following:
   a. Respondent graduated from the University of Minnesota Medical School
      in 1983. In July 1983, Respondent began residency training in Family Practice in Waterloo,
      Iowa. Respondent left the residency program after completing one year of the three-year

b. On April 8, 1996, the Board issued a Stipulation and Order suspending Respondent’s license to practice medicine and surgery due to mental impairment. Pursuant to the Order, Respondent’s license remained suspended until he could provide satisfactory evidence he was able to practice medicine with reasonable skill and safety to patients.

c. In October 1996, Respondent petitioned the Committee for removal of the suspension on his medical license.

d. On December 12, 1996, Respondent appeared before the Committee to discuss competence issues raised by a practice audit and Respondent’s petition for removal of the suspension. Following the conference, the Committee requested that Respondent submit to a comprehensive evaluation through the Professional Assessment Program (“PAP”) at Abbott Northwestern Hospital in Minneapolis, Minnesota, and complete a practice skills assessment at the Colorado Personalized Education for Physicians (“CPEP”).

e. Respondent completed the PAP evaluation and was found to be stable and fit to resume practice. Respondent also completed the CPEP practice skills assessment. The assessment results revealed Respondent needed improvement in the areas of new medications; follow-up of diabetic complications; medication side effects and interactions; and focused lab testing rather than complete, inclusive screening tests. The assessment also revealed that at times Respondent believed he understood all of the cases when, in fact, he overlooked important issues. Respondent completed an education plan through CPEP to address the practice concerns raised by the assessment.
f. On September 13, 1997, the Board approved an Amended Stipulation and Order ("1997 Order"), which lifted Respondent’s suspension and imposed limitations and conditions on Respondent’s license to practice medicine.

g. On March 13, 1999, the Board approved a Second Amended Stipulation and Order ("1999 Order"). The 1999 Order continued the limitations and conditions already in place and reprimanded Respondent for violations of the 1997 Order, including failure to obtain a treating physician, failure to establish a relationship with a supervising physician and practicing as a solo practitioner.

h. On February 18, May 4 and May 25, 2000, the Committee notified Respondent of allegations regarding his care of a number of patients. Respondent provided written responses to the allegations and met with the Committee on March 16 and on June 15, 2000, to discuss the allegations.

i. In December 2000, Respondent referred himself for another skills assessment by CPEP.

j. In March 2001, Respondent provided the Committee the results of his December 2000 CPEP assessment. Following a review of the CPEP report, Respondent and the Committee agreed to the following facts, statutes and remedy.

FACTS

4. 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. However, it is the intent of the parties that this stipulation and the facts set forth herein shall have no collateral estoppel effect, res judicata effect or other preclusive effect, and no evidentiary value in any action or proceeding in any forum or process other than proceedings
before the Minnesota Board of Medical Practice or another authorized licensing board or licensing agency. Nothing in this paragraph shall limit or affect the Board's obligation to fulfill any reporting requirements.

Patient #1

a. Respondent saw patient #1 (YOB: 1925 -- female) on October 13, 1997, and for five visits from October 20 through November 17, 1998. Respondent departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice in his care of patient #1, including, but not limited to the following:

1) Respondent failed to provide the minimum standard of care in regard to patient #1's primary care needs. For example, Respondent failed to perform or recommend a Pap smear to patient #1, failed to recommend an annual mammogram, although patient #1 reported her sister had a history of breast cancer, and failed to provide routine vaccinations.

2) On October 20, 1998, Respondent saw patient #1 for complaints of laxative abuse, depression and abdominal cramping. Respondent diagnosed patient #1 as having obsessive-compulsive disorder (OCD). Respondent noted in his plan that he would refer patient #1 for a gastrointestinal consult in a few weeks. Respondent did not document making such a referral. At patient #1's next visit on October 27, 1998, Respondent prescribed Luvox, a medication indicated for treatment of OCD. Respondent's diagnosis and treatment of patient #1 for OCD was not supported by an appropriate evaluation or clinical findings.

3) Patient #1's clinic medical record documents a history of a fasting cholesterol of 258 and an LDL of 182 in May 1996. From October 1997 through
November 1998, Respondent did not document addressing patient #1’s high cholesterol or ordering a cholesterol screen.

**Patient #2**

b. Patient #2 (YOB: 1944 -- female) was seen by Respondent in January and February 1996 for weight management. The patient had a history of hypertension and was on Procardia XL 30mg. Patient #2 was treated at Respondent’s clinic with fenfluramine and phentermine from about May 1996 through September 1997. Respondent resumed care of patient #2 in November 1997 and provided weight management and primary care of patient #2. Respondent departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice as follows:

1) Respondent did not appropriately treat patient #2’s hypertension. For example, on September 9, 1998, patient #2 had a blood pressure of 180/96. Respondent diagnosed hypertension but failed to make a reference to treatment. On October 30, 1998, patient #2’s blood pressure was 178/86. Respondent did not address treatment in his progress note.

2) Respondent failed to appropriately evaluate or follow up on patient #2’s abnormal liver function test results. For example, on April 28, 1998, patient #2’s SGOT was 112 and her SGPT was 89 and on May 29, 1998, patient #2’s SGOT was 118 and her SGPT was 85. The normal ranges for these tests are SGOT 1-45 and SGPT 1-50. Respondent told the Committee that he did not view these results as being very high elevations of liver functions. Respondent failed to document by exclusion possible causes of patient #2’s elevated liver function, such as hepatitis C or drug-induced hepatic abnormalities, as the patient was on Isoniazid (INH) that could cause these problems.
3) Respondent diagnosed patient #2 as having bronchospasm and bronchitis despite the lack of objective findings to support these diagnoses. On November 2, 1998, patient #2 came to the clinic complaining of shortness of breath and asthma. Respondent’s exam found “lungs clear.” On November 4, Respondent examined patient #2 and documented “Lungs clear.” For both of these visits, Respondent’s assessment was bronchospasm and bronchitis. Respondent stated in his March 2000 conference with the Committee that he knew the “classic hallmark of bronchospasm is expiratory wheeziness.” In addition, Respondent treated patient #2’s bronchospasms by administering two different broncho-inhalers, Ventolin and Metaproterenol, twenty minutes apart, which can cause a patient’s potassium to fall. Respondent told the Committee that he was not aware that large doses of bronchial dilators can cause the patient’s potassium to fall.

4) Respondent failed to diagnose patient #2’s congestive heart failure in a timely manner. Respondent saw patient #2 seven times between October 29 and November 16, 1998. During this time, patient #2 was experiencing shortness of breath, and Respondent treated patient #2 for cold and bronchial symptoms. Respondent prescribed patient #2 inhalers, Solu-Cortef IM, Prednisone, Rocephin, Dynabac, Biaxin and Cipro, in addition to continuing the patient on Celexa, phentermine and Tenuate for weight management. Respondent was aware of patient #2’s history of having taken fenfluramine and phentermine and should have been aware of the risk of cardiac valvular disease in such patients. Respondent did not refer patient #2 for a cardiology consultation until after a November 18, 1998, chest x-ray showed cardiomegaly.
5) Respondent failed to appropriately address patient #2’s elevated cholesterol level, identified as 214 on the April 28, 1998, screen and as 241 with LDL of 150 on November 13, 1998.

6) Respondent failed to document discussing with patient #2 the results of blood chemistry screens drawn on April 28 and May 29, 1998.

Patient #3


1) Respondent departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice when he failed to perform or document whether he recommended a Pap smear or other primary screening labs, including a mammogram, for patient #3.

2) Respondent failed to appropriately prescribe medications to patient #3. Respondent’s prescribing of multiple pain medications and combinations of narcotics and NSAIDs to patient #3 over a short period of time did not meet the minimum standard of care. For example:

   a) On August 27, 1998, Respondent saw patient #3 for knee pain and lower back tenderness. He prescribed #20 Percodan, one every 8-12 hours and #30 Empirin #3, 1-2 every 4-6 hours. Respondent told the Committee that he intended the patient to take Empirin #3 during the day and Percodan only at bedtime. However, Respondent’s documentation for August 27 and subsequent dates (see paragraphs b) and c) below) does not document this advice.

c) On September 8, 1998, Respondent saw patient #3 for knee pain and prescribed #30 Percodan, one every 6-8 hours, and #30 Empirin #3, 1-2 every 4-6 hours. On September 15, 1998, Respondent added #30 Lodine XL 500mg and amitriptyline to patient #3’s drug regimen and noted the Empirin #3 dose as 2 every 4 hours.

d) On September 22, 1998, Respondent prescribed #40 Empirin #3, 1-2 every 3-4 hours, and advised patient #3 to continue on Halcion and Percodan “1 qhs as needed.” On September 28, 1998, Respondent provided prescriptions for #30 Lodine XL, #30 amitriptyline, #40 Empirin #3, 1-2 every 3-4 hours as needed, and #30 Percodan, one every 6-8 hours.

e) On October 28, 1998, following patient #3’s arthroscopic knee surgery, Respondent noted the patient had 4-5 Halcion left. Respondent prescribed Indocin, Percodan and Dalmane. On November 4, 1998, Respondent prescribed Lodine, Dalmane and Trazodone to patient #3. On November 11, 1998, Respondent increased patient #3’s Trazodone from 50mg to 100mg, and also prescribed Dalmane, #40 Percodan (see paragraph 3)b) immediately below), #40 Empirin #3 and Lodine.

f) On December 4, 1997, Respondent prescribed Zoloft, an anti-depressant, to patient #3 with no documented reason.

3) Respondent improperly managed patient #3’s medical record, including the following examples:
a) As of June 24, 1999, Respondent had not dictated notes for his last two visits with patient #3 on February 3, and 17, 1999.

b) Respondent’s November 11, 1998, note does not reference a prescription for Percodan; pharmacy records reflect a prescription for #40 Roxiprin (a generic form of Percodan) was dispensed pursuant to Respondent’s prescription.

c) Respondent’s December 23, 1998, note lists several prescriptions but does not list #30 Vicoprofen and #15 morphine sulfate dispensed pursuant to Respondent’s prescription of that date.

Patient #4


1) Respondent departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice, including the following:

a) Respondent failed to appropriately manage patient #4’s diabetes in that he failed to appropriately address patient #4’s proteinuria and a creatinine of 1.5, although both are significant problems in a diabetic and possible signs of early renal failure. Patient #4 had elevated creatinine levels in lab reports dated December 22, 1995, August 6, 1996, February 26 and September 17, 1998.

b) Respondent failed to appropriately treat patient #4’s hypertension. Patient #4’s blood pressure was documented to be above 140/90 on numerous
occasions, including 202/98 on February 19, 1998, 184/90 on February 26, 1998, and 182/84 on March 5, 1998. Respondent told the Committee that patient #4 went on and off her hypertension medication. However, Respondent’s progress notes do not document this non-compliance and do not mention any instructions by Respondent to patient #4 that she needed to stay on the medication. Because of renal insufficiency and proteinuria, good blood pressure control is paramount to good diabetes management.

c) Respondent failed to identify a significant change in patient #4’s EKGS over a three-year period. Patient #4 had an EKG on December 20, 1995, and another EKG on February 26, 1998. Regarding the latter EKG, Respondent wrote “NSR, no acute or chronic changes.” However, changes from the earlier EKG were significant, including inverted T waves inferiorly and laterally, as well as voltage criteria for ventricular hypertrophy. Respondent failed to recognize previous myocardial infarction with EKG changes.

d) Respondent’s care of patient #4’s venostasis ulcers was substandard. Respondent saw patient #4 numerous times during 1998 and documented complaints of recurrent venostasis ulcers which were slow to resolve. Respondent placed patient #4 on a diuretic, however he did not document recommending other measures to treat the venostasis ulcers, such as leg wraps, elevation of the legs and salt restrictions.

2) Respondent improperly managed patient #4’s medical record by failing to accurately and/or completely document laboratory test results and medications he prescribed to patient #4. For example:

a) Respondent circled abnormal results on patient #4’s laboratory test results, and sometimes indicated orders on the lab test print-out regarding
medications to address abnormal results. However, Respondent failed to consistently document results of the laboratory tests and his interventions in his progress notes.

b) Respondent failed to accurately document his prescribing of patient #4's antihypertensive drugs. For example, on September 18, 1997, another physician noted patient #4 was on Captopril 50mg per day with good blood pressure control. On February 19, 1998, Respondent noted patient #4 was taking Captopril 25mg per day, with no indication of when or why the dosage was decreased. In addition, patient #4's dosage between March and August 1998 was noted to be increased or decreased several times without documentation as to when or why the changes were made. Respondent stated that the Captopril 25mg dose was a documentation error.

c) Respondent failed to accurately and completely document his prescribing of patient #4's hypothyroid medication. On October 29, 1997, Respondent noted: “[W]ill decrease her Synthroid to 0.15 mg.” From March 19 until September 1998, Respondent did not list Synthroid as one of patient #4’s current medications. On September 10, 1998, Respondent noted the patient was continued on Synthroid .15mg qAM. At his March 16, 2000, conference with the Committee, Respondent was asked about the absence of Synthroid in numerous notes regarding patient #4’s current medications. Respondent stated that the patient was on 0.2mg of Synthroid and had been for many years.
Patient #5

e. In November 1997, Respondent assumed patient #5’s medical care (YOB: 1926 -- female). Patient #5’s history included asthma, right total hip replacement, lumbar laminectomy and frequent headaches.

1) Respondent departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice, including the following:

   a) From December 1997 through November 1998, patient #5 received ten “trigger-point” injections of Celestone. Often, muscles were injected rather than tendons or bursae, which is the standard treatment for inflammatory changes in joints or bursae. Respondent’s documentation and responses to the Committee at his March 2000 conference indicate that he is unaware of the current definition of “trigger points.” Respondent failed to demonstrate an understanding of proper trigger point therapy or physiology.

   b) On January 15, 1998, patient #5 presented with a chief complaint of asthma, shortness of breath and blood pressure of 196/110. Respondent immediately started 5mg of Verapamil, slow IV push, which is not the standard of care for treatment of acute hypertension in the clinic setting.

   c) On October 26, 1998, Respondent diagnosed patient #5 as having migraines, although objective findings supporting this diagnosis are not found in Respondent’s notes. Respondent’s written response states that this diagnosis “was a carry forward” from his diagnosis made at a September 10, 1998 visit. At that visit, Respondent stated that patient #5 described unilateral throbbing headaches, a “Classic migraine picture.” However, on September 10, Respondent documented no other symptoms of migraine, such as, how long the headache lasted, severity of the pain, nausea, or sensitivity to light, sound or smell.
2) Respondent failed to appropriately prescribe patient #5’s medications. For example, Patient #5’s clinic record contains a report by a neurologist who evaluated the patient on April 30, 1998. The neurologist’s impression was tension headaches and he advised no further use of Darvon or narcotics for headaches. Patient #5 was seen by another clinic physician from April through July 1998. This physician provided two #20 Demerol prescriptions, a narcotic, to patient #5 through July 1998. Respondent assumed care of patient #5 in September 1998 and prescribed Darvocet #20 on September 8 and Imitrex #3 on September 10. On October 26, 1998, Respondent continued patient #5 on Demerol, despite the neurologist’s recommendation to the contrary.

Patient #6


1) Respondent departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice. For example:

a) Respondent did not obtain a medical or family history for patient #6.

b) Respondent listed cluster headaches as a diagnosis for patient #6, although he documented no specific symptoms such as pupillary changes or watery eyes which would support such a diagnosis. Respondent’s written response states that cluster headaches was a diagnosis patient #6 “had with him when he came to the clinic.” Respondent told the Committee that he had never diagnosed cluster headaches himself.
On July 28 and August 28, 1998, Respondent changed his diagnosis of patient #6's headaches to "migraines," although no objective findings supporting this diagnosis are found in Respondent’s notes.

d) Respondent documented that patient #6 had a "significant cocaine use and abuse history going back 16 years, but he has not used any cocaine for the last 6-7 years except for occasionally." Respondent failed to document a referral of patient #6 for a chemical dependency assessment of his cocaine use.

2) Respondent improperly managed patient #6’s medical record by failing to document the indication for medications he prescribed to patient #6. For example:

a) On or about June 30, 1998, Respondent began prescribing Propecia (finasteride) to patient #6 with no documented reason. Belatedly, on August 28, 1998, Respondent notes that Proscar (also finasteride) is being prescribed for alopecia.

b) On July 28 and August 28, 1998, Respondent prescribed "Tizac" to patient #6 for no documented reason. On September 28, 1998, Respondent again prescribed "Tizac" to patient #6; in the September 28 note, "Cardizem" is handwritten next to "Tizac." Apparently, Respondent had been prescribing Tiazac (not Tizac), which is a hypertension medication identical to Cardizem. On November 3, 1998, Respondent noted "Cardizem CD was lowered to 180mg q AM." Respondent never documented a reason for prescribing Cardizem to patient #6. Respondent’s written response states he provided samples of "Tizac" and then samples of Cardizem to patient #6 because he thought a calcium channel blocker would help the patient’s cluster headaches.
c) On June 30, 1998, Respondent started patient #6 on Zoloft for no documented reason. Respondent’s diagnoses for that visit were “Cluster headache” and “Insomnia.”

d) On September 28, 1998, Respondent started patient #6 on Celexa with no documented reason. Respondent’s note also states “Tizac for his nails.” At the previous visit, Respondent had prescribed Grisactin for patient #6’s nails. “Tizac 240mg qd” was also prescribed for an unspecified reason.

Patient #7

g. Patient #7 (YOB: 1946 -- female) was first seen by Respondent on May 28, 1998, with a complaint of urinary incontinence, and a history of bipolar disorder, an intestinal bypass and chronic diarrhea.

1) Respondent departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice, including the following:

a) Respondent’s care of patient #7’s bipolar disorder was substandard. Respondent failed to document his rationale for the diagnosis and failed to document whether it was Type I or II. Respondent failed to document whether he obtained a past treatment or medication history regarding the patient’s bipolar disorder. Respondent’s written response states he accepted the patient’s report of the bi-polar diagnosis, and that: “[T]o differentiate bipolar illness is something [sic] that we rely on psychiatric consult for (something this lady was not interested in).” However, Respondent prescribed 5-HTP to patient #7 for her bipolar disorder and in a number of subsequent visits stated the patient was being seen for “recheck of her bipolar disorder.”
b) On October 7, 1998, patient #7 complained of depression. Respondent failed to document a suicide risk assessment or change his treatment plan to address the depression.

c) On August 13, 1998, Respondent described patient #7 as hypomanic and sleep deprived since she was sleeping only three to four hours per night. Respondent failed to perform a mental status exam but encouraged patient #7 to sleep and prescribed Trazodone 50mg qhs.

d) Patient #7's blood chemistry of May 28, 1998, reflected a triglyceride level of 226, which Respondent failed to evaluate or treat.

e) Respondent failed to appropriately follow up on patient #7's history of intestinal bypass and chronic diarrhea. For example, Respondent failed to document patient #7's vitamin B12 levels or other electrolytes that should be followed and monitored after bypass surgery.

f) On May 28 and June 4, 1998, patient #7 reported menopausal symptoms. Respondent failed to discuss or offer hormone replacement therapy.

g) On May 28, 1998, patient #7's creatinine was 1.2 and there was protein in her urine. On August 28, 1998, patient #7's creatine was 1.3. Respondent failed to address or treat the elevated levels, which may be indications of early renal disease.

2) Respondent failed to properly prescribe medications to patient #7. Respondent prescribed 5-HTP and L-Tyrosine to patient #7 in addition to the St. John's Wort and Black Cohash she was already taking to treat her bipolar disorder. This combination of drugs is not the standard of care for treatment of bipolar disorder.
Patient #8

h. Patient #8 (YOB: 1949 -- female) first saw Respondent for weight-management treatment on June 3, 1998. Respondent departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice as follows:

1) On June 3, 1998, Respondent diagnosed patient #8 as having obsessive-compulsive disorder with no other assessment than Respondent’s OCD history questionnaire developed by Respondent and completed by the patient. Respondent’s diagnosis and treatment of patient #8 for OCD was not supported by an appropriate evaluation or clinical findings.

2) Patient #8 reported a family history of coronary artery disease. Patient #8’s blood chemistry on June 3, 1998, revealed elevated cholesterol of 245 with LDL of 163 and HDL of 47.7. Respondent failed to further evaluate patient #8’s high cholesterol and did not document that he discussed the high cholesterol result with the patient at her next visit.

3) Patient #8’s blood chemistry on June 3, 1998, also revealed an elevated creatine of 1.5 and mild proteinuria. Respondent failed to follow up or monitor these abnormal lab results, and did not document discussing the results with the patient.

4) On June 19, 1998, patient #8 reported poor sleep, nausea, anxiety, panic attacks with hyperventilation and increased stress. Patient #8 told Respondent she had not experienced these symptoms before starting his weight-loss program; however, Respondent denied that the symptoms could be caused by the drugs he prescribed. Rather, he noted “serotonin depletion syndrome” and increased patient #8’s Luvox to 150mg per day, and continued Tenuate at 75mg per day.
5) Patient #8 terminated her care with Respondent following the June 19, 1998 visit. On the advice of another physician, patient #8 discontinued the medications prescribed by Respondent. Patient #8’s symptoms of poor sleep, nausea, anxiety, panic attacks with hyperventilation and increased stress resolved shortly thereafter. When patient #8 told Respondent she had consulted with another physician about the symptoms she was experiencing, Respondent became upset and told patient #8 she could not see two physicians.

**Patient #9**

i. Respondent saw patient #9 (YOB: 1968 -- female) for weight-management treatment from March 18 through June 12, 1998. On March 18, 1998, Respondent diagnosed patient #9 with an eating disorder, placed her on an 800-calorie diet, and prescribed Luvox 50mg and phentermine 15mg per day. These were later increased to Luvox 100mg and phentermine 60mg per day. Respondent departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice as follows:

1) On May 27, 1998, patient #9 reported bruising, including six to seven lesions that measured two to three centimeters. Respondent failed to inquire if the bruises resulted from trauma or abuse. Respondent ordered a CBC and platelets but no pro-time. Patient #9’s CBC revealed a WBC (white blood count) of 10,800 with 74.9 polys, 9.8 percent monos and 8.9 percent eos. The absolute eosinophil count was 961, about twice the upper limit of normal. Respondent failed to evaluate the lab results or follow up with INR or other bleeding studies and made no changes in the patient’s medication.

2) There is no indication in the medical record that Respondent informed patient #9 of these abnormal lab results.
Patient #10

j. Patient #10 (YOB: 1936 -- female) first saw Respondent on March 12, 1998. The patient’s medical history included unstable angina, rheumatoid arthritis, chemical burns to her face, chest and hands in 1997, and an allergy to penicillin. The patient’s reported medications were Nitrostat as needed and Isosorbide Moni 20mg BID. Patient #10’s clinic record contains a copy of an emergency room report dated February 11, 1998, when the patient was seen for chest pain. The report states the patient’s symptoms could be angina, possibly unstable angina. Respondent departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice including, but not limited to, the following examples:


2) Respondent failed to appropriately evaluate patient #10’s rheumatoid arthritis. Respondent often listed rheumatoid arthritis on patient #10’s problem list, but did not order a work-up of the rheumatoid arthritis. Respondent diagnosed patient #10’s joint pain complaints as bursitis and treated her with steroid injections.

3) Respondent inappropriately diagnosed patient #10 as having congestive heart failure [CHF]. On May 20, 1998, Respondent diagnosed patient #10 as having mild CHF, based on a chest x-ray that showed mild cephalization. On May 27, 1998, patient #10 was seen by a cardiologist who reported to Respondent that: “[T]he possibility that she has coronary artery disease does remain relatively high[,]” and recommended patient #10 receive a
Thallium stress test. The cardiologist did not diagnose CHF. On May 28, 1998, Respondent examined patient #10 and wrote: “HEENT neg. Neck supple. Lungs clear. Heart nml. Chest x-ray today revealed cephalization is cleared...” Respondent listed “CHF” in the patient’s problem list and carried this diagnosis throughout his care of patient #10. Respondent did not document clinical findings to support this diagnosis, such as hypoxia, edema, jugular venous distention, increased rate, rales, murmurs, gallop, or abnormal EKG.

4) On April 16, 1998, Respondent wrote: “Also complains of epigastric pain and is wondering if her ulcer is back.” Patient #10 had not listed a history of an ulcer on her medical history form and Respondent did not document any other evaluation of the epigastric pain. Nevertheless, Respondent listed “Peptic Ulcer Disease” as a diagnosis and commenced prescribing Zantac to patient #10.

Patient #11

k. Patient #11 (YOB: 1961 -- female) was seen by Respondent from February 27 through August 11, 1998. Respondent treated patient #11 for chronic pain, depression and weight management. Respondent departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice as follows:

1) On February 27, 1998, Respondent first saw patient #11 for a complaint of shoulder pain and noted the patient was requesting a cortisone shot. The only medical history Respondent documented was that patient #11 had suffered from heel spurs for 4-5 years. From February 27 through March 26, 1998, Respondent saw the patient five times and ordered 11 Celestone (a corticosteroid) injections for various points on patient #11’s body. From June 2 through August 11, 1998, Respondent ordered 14 Celestone injections for various points on patient #11’s body. Respondent diagnosed heel spurs, bursitis and cervical strain to
support these injections, however, he did not perform a work-up to rule out rheumatoid arthritis, lupus or other significant arthritic problems. Respondent also failed to document discussing possible side effects of cortisone with patient #11.

2) On March 20, 1998, patient #11 complained of poor sleep, low energy, and poor ability to concentrate, and told Respondent she had been taking Prozac. Respondent failed to document previously that he reviewed patient #11’s history of taking Prozac. Respondent listed depression as a diagnosis, although there is no indication he made an independent evaluation to support this diagnosis. Respondent discontinued Prozac and prescribed Luvox, a medication indicated for treatment of obsessive-compulsive disorder. Later, Respondent added Trazodone to patient #11’s medications.

3) Respondent’s medical records for patient #11 contain a copy of lab results from another clinic dated December 11, 1997. Patient #11’s cholesterol level is reported as 254 with an LDL of 167. There is no indication in Respondent’s records that he ever discussed or followed up on patient #11’s elevated cholesterol.

4) On March 20, 1998, Respondent notes that a thyroid panel was drawn. The report of this panel was not in Respondent’s medical records for the patient. However, a thyroid panel ordered by Respondent on May 6, 1998, is in the patient’s file. The T3 Uptake result was low, 25.1 (normal range 27.8-40.7). Respondent initialed the lab report but did not comment on the results in his subsequent progress note.

5) On April 2, 1998, Respondent diagnosed patient #11 with obsessive-compulsive disorder, with no assessment other than his OCD history questionnaire completed by the patient. Respondent’s diagnosis and treatment of patient #11 for OCD was not supported by an appropriate evaluation or clinical findings.
Patient #13

1. Patient #13 (YOB: 1941 -- male) first presented to Respondent on May 22, 1998, complaining of paralysis on the left side of his face. Patient #13 had a history of neck pain and pain between his shoulders, knee pain, restless leg syndrome, obesity and post 1996 stomach stapling. Respondent’s written response identifies his diagnoses for patient #13 as including Bell’s Palsy, Ramsey Hunt Syndrome, Herpes Simplex, depression, obsessive-compulsive disorder, chronic pain syndrome, Ménière’s Disease, hypertension, anxiety, parietal neuralgia, de Quervain Syndrome and gastroesophageal reflux disease.

1) Respondent departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice as follows:

   a) In a clinical lab report of a specimen drawn June 2, 1998, patient #13’s triglycerides were noted to be 289 (normal range 40-199). Respondent failed to treat or address the elevated level. Respondent’s written response states that this was a non-fasting triglyceride and the patient was on active weight loss. However, through November 18, 1998, Respondent did not order a repeat test to confirm that dietary control was lowering patient #13’s triglycerides.

   b) Respondent failed to document or address an elevated GGT level of 117 (normal range 8-62) on June 2, 1998. Respondent’s written response characterizes this as a “mild elevation of the GGT” and states he opted to “watch and wait.” However, through November 18, 1998, Respondent did not order a repeat screen.

d) From May 22 through November 18, 1998, Respondent saw patient #13 for 26 weight management visits. During this time period, Respondent prescribed phentermine 90mg per day and, starting on October 23, 1998, Tenuate 75mg per day. Respondent also prescribed Luvox that was increased to 300mg per day on October 2, 1998, then replaced by Celexa. The patient initially weighed 271 pounds and lost fourteen pounds during this time period, which represents a 5 percent loss on several weight-loss drugs. Respondent’s decision to continue the extensive use of drugs with this degree of weight loss is not supported.

2) Respondent failed to properly prescribe medications to patient #13 as follows:

a) From May 29, 1998 through early August 1998, Respondent prescribed large amounts of narcotic medications to patient #13 for recurrent headaches. In this period of time, Respondent provided prescriptions for #230 Darvocet-N100 (propoxyphene napsylate and acetaminophen), approximately 3.5 per day and #290 Lortab 7.50/500mg (hydrocodone and acetaminophen), approximately 4 per day. In addition, from June through early August 1998, Respondent provided prescriptions for #230 Halcion, approximately 4 per day and #320 Soma. This quantity and combination of narcotic drugs and another analgesic are not indicated for simple headaches and increases the risk for side effects.

b) On August 10, 1998, patient #13 was seen by a neurologist. The neurologist’s report to Respondent states, in part:

I’m concerned about the patient’s headaches... I think he needs to have repeat imaging of the brain... I think the study will be negative, in which case one would have to be [sic] especially concerned about possible rebound headache secondary to excessive use of narcotics. It sounds to be the case that he’s using an inordinate amount of narcotic analgesia... and I certainly wouldn’t be surprised that he would have chronic daily headaches
as a result... This was discussed with him and the importance of tapering off the narcotic was emphasized.

c) On August 20, 1998, Respondent saw patient #13 and noted "Patient was given refills of Lortab, Darvocet, and Percodan as charted for his headaches. Discussion about the recommendations of [consulting neurologist] was noted." However, from mid-August through November 1998, Respondent failed to follow the recommendation of the neurologist regarding tapering narcotics. During this period of time, Respondent provided prescriptions to patient #13 for #220 Darvocet-N100, approximately 3.2 per day; #520 Lortab 7.50/500mg, approximately 5.4 per day; #54 Percodan (hydrocodone and ibuprofen); and #150 Vicoprofen (oxycodone and aspirin). In addition, from mid-August through November 1998, Respondent provided prescriptions for #380 Halcion, nearly 4 per day and #550 Soma. Respondent failed to recognize potential abuse in this patient.

**Patient #14**


1) Respondent departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice as follows:

a) A laboratory report of a chem-screen panel drawn on April 15, 1998, reflects that patient #14 had triglycerides of 240 (normal range 40-199) and total cholesterol of 276 (above 239 is high risk). Respondent did not document that he informed the patient of his triglyceride or cholesterol levels. There is no indication Respondent considered or implemented medication to reduce patient #14's cholesterol or triglyceride levels. Respondent
failed to perform a repeat cholesterol workup on patient #14 to ascertain if the weight-management program reduced the cholesterol or triglyceride levels.

b) Respondent diagnosed patient #14 as having obsessive-compulsive disorder. No documentation or assessment to support such a diagnosis was found in patient #14’s clinic record.

2) Respondent improperly managed patient #14’s medical record. For example, there are no progress notes for patient #14’s visits on April 15, May 3, 8, 22, 29, and June 12, 1998. The only documentation for each of these visits is an OCD and Eating Disorder Management Form and, for some visits, a computer generated “OCD Treatment Report.” For patient #14’s last three visits, June 19 and 26, and July 3, 1998, there is only a computer generated weight management progress note.

Patient #15

Patient #15 (YOB: 1965 -- female) presented to Respondent on May 20, 1998. Patient #15 was legally deaf, post hysterectomy and appendectomy and had a history of migraines. Respondent treated patient #15 for bilateral knee pain. Respondent failed to properly prescribe medications to patient #15 as follows:

1) From March 27 to August 18, 1998, Respondent provided eight bottles of Stadol nasal spray (a narcotic analgesic) to patient #15 for migraine headaches. Respondent saw patient #15 for the last time on April 16, 1998. Patient #15 moved to a different town.

2) On August 11, 1998, a prescription for Stadol with two refills was authorized by Respondent and sent to patient #15. Respondent’s written response states that the patient had been treated with Stadol by a previous physician and added: “I do not agree with
maintaining this patient on Stadol, but did feel her pain to be real in the brief period of time I worked with her.”

**Patient #16**

o. Patient #16 (YOB: 1935 -- male) first presented to Respondent on October 2, 1997, with neck and back pain from a motor vehicle accident. Respondent departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice, including the following:

1) On August 5, 1998, patient #16 complained of a recurrence of fungal toenails and Respondent documented: “Nail beds on great toes bilaterally showed fungal infestation once again.” Respondent provided griseofulvin to patient #16 for six months to treat the onychomycosis. Respondent failed to order base-line liver function tests (LFTs), and failed to order a CBC or follow up on the liver functions during the six-month period patient #16 received griseofulvin therapy. Respondent did not document discussing precautions and possible side-effects of griseofulvin therapy. Respondent did not state how he monitored the possible side-effects of griseofulvin, in the absence of follow-up LFTs and CBC.

2) Respondent’s assessment and documentation of patient #16’s chest pain does not meet the minimum standard of care. Respondent had not discussed angina in his progress notes for numerous visits since he began seeing patient #16 on October 2, 1997. Then, on September 11, 1998, Respondent saw patient #16 and documented: “He has no further chest pain during the last two years” and added “Angina pectoris” to the patient’s problem list. There is no reason stated in Respondent’s note as to why the subject of angina was raised at this visit. Respondent’s written response states the angina diagnosis “goes back for many years ... and was a carry-forward from his previous physician.” Respondent did not state whether any work-
up of patient #16’s angina had been done at his clinic or explain why he listed “Angina pectoris” in two subsequent notes on September 16 and 22, 1998. In addition, on September 22, 1998, Respondent wrote: “Notes he has had no further chest pain since seen last.” There was no mention of chest pain in Respondent’s notes of the September 16, 1998 visit.

3) On September 16, 1998, patient #16 requested a blood pressure check. Respondent failed to check patient #16’s blood pressure as requested.

Patient #18

Patient #18 (YOB: 1938 -- male) was first seen by Respondent on April 28, 1995, with a complaint of obesity and was seen by Respondent for weight management and other medical care through February 1996. Respondent documented a history of diabetes, hypertension, major affective disorder, sleep apnea, hypercholesterolemia, bronchitis, Verruca Vulgaris and benign prosthetic hypertrophy. Respondent resumed weight management and primary care of patient #18 in October 1997.

1) Respondent departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice when he diagnosed patient #18 with obsessive-compulsive disorder, without performing an appropriate assessment. In progress notes dated December 29, 1997 and January 12, 1998, Respondent noted “OCD” in patient #18’s list of diagnoses. There is nothing in the record to support a diagnosis of OCD on these dates. Respondent’s own assessment tool for diagnosing OCD, an OCD history questionnaire, was not completed by patient #18 until January 26, 1998.

2) Respondent failed to properly prescribe medications to patient #18, including, but not limited to, the following examples:
a) On February 10, 1998, Respondent stated patient #18 was started on BuSpar 15mg, one-half tablet bid for impotence. This was the first time impotence was noted in the chart. There were no subjective findings in the record and no diagnostic work-up regarding impotence. BuSpar, according to the PDR, is to be used to treat generalized anxiety disorder. There is no reference to its use for treatment of impotence.

b) Patient #18 had a documented history of alcohol abuse and polydrug issues. Respondent demonstrated poor management of narcotic medications by prescribing Tylenol #3 for patient #18. On October 18, 1998, patient #18 was admitted to the hospital on an emergency hold after he was thought to have discharged a firearm in a suicide gesture. Respondent's records contain a copy of the hospital discharge summary that states, in part, that patient #18 had been self-medicating with alcohol and Tylenol #3 prescribed by Respondent.

**Patient #21**


1) Respondent departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice when he failed to appropriately diagnose and treat a skin rash patient #21 developed while under his care, as more fully described below.

a) On November 3, 1998, Respondent diagnosed patient #21 as having an obsessive-compulsive disorder based on Respondent's OCD questionnaire
completed by the patient. Patient #21 told Respondent she did not think she had OCD. Respondent told patient #21 that OCD was the diagnosis insurance companies might cover for weight loss treatment.

b) Shortly after starting to take weight management medications, supplements and vitamins prescribed by Respondent, patient #21 developed a rash on her face that spread to arms, legs and buttocks. Patient #21 complained to Respondent about this rash at her visits of November 17 and 24, and December 1 and 8, 1998. Respondent denied that patient #21 complained to him about the rash at these visits and did not document such complaints in the medical record.

c) On December 30, 1998, Respondent’s notes reference the rash for the first time: “Pt. comes into clinic for rash on her arms and torso. Notes rash has been present for the last week.” Respondent wrote that his exam: “Reveals heavily excoriated rash consistent with scabies on the arms and torso but due to the degree of excoriation difficult to fully diagnose... small abscess on the medial aspect of the right and left thighs...” Respondent drained two abscesses on patient #21’s legs and diagnosed: “Non-specific dermatitis.” Respondent prescribed an antibiotic and Kwell lotion. (Kwell is the brand name of lindane, an insecticide used to treat scabies.)

d) On January 5, 1999, Respondent saw patient #21 for the last time and discussed the rash with the patient. Patient #21 told Respondent she had not used the Kwell lotion because the precautions on the label advised against applying the lotion to open sores. During this appointment, Respondent allegedly became angry with patient #21, pointing at her and stating: “If you want me to be your doctor you’ll do what I say.” Respondent disputes this allegation.
e) On January 14, 1999, patient #21 went to the emergency room for treatment of her rash and was told the rash was not scabies. She went to a dermatologist the same day, who told her to discontinue all medications prescribed by Respondent. Patient #21’s rash resolved shortly thereafter; however, she had complications and scarring that required plastic surgery.

2) Respondent improperly managed the medical record for patient #21 by failing to dictate notes in a timely manner and by failing to maintain an accurate record. Examples include, but are not limited to, the following:

a) On November 3, 1998, Respondent’s notes state he prescribed #14 Tenuate 75mg and #14 Celexa 20mg. Pharmacy records reflect #21 Tenuate and #21 Celexa were prescribed and dispensed.

b) Respondent’s November 17, 1998, documentation is contradictory. Respondent stated patient #21’s medication dosages were unchanged; yet, documentation shows he prescribed a double dose of phentermine from the previous week.

Patient #23


1) Respondent departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice in diagnosing and treating patient #23, as more fully described below.
a) On February 6, 1998, Respondent diagnosed patient #23 as having obsessive-compulsive disorder with no assessment other than Respondent’s Patient Eating Questionnaire completed by patient #23. Respondent’s diagnosis and treatment of patient #23 for OCD was not supported by an appropriate evaluation or clinical findings.

b) On August 28, 1998, Respondent’s progress note states, in part:

[Patient #23] comes into clinic for recheck of her numerous medical problems. Reports she has had no further panic attacks as of recently. Anxiety is much better. Depression is less. She is sleeping well at night. She generally feels better. . . .


This progress note is the first time depression, panic attacks and anxiety are documented in Respondent’s progress notes for patient #23 from February 6, 1998. There is no indication as to when Respondent made these diagnoses or of the assessments he performed to support these diagnoses. Respondent failed to document whether patient #23 was receiving ongoing psychological counseling for her depression and OCD.

c) On February 6, 1998, when patient #23 restarted weight management under Respondent’s care, she weighed 176.5 pounds. Patient #23 initially lost weight, 14 pounds as of August 28, 1998. However, from that date forward, patient #23 began to regain the weight she lost and, as of November 15, 1999, she weighed 178.3 pounds. Respondent’s prescribing of two anorectics, Phentermine 60mg per day and Tenuate 75mg per day for well over one year with no weight loss, does not meet the minimum standard of care.

2) Respondent failed to properly prescribe medications to patient #23, including but not limited to the following examples:
a) On April 3, 1998, Respondent added Naltrexone 50mg to patient #23's daily regimen with no documented reason. Naltrexone is indicated for use in chemical dependency treatment. Respondent continued prescribing Naltrexone to patient #23 until August 28, 1998, when a dictated progress note states the medication was discontinued, though no reason is stated for discontinuing the medication.

b) Respondent prescribed Zoloft and Celexa to patient #23 concomitantly. For over a month, patient #23 was taking the maximum recommended daily dose of both drugs. Zoloft and Celexa are both selective serotonin reuptake inhibitor (SSRI) antidepressants. The maximum recommended daily dose of Zoloft is 200mg per day and, of Celexa, 60mg per day. On October 19, 1998, patient #23 was taking Zoloft 200mg daily, and Respondent added Celexa 20mg without decreasing the Zoloft. On November 13, 1998, Zoloft was decreased to 100mg daily while Celexa was increased to 40mg daily, however thereafter, Respondent increased rather than tapered the Zoloft. By December 18, 1998 and January 20, 1999, Respondent was prescribing Celexa 60mg and Zoloft 200mg daily.

c) From May 24, 1999 through September 2, 1999, Respondent prescribed Celexa 80mg per day to patient #23. As noted above, Celexa 60mg per day is the maximum recommended daily dose.

3) Respondent failed to maintain a complete and accurate medical record for patient #23, including, but not limited to, the following examples:

a) Respondent has no progress notes for patient #23's eight clinic visits from February 6 through April 3, 1998.

b) On May 15, 1998, patient #23's "OCD and Eating Disorder Form" states that the patient's "Current Meds" (i.e., medications patient was on prior to the visit)
included “Phentermine 90 mg[,]” while the OCD Treatment Report Form states that at the May 15 visit the phentermine 60mg dose prescribed was “not changed” from the previous visit.

c) On July 3, 1998, Respondent apparently discontinued phentermine and initiated Tenuate, with no stated reason for the change. Respondent’s OCD progress note and the Treatment Report Form both state, “Tenuate Not Changed 75mg per day[,]” although there was nothing to change since Tenuate had not been prescribed previously.

Patient #24

s. Patient #24 (YOB: 1958 -- female) first presented to Respondent for weight management treatment on April 7, 1999. Respondent’s progress note states he performed a complete history and physical and that patient #24 had a history of cervical cancer. Patient #24’s only current medication noted was Prozac.

1) Respondent departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice in his care of patient #24 as follows:

a) On April 7, 1999, Respondent diagnosed patient #24 as having obsessive-compulsive disorder, with no assessment other than Respondent’s OCD history questionnaire completed by the patient. Respondent’s diagnosis and treatment of patient #24 for OCD was not supported by an appropriate evaluation or clinical findings.

b) Respondent’s notes for his complete physical exam of patient #24 on April 7, 1999, did not document whether the patient had had a hysterectomy. The exam did not include a pelvic exam or Pap smear, despite the patient’s history of cervical cancer. Respondent’s written response states that the patient was seen only for weight management and that Respondent is not the patient’s primary care physician. However, Respondent’s records do not reference a primary care physician and there is no indication that Respondent communicated
with the patient #24’s primary care physician when he diagnosed her with other medical problems, such as hypertension.

c) Respondent’s problem list for patient #24 includes “hypertension”; however, Respondent did not document when or on what basis he made this diagnosis. In the “Meds Sent Home On” section of patient #24’s OCD Eating Disorder Form dated July 16, 1999, a notation states: “d/c Maxid.” However, there is no medication known as “Maxid.” Furthermore, Respondent failed to document previously when or why “Maxid” was prescribed to patient #24 or why he decided to discontinue the medication at this visit.

d) Respondent ordered lab tests for patient #24, which were drawn on April 7 and October 15, 1999. On April 7, 1999, patient #24’s glucose was 67. On October 15, 1999, her glucose was 129 and the lab report noted: “Results suggest a provisional diagnosis of diabetes.” Respondent did not document that he discussed the test results with patient #24 or that he followed up on the increased glucose level.

2) Respondent improperly managed the medical record of patient #24. For example, Respondent maintained almost no record of clinic visits that apparently took place on October 15 and November 5, 1999, and January 19, 2000. For these dates, the date of the visit and the patient’s weight are noted on a piece of paper titled “Morgan Park Clinic Weight Management Program.” In addition, for these dates there are brief, unsigned notes recording patient #24’s temperature, pulse, blood pressure, medications, etc., and an occasional one-word comment such as “maintenance.”

Patient #25

t. Patient #25 (YOB: 1952 -- male) first presented to Respondent for weight management treatment on April 7, 1999. Respondent’s progress notes state he performed a
complete history and physical and that patient #25 had a history of tendonitis and eczema and smoked a pack of cigarettes per day. Patient #25’s only current medication was noted as Prozac. Respondent’s medical care of patient #25 departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice as more fully described below.

1) On April 7, 1999, Respondent’s “complete” physical examination of patient #25 did not include a rectal exam or hernia evaluation. Patient #25 also complained of sexual dysfunction. Respondent, however, treated the dysfunction without documenting an examination of the genital or rectal area.

2) From April 7, 1999, until January 20, 2000, Respondent failed to discuss smoking cessation with patient #25.

3) On April 7, 1999, Respondent’s progress notes document that BuSpar was prescribed for sexual dysfunction. BuSpar is labeled for use in the management of anxiety disorders or for short-term relief of anxiety symptoms. Treatment of sexual dysfunction is not a labeled use for BuSpar.

Patient #26


1) Respondent’s medical care of patient #26 departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice. For example, on April 16, 1998, Respondent diagnosed patient #26 as having obsessive-compulsive disorder, with no assessment other than Respondent’s OCD history questionnaire completed by the patient.
2) Respondent failed to maintain a complete and accurate medical record for patient #26, including, but not limited to, the following examples:

   a) On June 25, 1998, the OCD Eating Disorder Form notes patient #26's current daily medications as Luvox 200mg and phentermine 60mg. A Treatment Report dated “6/25/98” at the top, and incorrectly dated “6/19/98” on the signature line, documents that the Luvox prescription of 200mg was “Not Changed.” At the next visit on July 9, 1998, the OCD Eating Disorder Form notes Luvox 200mg as the patient’s current daily dose; however, the OCD progress note and the Treatment Report state: “LUVOX NOT CHANGED 100mg. per day.” Respondent’s dictated progress note state: “Pt continued on Luvox 100mg qAM...”

   b) On November 25, 1998, Respondent prescribed Luvox, phentermine and Tenuate to patient #26. At the next visit on December 8, 1998, the prescriptions for phentermine and Tenuate are not mentioned on either the OCD progress note or the Treatment Report. At the following visit, however, on January 6, 1999, phentermine and Tenuate appear on the OCD progress note and Treatment Report as prescribed and “Not Changed” from the previous visit.

Patient #27


   1) Respondent’s medical care of patient #27 departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice. For example, patient #27’s clinic medical records contain a copy of Respondent’s OCD history questionnaire completed by the patient on January 20, 1999. Respondent diagnosed obsessive-compulsive
disorder based on the patient’s questionnaire with no other assessment documented. Respondent’s diagnosis and treatment of patient #27 for OCD was not supported by an appropriate evaluation or clinical findings.

2) Respondent failed to maintain a complete and accurate medical record for patient #27. For example, on May 28, 1999, the comments section of patient #27’s Treatment Report contains a handwritten note that states, “Labs drawn.” Respondent billed patient #27’s insurance carrier for a comprehensive metabolic panel, lipid panel and routine venipuncture on this date. Respondent did not have a progress note for this date and did not document why the labs were drawn. There are no lab results for this date in the patient’s clinic medical record, and there is no indication that test results were discussed with patient #27.

**Patient #28**

Patient #28 (YOB: 1953 -- male) first presented to Respondent for weight management treatment on May 26, 1999. Patient #28 had a history of angioplasty of three different vessels, stent placement in the left anterior descending coronary artery in 1995, and hypercholesterolemia. Respondent provided weight management and other medical care for patient #28 through at least January 6, 2000. Respondent’s care of patient #28’s hypercholesterolemia departed from the minimal standard of acceptable and prevailing medical practice, including the following:

1) On May 26, 1999, Respondent first saw patient #28 and noted the patient was on Zocor, a cholesterol-lowering medication. A laboratory test ordered that day showed the patient’s cholesterol was 197 (normal range 120-199). There is no indication whether this was a fasting or non-fasting test.
2) On August 26, 1999, the patient requested cholesterol testing which resulted in a cholesterol reading of 221. On September 8, 1999, Respondent prescribed Lipitor, a cholesterol-lowering agent, with no record that the patient’s Zocor had been discontinued.

3) On September 23, 1999, Respondent apparently discontinued patient #28’s Lipitor. His progress note for September 23, 1999, states: “Cholesterol was drawn and pending... Will use dietary management for now on his cholesterol.” Respondent’s written response states: “On September 23, 1999 the cholesterol level now fasting and on Lipitor was found to be (sic) 140 and after discussion with the patient it was opted to once again discontinue the (sic) Lipitor and have the patient simply concentrate on a low fat diet with subsequent monitoring.” However, the laboratory report with the results of the September 23, 1999 test states the specimen was received on September 24, 1999. Thus, Respondent could not have discussed the results of this test with the patient on September 23, 1999, nor could he have made the decision on that date to discontinue the Lipitor based on the 140 cholesterol result, as he stated in his written response.

4) Patient #28’s records through January 6, 2000, do not contain the results of a cholesterol screen ordered by Respondent to monitor whether dietary management was effective in maintaining cholesterol in the normal range.

Patient #29

1) Respondent departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice in his care of patient #29. Specifically, Respondent failed to appropriately assess and diagnose patient #29's hyperthyroidism as more fully described below.

a) A laboratory report of specimens drawn on October 11, 1995, reflects several abnormal test results, including a TSH-3rd Generation result of .35 (normal range 0.40-4.20). Respondent did not document discussing the abnormal lab results with patient #29 at her next visit, and there is no indication that he evaluated or followed up on the results.

b) On November 5, 1997, patient #29 presented with complaints including depression, poor concentration, energy level and appetite, gastrointestinal reflux, skin lesions, back and knee pain, and weight gain. Respondent diagnosed “Major Affective Disorder.” He prescribed phentermine 15mg qAM and Zoloft 100mg 1/2 qAM and placed the patient on a 900 calorie-per-day-diet.

c) On or about November 7, 1997, Respondent received a laboratory report of patient #29's November 5, 1997, lab tests. Respondent circled and initialed two abnormal results, an elevated cholesterol of 221, and a TSH-3rd generation result of 0.29 (0.40-4.20 normal range). Respondent did not document that he discussed these results with patient #29 and did not repeat the thyroid panel until March 2000.

d) On December 16, 1998, patient #29 reported sinus pain and pressure along with flu-type symptoms and PMS. Her pulse rate was 120. Respondent did not address her elevated pulse rate in his progress note. Respondent ordered a CBC, and a chem-screen panel was ordered at the patient's request.
e) On December 30, 1998, patient #29 came to the clinic complaining of weakness, flu-type symptoms, a dry cough, sinus tachycardia and diarrhea. Respondent documented a pulse of 140 and performed an EKG, noting: “Sinus tachycardia on EKG was noted with no acute changes. Pt is given 10mg of Nifedipine PO in the clinic. After 20 minutes the heart rate was down to 90-100.” Respondent performed no further work-up of the PSVT. Respondent continued Inderal LA 80mg qAM, although his notes do not state whether the Inderal is for mouth sores or tachycardia. Respondent’s dictated progress note states he advised the patient to discontinue phentermine and Tenuate for the next few days. However, Respondent’s OCD Treatment Report and weight management progress note reflect that the patient's Tenuate was “Not Changed” at 75mg per day, and phentermine was “Not Changed” at 45mg per day. In addition, Respondent provided patient #29 with written prescriptions for Tenuate and phentermine dated December 30, 1998.

f) On January 6, 1999, patient #29 saw Respondent and reported upper respiratory problems and racing pulse. Respondent examined patient #29 and noted: “Lungs clear. Heart [normal] with tachycardia of 140. EKG revealed supraventricular tachycardia ("SVT"). [Patient] had IV started with D5W and was given Verapamil IV Push followed by another 5mg IV push. Five minutes later [patient] subsequently reverted NSR with a rate of 80-90.” Respondent did no further work-up of the SVT. He increased patient #29’s Inderal from 80mg to 160mg, decreased Celexa to 20mg qAM, started Zoloft 50mg qAM and discontinued the Tenuate and phentermine.

g) On January 8, 1999, Respondent saw patient #29 and documented that the patient was taking Inderal 160mg per day and had a pulse of 100.
Respondent noted that the upper respiratory infection “apparently has cleared” and that the patient was “complaining of sleep problems... sleeping only 2-3 hours a night.”

h) On January 27, 1999, patient #29’s pulse was documented as 114 in the vital signs portion of the chart. Respondent’s dictated progress note states: “[Patient’s] pulse was in the 100-110 range.” Respondent wrote, “encouraged [patient #29] to take her Inderal LA 160mg qAM. She has just been taking it intermittently. She apparently whenever she takes it on a regular basis her pulse slows down to about 70 she reports.” Respondent continued patient #29 on Zyrtec and Zoloft, and provided prescriptions for phentermine and Tenuate to take if her weight increased by four pounds. Respondent did no further work-up of patient #29’s tachycardia and scheduled her to return to the clinic in two months.

i) Patient #29’s condition worsened throughout February 1999, including watery eyes, loss of bowel control and exhaustion. After researching her symptoms, the patient concluded she might be hyperthyroid and made an appointment to see Respondent on March 10, 1999. On March 10, Respondent ordered a thyroid panel that revealed results of T4, total 20.8 (reference range: 4.5-12.5); T3 uptake 47.0 (reference range: 27.8-40.7); T4 free 9.8 (reference range: 1.6-3.7) and TSH: less than 0.01 (reference range: .40-4.20). Respondent referred patient #29 to an endocrinologist who diagnosed patient #29 as having “moderately severe hyperthyroidism due to Graves’ disease.”

2) Respondent failed to maintain adequate and accurate medical records for patient #29 including, but not limited to, the following examples:

a) Numerous discrepancies and inaccuracies in Respondent’s documentation make it impossible to track when certain medications were prescribed to
patient #29 and/or to accurately identify the daily dose of prescribed medications. Examples include, but are not limited to, the following:

i. On September 30, 1998, patient #29's OCD eating disorder form lists Zoloft 200mg as a current medication, and Respondent's dictated progress note states "Zoloft 200mg qAM." However, the September 30 weight management progress note and Treatment Report list Zoloft as "Not Changed" at 150mg per day. Respondent states that the 150mg entry was a transcription error.

ii. On October 28, 1998, Respondent’s dictated progress note states Tenuate 75mg per day was started; however, the weight management progress note and Treatment Report list Tenuate as "Not Changed 75mg per day." Respondent states that the "Not Changed" entry was a transcription error.

b) Respondent’s progress note for patient #29’s March 10, 1999, visit is initialed by Respondent at the bottom of the note where it states that the note was dictated on March 10, 1999. The note states, in part: "Lab work revealed that she was hyperthyroid." The laboratory report referenced in this note reflects that patient #29’s specimens drawn on March 10 were received by the laboratory on March 11, 1999. Respondent could not have dictated the progress note that contained lab results on March 10 as he so represented in the medical record.

Patient #31

y. Patient #31 (YOB 1934; male) was first seen by Respondent on November 24, 1997. Patient #31’s medical records from his previous clinic document a history and diagnoses of chronic obstructive pulmonary disease, asthma, CVA in 1994, and hypertension. In March 1999, a medical center discharge summary received by Respondent
identified patient #31 as having a history of chronic alcoholism. Respondent provided primary care to patient #31 through at least May 2000.

1) Respondent departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice in his care of patient #31. Specifically, Respondent's care of patient #31's pneumonia was substandard as follows:

a) On November 8, 1999, patient #31 came to the clinic complaining of shortness of breath, non-productive cough and increasing dyspnea on exertion. Respondent diagnosed patient #31 with pneumonia. The patient received Alupent and Ventolin Nebulizers, Solu-Cortef 250mg IM and Rocephin 1 gram IM and was started on an 8-day course of Prednisone. The patient then received Rocephin 1 gram IM on November 9, 10 and 11, 1999.

b) On November 16, 1999, patient #31 returned to the clinic reporting shortness of breath in cold air. Respondent did not dictate a progress note and there are no exam, x-ray or diagnoses noted. The patient received Alupent, Ventolin and Azmacort Nebulizers, Solu-Cortef 250mg IM and Rocephin 1 gram IM that day and Rocephin 1 gram IM on November 17 and 18.

c) On November 19, 1999, patient #31 came to the clinic and Respondent documented: “He is breathing easier . . . No complaints today . . . HEENT neg. Neck supple. Lungs clear. Heart nml.” The patient received Rocephin 1 gram IM and Respondent noted: “He was started on Pen VK 500mg BID #40.” Respondent failed to meet the minimal standard of care by prescribing penicillin to treat patient #31’s pneumonia.

2) Respondent failed to maintain an accurate and complete medical record for patient #31. For example, as of May 1, 2000, when patient #31’s medical records were subpoenaed by the Board, progress notes for visits of February 9, March 1, 3, 6, 21, 24 and
April 7, 2000, were not included in the patient’s medical record. Respondent’s written response states the progress notes for the dates listed above “had been dictated and transcribed in a timely manner but were sitting on the record for final posting and not taken...Copies of the records are enclosed with this response.” Respondent did not explain what caused the lengthy delay in “final posting” of progress notes for visits that occurred in February, March and April 2000.

Patient #32

z. Patient #32 (YOB 1938; female) was first seen by Respondent on November 24, 1997. Patient #32’s medical records from her previous clinic documented diagnoses of hypertension, hypothyroidism and multiple sclerosis. Patient #32’s medications included Vaseretic, Synthroid, Premarin, amitriptyline, Cylert, amantadine, Valium and a Betaseron 0.3 mg injection every other day. Respondent provided primary care and weight management treatment to patient #32 through at least May 2000.

1) Respondent departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice in his care of patient #32, including the following examples:

a) Respondent failed to appropriately address patient #32’s high cholesterol and triglyceride results. For example, patient #32’s cholesterol was 260 on December 17, 1997; 393 on December 31, 1997; 235 on October 14, 1999; and 360 on February 4, 2000. Patient #32’s triglycerides were 1237 (normal range 50-250) on December 17, 1997; 345 on October 14, 1999; and 1361 on February 4, 2000. Until May 1, 2000, when Respondent prescribed Lipitor, Respondent failed to discuss these results with patient #32 or to document that he recommended any intervention to address the patient’s elevated cholesterol and triglycerides. This placed patient #32 at risk for developing serious health problems such as
heart disease and pancreatitis. Respondent told the Committee that he thought records from the patient’s previous treating physician indicted that she had refused cholesterol-lowering agents at some time in the past.

b) Respondent prescribed two and sometimes three different diuretics to patient #32 every day. For example, on February 2, 2000, Respondent prescribed Spironolactone 1 pill qAM, Lasix 40mg qd and Vaseretic 10/25 - 1qAM. Respondent stated that he had inherited this prescribing from patient #32’s previous prescribing physician and was unable to explain to the Committee his rationale for continuing the patient on multiple diuretics. Respondent’s records clearly document that he added the Spironolactone to patient #32’s regimen without discontinuing other diuretics. In addition, Respondent’s prescribing of the Spironolactone once a day is not the usual dosing; it is usually dosed twice a day and sometimes four times a day.

c) Respondent’s use of multiple Solu-Cortef injections to treat patient #32’s multiple sclerosis flare-ups is not the standard of care. Respondent failed to appreciate that Solu-Cortef, a short acting steroid, is not a therapeutic equivalent to Solu-Medrol, a long-acting steroid that is more appropriate for treating exacerbations of multiple sclerosis.

2) Respondent failed to maintain an accurate and complete medical record for patient #32, including, but not limited to, the following examples:

a) On May 4, 2000, patient #32’s entire clinic record was subpoenaed by the Board. The records contain no dictation by Respondent for patient #32’s November 15, 1999 and April 7, 2000 visits. For each of these dates, the clinic record obtained by the Board shows only vitals signs and several words of notes in Respondent’s handwriting. On both dates, the rest of the chart page is blank following these entries.
b) Respondent’s documentation of his prescribing Synthroid to patient #32 is unclear. For example, on January 28, 1998, Respondent authorized a prescription for Synthroid 88 mcg #100 with three refills. However, on May 5, 1998, Respondent documented that the patient “was continued on Synthroid .1mg qAM . . . .” The previous notes do not indicate that the Synthroid dosage was increased. The next reference to Synthroid is on March 16, 1999, when Respondent’s dictated note (which is erroneously dated “3-16-98”) reflects a prescription for Synthroid .088mg qd. Respondent’s documentation does not specify whether patient #32 had been taking Synthroid (at .088 or .1 mg per day) continuously, or if the Synthroid had been discontinued at some point and restarted as of March 16, 1999.

STATUTES

5. 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) (q) and (s) (1998), and Respondent agrees that the conduct cited above constitutes a reasonable basis in law and fact to justify the disciplinary action under these statutes.

REMEDY

6. 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 rescinding and replacing the Second Amended Stipulation and Order issued to Respondent on March 13, 1999, with an order suspending Respondent’s license to practice medicine and surgery in the State of Minnesota.
Such suspension shall be stayed contingent on Respondent’s compliance with each and every
term, condition and deadline set forth in subparagraphs a through n below.

a. By August 1, 2001, Respondent shall have successfully completed or shall be in the process of completing the following courses, approved in advance by the Committee:

1) medical records management course; and
2) pharmacology course.

b. In addition to the above coursework, Respondent shall satisfactorily complete the following reading and related materials.

1) *Rapid Interpretation of EKG’s*, by Dale Durbin. Respondent shall complete this reading before beginning the cardiology rotations referenced in subparagraph d.1) below, and Respondent shall document completion of this requirement in the education log referenced in subparagraph c.7) below.

2) University of Washington *Manual of Medical Therapeutics*, Little, Brown and Company, publisher. Respondent shall read the sections related to each clinical rotation practice area (*see* subparagraphs c through e below) before beginning the rotation and shall refer to and utilize appropriate sections during the rotations. Respondent shall document completion of this requirement in the education log referenced in subparagraph c.7) below.

3) *Medical Knowledge Self-Assessment Program 12* (MKSAP) and assessments. Respondent shall complete the MKSAP 12 sections and assessments related to each clinical rotation (*see* subparagraphs c through e below) immediately after completing the rotation. Respondent shall document progress toward completion of this requirement, including assessment results, for each MKSAP section completed, in the education log referenced in subparagraph c.7) below.
4) The Medical Letter and CME. Respondent shall subscribe to and read the biweekly newsletter, The Medical Letter, and shall enroll in the CME semi-annual, self-examination program offered by The Medical Letter/Yale University School of Medicine. Respondent shall submit to the Committee documentation of progress toward completion of this requirement on an on-going basis in the education log referenced in subparagraph c.7) below, and shall provide the Committee with verification of his successful completion of the examinations associated with The Medical Letter CME program.

c. Respondent shall successfully complete twelve (12) clinical rotations in the practice/specialty areas and with the objectives described in subparagraph d below. At least six weeks in advance of the anticipated starting date of each proposed rotation, Respondent shall submit a written proposal to the Committee that identifies the rotation preceptor, clinical site(s) and rotation description. Each rotation shall include, and the rotation proposal shall address, the following:

1) Each rotation shall be two consecutive weeks of full-time practice at a pre-approved clinical practice site under the direction of a pre-approved physician preceptor.

2) Respondent's proposal for each rotation must be signed by the proposed preceptor, indicating that the preceptor has received a copy of and reviewed this Stipulation and Order, and agrees to supervise Respondent and conduct the rotation in accordance with the rotation objectives and evaluation requirements contained herein.

3) Each rotation and proposal must include an academic component (e.g., readings, CMEs and textbooks) and clinical experience to address the objectives listed in subparagraph d below.
4) In addition to other specified clinical rotation requirements, Respondent shall accompany the preceptor on all hospital rounds, consultations, and clinic activities during each rotation.

5) Each rotation must include a plan for on-going preceptor assessment of Respondent’s performance.

6) The preceptor for each rotation shall submit a written evaluation of Respondent’s performance, including commentary on Respondent’s progress in addressing the rotation objectives and a specific statement by the preceptor whether Respondent’s performance was satisfactory or unsatisfactory. Respondent is responsible for ensuring that the preceptor’s evaluation is submitted to the Board within three weeks of the date the rotation is completed.

7) Respondent must submit to the Committee an education log for each clinical rotation, within two weeks of the date the rotation is completed. The education log shall document Respondent’s completion of all required reading and related activities, assessments or tests appropriate to the rotation (see subparagraph b above), address the academic and clinical experience Respondent gained in the rotation, and include Respondent’s self-assessment of his performance in the rotation.

8) Respondent agrees to use such forms for rotation proposals, preceptor evaluation and education logs as directed by the Committee.

d. Respondent shall complete the twelve clinical rotations in the practice/specialty areas listed below. The clinical rotations shall include, but shall not be limited to, the learning objectives stated below.

1) Two clinical rotations in Cardiology completed with a board certified Cardiologist preceptor. Learning objectives shall include:
a) Understand how to interpret common EKG rhythms
b) Understand basic principles of treating CHF in primary care
c) Understand the treatment and management of common rhythm problems (e.g., atrial fibrillation, PSVT, acute MI and ischemic changes on EKGs)
d) Recognize and treat angina/unstable angina/and non-cardiac chest pain
e) Manage cardiovascular risk factors
f) Gain a general understanding of Beta blockers, Calcium blockers, nitrates, and basic anti-arrhythmic medication as they would apply to family practice

2) Two clinical rotations in Pulmonology completed with a board certified Pulmonologist. Learning objectives shall include:

a) Gain insight and understanding into the treatment of asthma
b) Gain insight and understanding into the treatment of COPD
c) Evaluate a chest x-ray as it would apply to family practice
d) Understand diagnoses/differential diagnoses of commonly acquired lung infections
e) Be able to evaluate and complete an appropriate work-up of a patient who complains of shortness of breath
f) Develop a primary care insight into pulmonary embolism, including an understanding of risk factors and prevention techniques

3) Two clinical rotations in Internal Medicine completed with a board certified Internal Medicine physician. Learning objectives shall include:

a) Gain an understanding of general health maintenance and preventive care screening exams (e.g., common immunizations, weight control, smoking cessation, mammograms, diabetes testing and treatment, blood pressure control, cholesterol testing, and flexible sigmoidoscopies)
b) Gain insight into common drug interactions in polypharmacy patients
c) Gain insight into the appropriate work-up for fatigue, weight loss, anemia, and dyslipidemia
d) Gain insight into the appropriate work-up for newly diagnosed hypertension and management of chronic hypertension
e) Gain insight into the indications for commonly ordered lab tests (e.g., CBCs, electrolytes, UAs, Microalbumens, Lipid profiles, PSAs, chest x-rays, EKGs, TSHs, Hemoglobin A1Cs, Rheumatoid factors and FANAs)
f) Gain insight into treating aged and terminally ill patients as well as chronic disease states

4) Two clinical rotations in Family Practice completed with a board certified Family Practice physician. Learning objectives shall include:

a) A special focus on “Routine Health Maintenance” evaluations
b) Gain an understanding of how to manage primary hypertension
c) Evaluate and appropriately work-up headaches, and gain an understanding of commonly used treatment modalities
e) Gain insight into assessment of the walk-in patient who complains of chest pain, abdominal pain, anemia, and/or fatigue
f) Gain insight into the appropriate work-up for and management of simple musculoskeletal disorders such as sprains, strains and chronic pains
g) Gain insight into appropriate management of obese patients who have other medical illnesses
h) Gain insight into appropriate work-up and treatment of edema

5) One clinical rotation in Gastroenterology completed with a board certified Gastroenterologist. Learning objectives shall include:

a) Gain insight into examination and testing of the patient with abdominal pain
b) Gain insight into approaching the patient with positive guaiac test results
c) Formulate differential diagnoses for diarrhea or constipation, and select appropriate laboratory tests
d) Gain insight into assessment of the patient with abnormal liver function tests and be able to formulate a differential diagnosis
e) Gain insight into when it is appropriate to refer patients for specialty work-ups in GI
f) Gain insight into the work-up for and treatment of GERD and its complications
g) Gain an understanding of the risks for colorectal and esophageal cancers and make appropriate preventative health care recommendations
h) Gain an understanding of common GI infections as they would apply to family practice

6) One clinical rotation in Infectious Diseases completed with a board certified Infectious Disease physician. Learning objectives shall include:
a) Gain insight into common community acquired infections and appropriate treatment modalities
b) Gain insight into ordering diagnostic cultures as well as an understanding of how to base therapy on the results
c) Gain insight into treatment of community acquired pneumonia
d) Gain insight into the selection of appropriate antimicrobial treatments
e) Gain insight into treatment of neutropenic patients
f) Understand antimicrobial drug classes and their uses

7) One clinical rotation in Endocrinology completed with a board certified Endocrinologist. Learning objectives shall include:

a) Gain insight into commonly ordered tests as they apply to primary care
b) Gain insight into evaluating and treating common thyroid disorders
c) Gain insight into management of diabetes, including ordering appropriate tests and recommending preventative care for diabetes
d) Gain insight into treatment of dyslipidemia
e) Gain insight into diagnosing and treating osteoporosis
f) Gain insight into management of obesity

8) One clinical rotation in Psychiatry completed with a board certified Psychiatrist with expertise in diagnosing, treating and managing eating disorders (e.g., through the HCMC or Mayo eating disorders clinic). Learning objectives shall include:

a) A special focus on understanding the proper diagnosis and treatment of obsessive-compulsive behavior
b) Gain insight into diagnosis of and work-up for eating disorders
c) Gain insight into diagnosis of, work-up for, and treatment of major depression

e) Respondent shall adhere to the following requirements for scheduling of clinical rotations.

1) Respondent’s first rotation shall begin no later than August 1, 2001.
2) Rotations shall be scheduled to begin every two months and must be successfully completed within the time frame of this Order.

3) Respondent shall have at least three clinical rotations scheduled and approved by the Committee prior to August 1, 2001. For each remaining clinical rotation, Respondent shall submit the proposal to the Committee no later than six weeks prior to the anticipated starting date of the proposed rotation. Respondent agrees that approval of proposed rotations is at the discretion of the Committee. Approval will be communicated to Respondent in writing.

4) Respondent shall adhere to the schedule of Committee-approved rotation(s). Changes to the approved schedule of rotation(s) must be submitted to the Committee in writing and may be approved at the Committee’s discretion for good cause.

5) Respondent shall repeat any rotation for which he receives an unsatisfactory performance evaluation by a preceptor. Additional rotations shall be completed within the time frame of this Order.

f. In addition to the requirements of each clinical rotation, Respondent shall attend Medical Grand Rounds at least once each month, at a hospital approved in advance by the Committee. Monthly reports regarding Respondent’s attendance shall be submitted to the Committee by hospital personnel.

g. Within three months following Respondent’s successful completion of the required courses, required reading and twelve clinical rotations, and prior to petitioning for reinstatement in accordance with subparagraph m below, Respondent shall arrange to undergo a practice skills reassessment through an assessment program designated by the Committee. Respondent shall be responsible for all costs associated with the assessment.
h. Any practice of medicine by Respondent that is not part of the clinical rotations required above, shall be in a group setting approved in advance by the Committee, which has another physician on site at all times when Respondent is practicing.

i. For any pre-approved group practice setting, Respondent shall meet monthly with a supervising physician, approved in advance by the Committee, to review at least ten percent 10% of Respondent’s patient charts and to discuss Respondent’s patient care decisions. The supervising physician shall provide quarterly reports to the Board regarding the quality of Respondent’s documentation and clinical judgment, including development of differential diagnoses, understanding of pathophysiology, and assessment of and response to abnormal test results. Reports shall specifically address whether Respondent’s documentation lists the patient complaint, examination, diagnosis, treatment plan, response to therapy, and medications prescribed, including directions for use and refills authorized. Reports shall summarize how Respondent is applying in his practice the knowledge and techniques gained through required and recommended coursework. The supervising physician shall immediately notify the Board of any conduct that appears to be in violation of this Order or of the Medical Practice Act.

j. 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 is to review Respondent’s progress under the terms of this Stipulation and Order.

k. Respondent shall be responsible for all expenses incurred in fulfilling the terms and conditions of this Order.
l. Respondent shall pay a $23,000 civil penalty in partial reimbursement of the Board’s investigative costs. The civil penalty amount has been partially reduced in consideration of the expenses incurred by Respondent toward fulfilling the educational requirements of this Order.

m. Upon completion of the requirements of this Order, but no later than three years from the date of this Order, Respondent may petition for reinstatement of an unconditional license. Upon petitioning, Respondent shall appear before the Committee to discuss his petition and his progress under the terms of this Order, as well as the results of the practice skills reassessment. Upon meeting with Respondent, the Committee may recommend that the Board approve an Order of Unconditional Licensure, or issue an Amended Stipulation and Order that imposes conditions and restrictions as deemed necessary to protect the public.

n. The stay of suspension shall be immediately revoked in accordance with paragraphs 9 and 10 below, for the following reasons:

1) Respondent fails to comply with any term or condition of this Order, or

2) After three years from the date of this Order, Respondent is unable to demonstrate that he has satisfactorily completed the requirements of this Order.

7. 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, a list of all states in which Respondent is licensed or has applied for licensure, and the addresses and telephone numbers of Respondent’s residences. Within seven (7) days of any change, Respondent shall provide the Board with the new address and telephone information. The information shall be sent to Robert A. Leach, Minnesota Board of Medical
Practice, University Park Plaza, 2829 University Avenue S.E., Suite 400, Minneapolis, Minnesota 55414-3246.

8. In the event Respondent resides or practices outside the State of Minnesota, Respondent shall promptly notify the Board in writing of the location of his residence and all work sites. Periods of residency or practice outside of Minnesota will not be credited toward 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.

9. If Respondent shall fail, neglect, or refuse to fully comply with each of the terms, provisions, and conditions herein, the license of Respondent to practice medicine and surgery in the State of Minnesota shall be suspended immediately upon written notice by the Committee to Respondent, such a suspension to remain in full force and effect until Respondent demonstrates to the satisfaction of the Committee that he has come into full compliance with each term of this Order.

10. Should Respondent dispute the factual basis for any suspension imposed in accordance with paragraph 9 above, he may appear before the Committee and present affidavits and documents. The Committee may find a violation based on a preponderance of the evidence. The Committee may continue, modify or remove the suspension based on the evidence before them. Respondent may not dispute the remedy imposed. Should Respondent continue to dispute the factual basis for a suspension, he may appear before the Board and present affidavits and documents. The Board may find a violation based on a preponderance of the evidence. The Board's decision shall be final and not subject to appeal or additional procedures under Minnesota Statutes chapters 14 or 214.
11. 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.

12. 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.

13. 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: 4-30-2001

Dated: 5/12-2001

Martin C. Hinz, M.D. For the Committee

Respondent

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 12th day of May, 2001.

MINNESOTA BOARD OF MEDICAL PRACTICE

By:

AG: 470245.v.01
AFFIDAVIT OF SERVICE BY U.S. MAIL

Re: In the Matter of the Medical License of Martin C. Hinz, M.D.
OAH Docket No. 15-0903-13232-2

STATE OF MINNESOTA )
COUNTY OF RAMSEY ) ss.

SANDRA A. BUSH, being first duly sworn, deposes and says:

That at the City of St. Paul, County of Ramsey and State of Minnesota, on May 16, 2001, she caused to be served the STIPULATION AND ORDER, 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:

David P. Bunde, Esq.
Fredrikson & Byron, P.A.
1100 International Centre
900 Second Avenue South
Minneapolis, MN 55402-3397

Subscribed and sworn to before me on May 16, 2001.

SANDRA A. BUSH

NOTARY PUBLIC