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MARCIA J. MENGEL, CLERK
SUPREME COURT OF OHIO

The Supreme Court of Ohio

Glenda M. Dahlquist, M.D.

v.

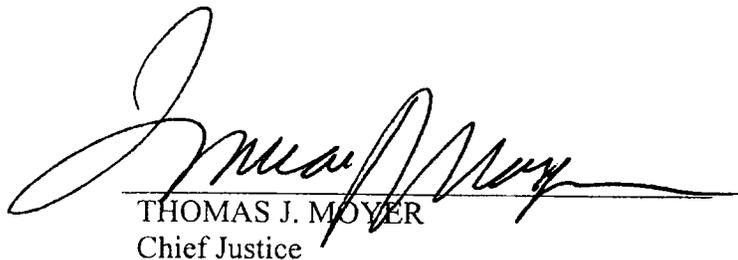
Ohio State Medical Board

Case No. 05-1123

ENTRY

Upon consideration of the jurisdictional memoranda filed in this case, the Court declines jurisdiction to hear the case and dismisses the appeal as not involving any substantial constitutional question.

(Franklin County Court of Appeals; No. 04AP811)



THOMAS J. MOYER
Chief Justice

IN THE SUPREME COURT OF OHIO

Glenda M. Dahlquist, M.D.

Appellant

v.

State Medical Board of Ohio

Appellee

05-1123

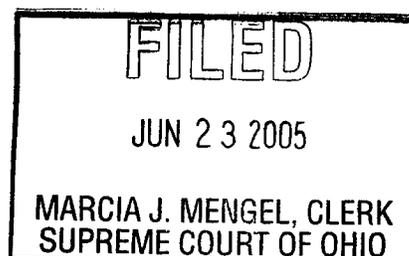
On Appeal from the
Franklin County Court
of Appeals, 10th Appellate
District

Court of Appeals
Case No. 04-AP-811

NOTICE OF APPEAL OF APPELLANT GLENDA M. DAHLQUIST, M.D.

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Glenda M. Dahlquist, M.D.



Notice of Appeal of Appellant Glenda M. Dahlquist, M.D.

Appellant Glenda M. Dahlquist, M.D. hereby gives notice of appeal to the Supreme Court of Ohio from the decision of the Franklin County Court of Appeals, Tenth Appellate District, entered in Court of Appeals Case No. 04-AP-811 on May 10, 2005.

This case raises a substantial constitutional question and is one of public or great general interest.

Respectfully submitted,



Elizabeth Y. Collis
Terri-Lynne B. Smiles
Counsel for Appellant, Glenda
M. Dahlquist, M.D.

Certificate of Service

The undersigned hereby certifies that the true and accurate copy of the foregoing Notice of Appeal was sent by regular U.S. Mail, postage prepaid, to the following counsel for appellee on this 23rd day of June, 2005:

Rebecca Albers
Senior Assistant Attorney General
Health and Human Services Section
30 E. Broad Street, 26th Floor
Columbus, Ohio 43215-3400



Elizabeth Y. Collis
Counsel for Appellant

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IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT

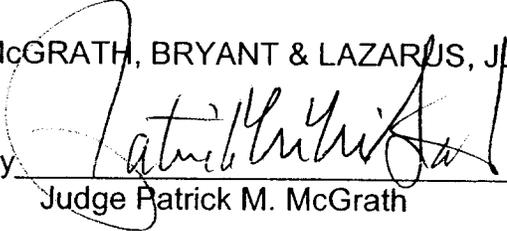
Glenda M. Dahlquist, M.D., :
Appellant-Appellant, :
v. : No. 04AP-811
Ohio State Medical Board, : (C.P.C. No. 04CVF-1708)
Appellee-Appellee. : (REGULAR CALENDAR)

JUDGMENT ENTRY

For the reasons stated in the opinion of this court rendered herein on May 10, 2005, appellant's three assignments of error are overruled, and it is the judgment and order of this court that the judgment of the Franklin County Court of Common Pleas is affirmed. Costs shall be assessed against appellant.

McGRATH, BRYANT & LAZARUS, JJ.

By



Judge Patrick M. McGrath

IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT

Glenda M. Dahlquist, M.D.,	:	
Appellant-Appellant,	:	
v.	:	No. 04AP-811 (C.P.C. No. 04CVF-1708)
Ohio State Medical Board,	:	(REGULAR CALENDAR)
Appellee-Appellee.	:	

O P I N I O N

Rendered on May 10, 2005

Freund, Freeze and Arnold, and Neil Freund, Collis & Collis, L.L.C. and Elizabeth Y. Collis, for appellant.

Jim Petro, Attorney General, and Rebecca Albers, for appellee.

APPEAL from the Franklin County Court of Common Pleas.

MCGRATH, J.

{¶1} Appellant, Glenda M. Dahlquist, M.D., appeals from a judgment of the Franklin County Court of Common Pleas affirming the order of appellee, State Medical Board of Ohio ("board"), permanently revoking appellant's license to practice medicine and surgery in the state of Ohio. For the reasons that follow, we affirm.

{¶2} By letter dated February 13, 2002, the board notified appellant, a pain management specialist, of its intention to initiate disciplinary proceedings against her certificate to practice medicine and surgery in the state of Ohio based upon her treatment of sixteen patients. The board alleged that appellant's treatment of the patients failed to conform to minimal standards of care of similar practitioners under the same or similar circumstances in violation of R.C. 4731.22(B)(6). The board further alleged that in treating the patients, appellant failed to maintain minimal standards applicable to the selection or administration of drugs, or failed to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease in violation of R.C. 4731.22(B)(2) as in effect March 9, 1999. The board also alleged that appellant failed to use reasonable care discrimination in the administration of drugs or failed to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease in violation of R.C. 4731.22(B)(2) as in effect prior to March 9, 1999.

{¶3} Pursuant to appellant's request, an adjudication hearing was held before the board's hearing examiner in October and November 2002. At the hearing, the board offered the medical records of the sixteen patients and the expert testimony of Dr. Paul Shin. Appellant testified extensively on her own behalf and presented expert testimony from Dr. Hal Blatman. In addition, three of appellant's patients testified on her behalf.

{¶4} In November 2003, the hearing examiner issued a 142-page report and recommendation which contained an exhaustive patient-by-patient summary of the facts concerning the medical care provided by appellant, along with a detailed patient-by-patient summary of the testimony of appellant and Drs. Shin and Blatman. The hearing examiner found that appellant prescribed medications in types, amounts, and

combinations that were inappropriate and for protracted periods of time that were not justified, and inappropriately administered injections or blocks. He further found that appellant failed to adequately recognize and address indications of drug abuse or the increased risk of drug abuse. He also found that appellant failed to identify reasonable pain diagnoses, failed to obtain records of the patients' prior or concurrent medical treatment, failed to make necessary referrals for treatment and failed to document the findings of outside specialists. He further found that appellant failed to appropriately document results of toxicology screens, failed to consider whether psychological factors affected patients' pain, failed to obtain or document appropriate liver function studies, and continued to utilize treatment modalities that provided only temporary pain relief.

{¶5} The hearing examiner concluded that appellant's conduct constituted a violation of R.C. 4731.22(B)(6) and 4731.22(B)(2) as in effect both prior to and after March 9, 1999 and recommended permanent revocation of appellant's medical license. After appellant filed objections, the board convened to consider the matter on January 14, 2004. Following discussion, the board amended the hearing examiner's report and recommendation to permit appellant 30 days to wind down her practice and then approved, as amended, the order permanently revoking appellant's certificate to practice medicine and surgery in the state of Ohio.

{¶6} Appellant appealed the board's order to the Franklin County Court of Common Pleas pursuant to R.C. 119.12. The court affirmed the board's order, finding it to be supported by reliable, probative, and substantial evidence and in accordance with law. Appellant has timely appealed that judgment, and advances the following three assignments of error:

[1]. The decision of the Court of Common Pleas should be reversed as the trial court abused its discretion in finding that pursuant to R.C. 4731.22(F)(5) the expert witness for the State did not need to disclose to Appellant conversations that the expert had with Board personnel, which may have led the expert to alter his report and change the expert's opinion prior to testifying at the administrative hearing in this case.

[2]. The decision of the trial court should be reversed as Appellant was denied the right of due process of law by the Board's failure to follow R.C. 4731.052 and O.A.C. 4731-21 et seq. regarding the treatment of patients with intractable pain, holding Dr. Dahlquist instead to an undefined "standard of care".

[3]. The decision of the trial court should be reversed as the trial court abused its discretion when it affirmed the decision of the Board which was not supported by the evidence presented at the hearing.

{¶7} Initially, we note that a court of common pleas is bound to uphold an order of the medical board if the order is supported by reliable, probative, and substantial evidence and is in accordance with the law. *Pons v. Ohio State Med. Bd.* (1993), 66 Ohio St.3d 619, 621; *Hayes v. State Med. Bd. of Ohio* (2000), 138 Ohio App.3d 762, 767. Generally, a common pleas court should defer to administrative resolution of evidentiary conflicts. *General Motors Corp. v. Joe O'Brien Chevrolet, Inc.* (1997), 118 Ohio App.3d 470, 482. Thus, as long as there is reliable, probative, and substantial evidence to support the board's findings, a common pleas court may not substitute its judgment on disputed facts for that of the board. *Id.* Whether any evidence supports the decision is a question of law. *Id.* at 483.

{¶8} Appellate review of an administrative appeal is, however, limited to determining whether the common pleas court abused its discretion. *Pons, supra.* Absent an abuse of discretion, a court of appeals may not substitute its judgment for that of the

board or the common pleas court on issues of fact. However, a court of appeals' review of whether the board's order is in accordance with law is plenary. *Pons*, supra.

{¶9} By the first assignment of error, appellant contends that the common pleas court abused its discretion in finding that a discussion between a board staff member and the state's expert witness, Dr. Shin, was protected by the confidentiality privilege set forth in R.C. 4731.22(F)(5).

{¶10} Dr. Shin testified that at the board's request, he reviewed the sixteen patient files at issue and prepared a written report outlining his opinion as to appellant's treatment and care of those sixteen patients. On cross-examination, Dr. Shin testified that he revised his report following a discussion with a board staff member. Upon the state's objection to appellant's attempt to further question Dr. Shin on the matter, the hearing examiner, citing R.C. 4731.22(F)(5), ruled that appellant was not permitted to question Dr. Shin concerning the identity of the board staff member, the content of his discussion with that individual, or any revisions he may have made to the report pursuant to that discussion. The common pleas court upheld the hearing examiner's ruling, finding it to be "consistent with the statutory provision that such investigations are confidential." (June 29, 2004 Dec., pg. 15). The common pleas court further found that appellant had failed to demonstrate prejudice arising from any alleged error in the hearing examiner's ruling.

{¶11} R.C. 4731.22(F)(5) mandates that the board "conduct all investigations and proceedings in a manner that protects the confidentiality of patients and persons who file complaints with the board." The statute further provides that "[i]nformation received by the board pursuant to an investigation is confidential and not subject to discovery in any

civil action." In *State Med. Bd. of Ohio v. Murray* (1993), 66 Ohio St.3d 527, the Ohio Supreme Court applied this statutory language, formerly found in R.C. 4731.22(C)(1), to the adjudication of a disciplinary matter before a board appointed hearing examiner. The court held that information contained in board records and obtained pursuant to an investigation "is to be kept confidential at all times and is not, under any circumstances * * * discoverable in a civil action." *Id.* at 536.

{¶12} Several groups enjoy a privilege of confidentiality in the board's investigative files. *State ex rel. Wallace v. State Med. Bd. of Ohio* (2000), 89 Ohio St.3d 431, 435. These groups include investigation witnesses, patients, physicians under investigation, and any other person whose confidentiality right is implicated by a board investigation. *Id.* The state argues that the hearing examiner's ruling was correct because Dr. Shin, as an agent for the board under a contract to provide record review and testimony, qualifies as an investigation witness whose testimony is privileged under R.C. 4731.22(F)(5). In contrast, appellant contends that because Dr. Shin was retained by the board only as an expert witness to review the patient files and opine as to whether appellant's treatment practices fell below the applicable standard of care, he does not qualify as an investigation witness under R.C. 4731.22(F)(5). Accordingly, appellant avers that because R.C. 4731.22(F)(5) does not apply to Dr. Shin, he should have been required to testify regarding all the information he gathered in formulating his expert opinion, including his discussions with board personnel. Appellant argues, alternatively, that the board waived its confidentiality privilege when it provided confidential investigative information to Dr. Shin.

{¶13} Assuming, without deciding, that we accept either, or both, of appellant's arguments, we conclude that appellant has not demonstrated how she was prejudiced by the hearing examiner's ruling or how she was unable to defend herself in this matter. The hearing examiner precluded appellant only from inquiring about the identity of the board staff member, the content of that discussion, and the specific revisions Dr. Shin made to the report. The hearing examiner did not preclude appellant from questioning Dr. Shin as to his ultimate opinion about appellant's medical practices, including whether or not that opinion had ever changed over the course of his record review. As well, appellant was not prevented from questioning Dr. Shin about what information he reviewed or relied upon in preparing his report and whether he was influenced by any information other than that referenced in his report in formulating his opinion. Appellant cross-examined Dr. Shin extensively for two days regarding his report and opinion and was thus provided ample opportunity to question him within the parameters of the hearing examiner's ruling. Further, to the extent appellant intended to impeach Dr. Shin by soliciting testimony that he was coached by a board staff member to revise his opinion about appellant's medical practices in a manner that would support the allegations referenced in the notice so that the board could prove its case against appellant, we find that appellant successfully created such an implication through questioning which resulted in the disclosure that the report was revised following discussion with the board staff member. Accordingly, the trial court did not abuse its discretion in upholding the hearing examiner's ruling. The first assignment of error is overruled.

{¶14} By the second assignment of error, appellant contends she was denied her right to due process of law by the board's failure to follow the standards of care set forth in R.C. 4731.052 and Ohio Adm.Code 4731-21 regarding the treatment of intractable pain.

{¶15} A fundamental requirement of due process is notice and the opportunity to be heard in an administrative proceeding which permanently revokes an individual's certificate to practice medicine. *Korn v. Ohio State Med. Bd.* (1988), 61 Ohio App.3d 677, 684. In other words, due process requires the board to furnish a charged individual with sufficient information to enable such person to challenge adverse evidence and respond to the charges. *In re Kralik* (1995), 101 Ohio App.3d 232, 237; *Johnson v. State Med. Bd. of Ohio* (Sept. 28, 1999), Franklin App. No. 98AP-1324.

{¶16} In October 1997, the General Assembly enacted R.C. 4731.052, which addresses a physician's authority to treat intractable pain¹ with dangerous drugs. R.C. 4731.052(B) directed the board to "adopt rules * * * that establish standards and procedures to be followed by physicians in the diagnosis and treatment of intractable pain, including standards for managing intractable pain by prescribing, personally furnishing, or administering dangerous drugs in amounts or combinations that may not be appropriate when treating other medical conditions." Pursuant to that mandate, the board, in November 1998, adopted Ohio Adm.Code Chapter 4731-21, which, inter alia, sets forth a series of standards to be utilized by practitioners specializing in the treatment of intractable pain.

¹ R.C. 4731.052(A)(2) defines "intractable pain" as "a state of pain that is determined, after reasonable medical efforts have been made to relieve the pain or cure its cause, to have a cause for which no treatment or cure is possible or for which none has been found."

{¶17} Dr. Shin testified that in formulating his opinion about appellant's treatment practices, he did not reference or review either R.C. 4731.052 or Ohio Adm.Code Chapter 4731-21. Appellant argues that because Dr. Shin's opinion testimony was based upon prevailing standards of medical care rather than upon the specific standards for treating patients with intractable pain set forth in the statute or rules, she was, in essence, held to an undefined standard of care, and, accordingly, little weight should be given to Dr. Shin's testimony. The state asserts that appellant was not charged with specific violations of R.C. 4731.052 or Ohio Adm.Code Chapter 4731-21 because appellant treated many of the patients at issue prior to enactment of the statute and rules. A review of the record supports the state's assertion - ten of the 16 patients at issue were treated prior to the effective date of the statute; 13 of the 16 were treated prior to the effective date of the rules. Thus, the state argues, Dr. Shin's testimony concerning the prevailing standards of care in the field of pain management was appropriate and supports the board's order.

{¶18} Both parties assert in their briefs that the standard of care for treating patients with intractable pain was established by those physicians practicing pain management prior to the enactment of the statute and rules and that the statute and rules merely codified those standards. Indeed, R.C. 4731.052(C) states that "[t]he physician's diagnosis and treatment decisions shall be made according to accepted and prevailing standards for medical care." Similarly, Ohio Adm.Code 4731-21-02(A) provides that "a practitioner shall comply with accepted and prevailing standards of care which shall include, but not be limited to" those set forth in the rules.

{¶19} Dr. Shin is board certified by the American Board of Anesthesiology with a subspecialty in pain management. After completing the certification process in 1994, he

directed the Pain Management Center at Lakewood Hospital. Eighteen months later, he joined the staff at the Cleveland Clinic and practiced exclusively in the area of pain management. He has been at the Crystal Clinic Surgery Center since 1999 and is currently the Director of Pain Management.

{¶20} At the hearing, Dr. Shin provided detailed testimony about the medical treatment appellant provided to each of the sixteen patients in question. In each case, Dr. Shin opined that based upon the prevailing standards of care in the area of pain management, appellant either failed to conform to minimal standards of care of similar practitioners under the same or similar circumstances, failed to maintain minimal standards applicable to the selection or administration of drugs, or failed to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease or failed to use reasonable care discrimination in the administration of drugs or failed to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease.

{¶21} Moreover, appellant's argument ignores the fact that the board is comprised primarily of physicians and surgeons who are familiar with the prevailing standards of care in the medical profession. In *Murray*, supra, the Ohio Supreme Court addressed the case of a physician the board found to have failed to use reasonable care discrimination in the administration of drugs and failed to conform to minimal standards of care with regard to the prescribing of anabolic steroids to patients for purposes of enhancing athletic ability. Much of the physician's conduct occurred prior to the effective date of the board's rule prohibiting such conduct. The physician maintained that because no medical standards existed regarding steroid use prior to the board's rule prohibiting that conduct,

his alleged failure to meet minimal standards of care prior to the effective date of the rule was not supported by reliable, probative, and substantial evidence due to the lack of expert testimony. The court disagreed, explaining:

Murray also appears to ignore the fact that the board is comprised primarily of experienced health professionals. The legislature and the courts of Ohio have delegated comprehensive decision-making power to the board. Such power includes, but is not limited to, the authority to rely on the board's own knowledge when making a decision * * *.

It is well established that " * * * the board may rely on its own expertise to determine whether a physician failed to conform to minimum standards of care." *Arlen v. State* (1980), 61 Ohio St.2d 168, 172, 15 O.O.3d 190, 193, 399 N.E.2d 1251, 1254 * * *.

Id. at 533.

{¶22} The General Assembly, under Chapter 4731, has delegated the interpretation of the technical requirements of the medical profession to a twelve-member medical board, eight of whom are physicians and surgeons licensed to practice in Ohio. The Supreme Court of Ohio has upheld this delegation. See *Pons*, supra at 623. A majority of the board members thus possess the specialized knowledge required to determine acceptable standards of medical practice. Id. Armed with such specialized knowledge, the board is capable of interpreting the technical requirements of the medical profession and determining whether a physician's conduct falls below the minimal standard of care. Id. "When reviewing a medical board's order, courts must accord due deference to the board's interpretation of the technical and ethical requirements of its profession." Id. at syllabus.

{¶23} Following *Pons*, this court must accord due deference to the board's interpretation of the prevailing standards of care in the treatment of patients with intractable pain. The record establishes that the board reviewed the evidence presented at the hearing, including the testimony of both experts, as well as the hearing examiner's findings and recommendations. The board examined appellant's conduct independently, applied its professional expertise to the material presented, and reached a conclusion fully supported by the evidence. Accordingly, the second assignment of error is overruled.

{¶24} By the third assignment of error, appellant contends that the board's determination that appellant is not amenable to reeducation is not supported by reliable, probative, and substantial evidence. Appellant argues that her testimony as to the significant improvements she made to her practice over the years should have been accepted by the board as clear evidence that she was amenable to reeducation.

{¶25} In his report and recommendation, the hearing examiner found that appellant demonstrated a reckless and unjustifiable disregard of her patients' obvious drug seeking behavior, alcohol and drug abuse, depression, and suicidal tendencies, and had disregarded the advice and concerns of consultants and family members. He also determined that appellant had prescribed depressant medications in amounts that could have had, and may have had, disastrous effects. The hearing examiner concluded that appellant's conduct constituted violations of R.C. 4731.22(B)(6) and (B)(2) as in effect both prior to and after March, 1999 and recommended permanent revocation of appellant's medical license, stating as follows:

It is difficult to imagine that any physician could fail to recognize the inherent dangers in Dr. Dahlquist's treatment of Patients 1 through 16. Nevertheless, even at hearing, Dr. Dahlquist argued that her care of these patients had been appropriate. Dr. Dahlquist's failure to comprehend the egregiousness of her conduct suggests that Dr. Dahlquist is not amenable to reeducation.

(Nov. 13, 2003 Report and Recommendation, pg. 142.)

{¶26} At their January 14, 2004 meeting, the board deliberated extensively before voting to adopt the hearing examiner's recommendation. Those deliberations wholly support that recommendation, including the hearing examiner's finding that appellant could not be rehabilitated. Only one physician on the board spoke in favor of rehabilitation. The other board members plainly believed that appellant's license should be permanently revoked. For instance, one of the physicians, apparently rejecting appellant's testimony concerning the changes she made to her practice, stated that there was no evidence in the record that appellant's style of practice changed at all over a long period of time. That same physician also expressed concern that appellant continued to claim that she did not deviate from the standards of care. Another physician opined that appellant was not a candidate for rehabilitation due to the overwhelming danger appellant's prescribing practices presented to her patients. A non-physician member of the board remarked that appellant did not seem to understand that instead of helping her patients, she was actually hurting them.

{¶27} In short, the record establishes that the board reviewed the evidence presented at the hearing, including appellant's testimony that she changed several aspects of her practice in an effort to benefit her patients. While appellant's efforts to improve her practice were certainly laudable, a majority of the board members concluded

that appellant's violations were so severe that she could not be rehabilitated. The record in this case supports that determination. Accordingly, the third assignment of error is overruled.

Having overruled each of appellant's assignments of error, we hereby affirm the judgment of the Franklin County Court of Common Pleas.

Judgment affirmed.

BRYANT and LAZARUS, JJ., concur.

IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT

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Glenda M. Dahlquist, M.D.,

Appellant-Appellant,

v.

Ohio State Medical Board,

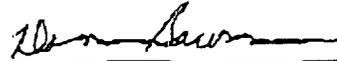
Appellee-Appellee.

No. 04AP-811

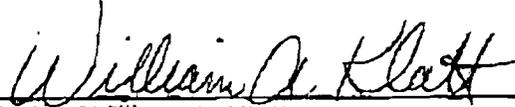
(REGULAR CALENDAR)

JOURNAL ENTRY

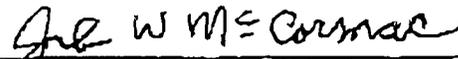
Appellant's August 12, 2004 motion to suspend the revocation order of the State Medical Board of Ohio pending appeal is hereby denied.



Judge Donna Bowman



Judge William A. Klatt



Judge John W. McCormac, retired of the Tenth Appellate District, assigned to active duty under the authority of Section 6(C), Article IV, Ohio Constitution.



STATE MEDICAL BOARD
OF OHIO
2004 AUG 19 P 2:03

NOTICE OF APPEAL TO A COURT OF APPEALS
FROM A JUDGEMENT OR
APPEALABLE ORDER

IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO

GLEND A M. DAHLQUIST, M.D.
369 West First Street
Dayton, Ohio 45402
Appellant/Appellant

Case No. 04CVF-02-1708
NOTICE OF APPEAL

FILED
COURT OF APPEALS
FRANKLIN CO. OHIO
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CLERK OF COURTS

v.

STATE MEDICAL BOARD OF OHIO
77 South High Street, 16th floor
Columbus, Ohio 43215-6127
Appellee/Appellee

HEALTH & HUMAN

AUG 12 2004

SERVICES SECTION

Notice is hereby given that Glenda M. Dahlquist, M.D., Appellant/Appellant, hereby appeals to the Court of Appeals of Franklin County, Ohio, Tenth Appellant District from the Judgment Entry entered in this action on the 19th day of July, 2004, and the corresponding Decision Affirming the Order of the State Medical Board dated June 29, 2004.

Counsel of Record for Appellee, Ohio State Medical Board, is Rebecca Albers, Assistant Attorney General, Office of the Ohio Attorney General, Health and Human Services Section, 30 E. Broad Street, 26th Floor, Columbus, Ohio 43215.

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CLERK OF COURTS

Respectfully submitted,

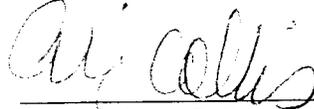
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04 APE 08 -- 0811

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Counsel for Appellant, Dr. Dahlquist

Certificate of Service

I hereby certify that a copy of the foregoing Notice of Appeal has been served on Counsel for Appellee, Rebecca Albers, Assistant Attorney General, 30 E. Broad Street, 26th Floor, HHS, Columbus, Ohio 43215 by regular U.S. mail, this 12th day of August, 2004.



Elizabeth Y. Collis, (#061961)

IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO

GLEND A M. DAHLQUIST, M.D., :

Appellant, :

v. :

STATE MEDICAL BOARD OF OHIO :

Appellee. :

Case No. 04CVF-02-1708

JUDGE DALE CRAWFORD

ENTRY DENYING APPELLANT'S MOTION FOR CONTINUATION OF STAY ORDER

This matter came before the Court upon Motion of Appellant, Glenda M. Dahlquist, M.D. for a continuation of the stay granted by the Court on March 3, 2004. Based upon the Decision of the Court rendered on June 28, 2004, affirming the January 14, 2004 Order of the State Medical Board, Appellant's Motion for Continuation of Stay Order is hereby DENIED. The Final Judgment Entry in this matter was filed on July 19, 2004. Therefore, pursuant to the State Medical Board's Order, Appellant has thirty days from that date to close her practice.

IT IS SO ORDERED.

JUDGE DALE CRAWFORD

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COMMON PLEAS COURT
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CLERK OF COURT'S - CV

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Counsel for Dr. Dahlquist

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

GLENDAM. DAHLQUIST, M.D., : **FINAL APPEALABLE ORDER**
Appellant, : Case No. 04CVF-02-1708
v. : JUDGE DALE CRAWFORD
STATE MEDICAL BOARD OF OHIO : **TERMINATION NO. 10**
Appellee. : BY *[Signature]*

**JUDGMENT ENTRY AFFIRMING THE STATE MEDICAL BOARD'S
JANUARY 14, 2004 ORDER PERMANENTLY REVOKING
APPELLANT'S LICENSE TO PRACTICE MEDICINE AND SURGERY IN
OHIO**

FILED
COMMON PLEAS COURT
FRANKLIN COUNTY, OHIO
2004 JUL 19 AM 9:26
CLERK OF COURTS

This case is before the Court upon the appeal, pursuant to R.C. 119.12, of the January 14, 2004 Order of the State Medical Board of Ohio which permanently revoked Appellant, Glenda M. Dahlquist, M.D.'s license to practice medicine and surgery in Ohio. For the reasons stated in the decision of this Court rendered on June 28, 2004, and filed on June 29, 2004, which decision is incorporated by reference as if fully rewritten herein, it is hereby.

ORDERED, ADJUDGED AND DECREED that judgment is entered in favor of Appellee, State Medical Board of Ohio, and the January 14, 2004 Order of the State Medical Board in the matter of Glenda M. Dahlquist, M.D., is hereby AFFIRMED. Costs to Appellant.

IT IS SO ORDERED.

Date

JUDGE DALE CRAWFORD

APPROVED:

JIM PETRO (0022096)
Attorney General

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IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO

GLEND A M. DAHLQUIST, M.D.,

Appellant,

vs.

STATE MEDICAL BOARD OF OHIO

Appellee

CASE NO. 04CVF-02-1708

JUDGE CRAWFORD

DECISION AFFIRMING THE ORDER OF
THE OHIO STATE MEDICAL BOARD

Rendered this 28th day of June, 2004

CRAWFORD, JUDGE

This is an appeal pursuant to R.C. 119.12 of a January 14, 2004 Order of the State Medical Board of Ohio ("the Board") revoking the medical license of Appellant Glenda M. Dahlquist, M.D.

I. HISTORY OF THIS MATTER

By letter dated February 13, 2002, the Board notified Appellant that it proposed to take disciplinary action against her medical license based upon her treatment of sixteen patients. The Board alleged that Appellant's treatment of the patients failed to conform to minimal standards of care of similar practitioners under the same or similar circumstances, in violation of R.C. 4731.22(B)(6). The Board alleged that in treating these patients, Appellant had failed to maintain minimal standards applicable to the selection or administration of drugs, or failed to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease, in violation of R.C.

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4731.22(B)(2) as in effect March 9, 1999. The Board also alleged that Appellant had failed to use reasonable care discrimination in the administration of drugs or failed to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease, in violation of R.C. 4731.22(B)(2) as in effect prior to March 9, 1999.

Appellant requested a hearing on the charges. An administrative hearing was held on October 7, 8, 10, 11, 14, 15, 16, 17, 18, and November 7, 8, 25 and 26, 2002.

On November 13, 2003, the Hearing Examiner issued a Report and Recommendation concluding that Appellant had committed the violations charged, and recommending permanent revocation of her medical license.

The Board considered this matter at its January 14, 2004 meeting. At the conclusion of the discussion, the Board voted to confirm the Report and Recommendation and revoke Appellant's medical license.

On February 13, 2004, Appellant filed this appeal of the Board's Order.

II. FACTS

Testimony of Dr Shin

At the hearing, Paul Shin, M.D., testified as an expert witness for the State. Dr. Shin is a 1990 graduate of the Medical College of Ohio. Dr. Shin had fellowship training in pain management. (Tr. 300-301). He is board certified by the American Board of Anesthesiology and has a subspecialty in pain management. (Tr. 302-303). He was Director of the Pain Management Center for Lakewood Hospital. He is currently the Director of Pain Management for Crystal Clinic Surgery Center. (Tr. 303-304). Fifty percent of his practice is in pain management. (Tr. 624-625).

Dr. Shin testified that Appellant fell below the standard of care in her treatment of the sixteen patients in that she failed to use reasonable care in administering drugs. Dr. Shin testified that Appellant provided increasing doses of opioids to patients for lengthy time periods without objective improvement of pain. (Tr. 574-577). He stated that the patients frequently returned for refills of opioids and their requests were fulfilled. (State's Ex. 25 at p. 19). He stated that patients were able to receive their choice of opioids. Dr. Shin stated as follows: "Under her care, the patients generally required higher and higher doses of medications. In many cases, these trends of care went on for several months to years. On a consistent basis, there was a clear evidence of failure to provide pain control despite escalating doses of opioids." (*Id.*). He stated: "Dr. Dahlquist failed to describe accurate pain diagnoses that justify the protracted use of multiple and high doses of opioids" and "did not order or review pertinent laboratory findings." (*Id.*)

Dr. Shin stated that Appellant failed to address drug abuse among her patients. He stated that Appellant failed to recognize drug-seeking behavior and "psychological factors, secondary gains and abuse potentials affecting the treatment course." (State Ex. 25 at 19; Tr. 576-577). He stated: "Many of her patients were abusing the drugs. There was no attempt at weaning the opioids, or referring to an addiction specialist or to an inpatient type of multidisciplinary rehab/pain management program." (*Id.*)

Dr. Shin testified in detail regarding the treatment of the sixteen patients. Patient 1, for example, was diagnosed by Appellant with Crohn's disease with abdominal pain and cramping. (Tr. 72). At one point in the patient's treatment, Appellant was prescribing Prevacid, Duragesic patches, Roxanol, Soma, Darvocet, Vicodin, Xanax, MS

Contin, and Phenergan. (Tr. 88-90). Dr. Shin testified that the patient's pain was not from an exacerbation of Crohn's disease, as the sigmoidoscopy and upper GI studies were normal, and that the drugs prescribed were not justified. (Tr. 329-335; Ex. 1 at 36-37, 209).

Patient 4 presented to Appellant in 1997 with complaints of neck strain and sprain and low back pain. (Tr. 403). The patient also had a history of alcohol abuse. (Tr. 395-396). The patient was seen 26 times, and received trigger point injections, cervical and lumbar epidural injections, Oramorph (oral Morphine), Percocet, Vicodin, OxyContin, Toradol and Norflex. (Tr. 396). Dr. Shin testified that Appellant violated standards of care by prescribing medications that were not justified by the diagnosis and using combinations of medications in escalating dosages with no improvement in the patient. (Tr. 399-400). Dr. Shin testified that Appellant should have done a toxicology screen or considered a detox program for the patient, but failed to do so. (Tr. 405).

In 1995, Patient 10 presented to Appellant with head and neck pain. (Tr. 489). The patient had a history of major depression. (Tr. 495). Medications prescribed by Appellant included Tramadol, Baclofen, Duragesic patches, Fioricet, Percodan, Percocet, MS Contin, Oxycontin, OxyIR, Dilaudid, Talwin, Demerol, Phenergan injections, Zydone, and Methadone. (Tr. 490-493). Dr. Shin testified that Appellant violated standards of care by using escalating doses of opioids over a protracted time period, when the medications were unwarranted by the diagnosis and resulted in no objective improvement of the patient's condition. (Tr. 495). Dr. Shin stated that the patient should have been referred and treated for depression, but was not. (Tr. 500). Appellant

treated patient 10 from 1995 to 2000. Patient 10 died of drug intoxication in 2000. (St. Ex. 22).

Patient 15 presented to Appellant in 1995 with complaints of back pain. (Tr. 553). The patient's record included a notation that she was a possible drug seeker and had been in drug rehabilitation. (Tr. 555). Nevertheless, from 1995 through 1997, Appellant prescribed high doses of Percocet, Soma, Vicodin, MS Contin, Demerol, OxyContin, and Methadone, which doses were increased over time. (Tr. 555-556). In 1997, there is a notation in the patient record that the patient claimed that her car was broken into and that her medications and \$1,200 in cash were stolen. The patient advised Appellant that no police report had been made. (Tr. 555, St. Ex. 15 at 35). Appellant filled the "stolen" prescription again. (St. Ex. 15 at 36; Tr. 556). On another occasion, the patient called Appellant's office to obtain more medications stating that she had misplaced her medications. (Tr. 560). The records included consultations by outside physicians advising that the patient not be treated with narcotics. (Tr. 566). Appellant continued to prescribe medications to the patient during these time periods. In April, 1998, the patient checked herself into a hospital detox center. (Tr. 1984). After the patient was released, Appellant continued to prescribe opioids and combinations of opioids. (*Id.*). Dr. Shin testified that Appellant violated standards of care by failing to use reasonable care in the administration of drugs or the selection of drugs for treatment and by failing to address signs that the patient was abusing drugs. (Tr. 556, 565).

Patient 16 presented to Appellant in 1998 with complaints of back and leg pain. (Tr. 567). The patient reported a history of alcohol abuse and marijuana use and attendance of substance rehabilitation treatment. (Tr. 568). Dr. Shin testified that

Appellant violated minimal standards of care by failing to request or obtain records of the patient's prior treatment. (Tr. 572). Appellant prescribed Lorcet, Methadone, Valium, and Soma in increasing doses. (Tr. 568). Dr. Shin testified that the diagnoses did not explain the protracted use or the amounts of the opioids that were prescribed. (Tr. 569). The records also indicated that the patient had obtained Dilaudid from a friend. (Tr. 571). Dr. Shin testified that given the patient's history of use of alcohol and marijuana, which are depressants, "when you're adding all these medications to the regimen, then you are really closing the critical area where a patient is in a danger zone, particularly by an increased state of sedation, can easily overdose because of mental status changes, certainly respiratory depression and respiratory failure, and death could occur." (Tr. 572). Dr. Shin testified that because of the signs of drug abuse, Appellant should have attempted to decrease the doses of opioids or referred the patient to a detoxification program, but did not do so. (Tr. 572-573; Ex. 25, p. 18). In 1999, the patient died of multiple drug intoxication. (Tr. 570).

Dr. Shin testified in similar detail regarding the rest of the sixteen patients whose records were reviewed. He testified that in all the cases, Appellant failed to meet minimal standards of care. (Ex. 25, p. 19).

Testimony of Appellant and Dr. Blatman

Appellant testified and called Hal Blatman, M.D., as an expert witness.

Appellant testified that she received her medical degree from the University of Kentucky in 1982. She completed an internship in internal medicine and a three-year residency in anesthesiology with a specialty in pain management. In 1996, she opened

her own practice in pain management. (Tr. 1498-1504). She is board-certified in anesthesiology and pain management. (Tr. 1504-1507).

Appellant testified that the sixteen cases at issue are among the most complex cases in her practice. (Tr. 1600-1601). She stated that these patients were not curable and had been treated by other physicians with other modes of therapy before she treated them. (Tr. 2023-2024). She testified that she complied with minimal standards of care and the Board's rules regarding treatment of patients with intractable pain. (Tr. 2055).

Dr. Blatman received his medical degree from the Medical College of Pennsylvania in 1980. In 1988, he opened a practice in pain management. He is board-certified and published in the field of pain management. (Tr. 988-990, 994-995). Dr. Blatman testified that in Appellant's treatment of each of the sixteen patients, Appellant complied with the standards of care. (Tr. 1003-1168).

Dr. Blatman testified that a cure does not always exist for intractable pain. He noted that Patients 1-16 had failed prior therapy and treatment for pain management. (Tr. 1023-1030). According to Dr. Blatman, no ceiling exists with regard to the dosage of opioids which can be prescribed to a patient and combinations of opioids may be more effective. (Tr. 1040-1041). He stated that Appellant was not required to refer the patients to another health care provider to relieve the patients' pain. (Tr. 1029-1030).

Dr. Blatman stated that Appellant is a "conscientious and caring algologist. She has been careful and discriminating with regard to prescribing opioid medications. Her patients have typically responded with decreased pain and increased function." (Resp. Ex. C at 21).

With respect to patient 1, Dr. Blatman stated that the diagnosis of Crohn's disease was well-established and reasonable as a pain diagnosis. (Tr. 1045-1046). Dr. Blatman stated that patient 1 was not prescribed medications in types or amounts or in combinations that were inappropriate or for protracted periods that were not justified. (Tr. 1049-1050).

With respect to patient 4, Dr. Blatman stated that Appellant "did as much as possible to identify a reasonable pain diagnosis and the source of the patient's pain." (Resp. Ex. B p. 10). He also stated: "previous alcohol detoxification does not absolutely require toxicology screening or a detoxification program as part of a patient's treatment. The treating doctor felt that this patient had obvious sources for pain, was obviously in severe pain, and therefore required this level of medication for treatment." (*Id.* at 11).

Dr. Blatman testified that patient 10's diagnosis of myofascial pain syndrome supported the protracted use of opioids and combinations of opioids and that the prescribed medications and combinations of medications were appropriate. (Tr. 1151, 1157-1158).

With respect to patient 15, Dr. Blatman testified that drug addiction does not preclude appropriate treatment for pain. (Tr. 1203-1205). He stated that it is sometimes difficult to determine whether to continue to treat a patient who reports medications as lost and stolen, and the physician has to decide whether to believe the patient. (Tr. 1208-1209). He stated that Appellant responded appropriately by limiting the patient's refills and advising the patient to guard future medications. (Tr. 1205-1206).

With respect to patient 16, Dr. Blatman stated that it would have been appropriate to counsel the patient about alcohol use. (Tr. 1213-1215). He said that as for marijuana

usage, “detoxification is entirely unrealistic.” He said that “Medically, denying this patient appropriate medication for pain in this circumstance, is very much like denying insulin to a diabetic because the patient will not stop eating sugar, despite dietary counseling.” (Resp. Ex. B at 27-29). Dr. Blatman stated that it is not possible to make a reasonable inference from the postmortem report that medications prescribed by Appellant caused or contributed to the patient’s death from multiple drug intoxication. (Tr. 1216-1219).

Appellant and Dr. Blatman testified in detail regarding the rest of the sixteen patients whose records were reviewed and stated that in all the cases, Appellant met the standards of care.

III. FINDINGS OF THE BOARD

In his 142-page Report and Recommendation, the Hearing Examiner reviewed the evidence in great detail and found that Appellant prescribed medications in types, amounts, and combinations that were inappropriate and for protracted periods of time that were not justified. (Report, p. 138). The Hearing Examiner found that Appellant failed to adequately recognize and address indications of drug abuse. (*Id.*, p. 139). He found that Appellant failed to identify reasonable pain diagnoses, failed to obtain records of prior or concurrent medical treatment of the patients, and failed to make necessary referrals for treatment. (*Id.*, p. 140). The Hearing Examiner found that Appellant had violated R.C. 4731.22(B)(6) and R.C. 4731.22(B)(2) as in effect prior to and after 1999. He recommended permanent revocation of Appellant’s license, stating as follows:

At hearing, Dr. Dahlquist argued that the heart of this matter is the controversy regarding the use of controlled substances to treat chronic pain. Nevertheless, the provision of safe and effective care for chronic pain should be the true objective. In this matter, Dr. Dahlquist

demonstrated reckless and unjustifiable disregard of patients' obvious drug seeking behavior, alcohol and drug abuse, depression, and suicidal tendencies. She further disregarded the advice and concerns of consultants and family members. In addition, Dr. Dahlquist prescribed depressant medications in amounts that could have had, and may have had, disastrous effects.

It is difficult to imagine that any physician could fail to recognize the inherent dangers in Dr. Dahlquist's treatment of Patients 1 through 16. Nevertheless, even at hearing, Dr. Dahlquist argued that her care of these patients had been appropriate. Dr. Dahlquist's failure to comprehend the egregiousness of her conduct suggests that Dr. Dahlquist is not amenable to reeducation. (*Id.*, pgs. 141-142).

When the Board considered this matter at its January 14, 2004 meeting, the comments of the Board members included the following:

Dr. Steinbergh stated that, in reviewing Dr. Dahlquist's case extensively, she finds fault in every case, some worse than others. Dr. Dahlquist's ability to properly diagnose was compromised by her lack of review of previous medical records on many of these patients. She often continued to prescribe without proper assessment. Her treatment choices were sometimes inappropriate, but the inappropriate treatments were dangerous to patients' health. The medications, although very often necessary for pain management, were used in combinations that would cause patients to be potentially addicted, and, in fact, were addicted.

Dr. Steinbergh continued that, without realizing the dangerous combinations and escalating use in many of these patients, Dr. Dahlquist failed to meet the needs of patients regarding their general health. Dr. Dahlquist often caused potential harm, and did, in fact, cause serious harm to patients. She failed to recognize the seriousness of abuse, and she failed to refer for addiction therapy. She failed to properly manage these cases.

Dr. Steinbergh stated that, in her mind, Dr. Dahlquist used the moniker of 'pain management specialist' to recklessly prescribe narcotics to the patients the Board reviewed, and Dr Dahlquist fails to recognize her errors
....

Dr. Steinbergh stated that she believes it is important that the Board encourage the appropriate management of chronic pain and make physicians aware that all modalities and pharmaceuticals may be used by law. She added, however, that physicians must be guided by the very basic medical standards of appropriate history taking, thorough

examination as it pertains to each case, the wise choice of pharmaceuticals, alternative treatment options and consulting with other specialists, if needed, and to be thorough in the approach to each patient in order to maintain good health as the physician relieves their pain.

Dr. Egner stated that ... there was not any testing done to look for the cause of that pain. They were just given more and more pain medication.

Dr. Egner stated that, in the case of Patient 5, there was obvious drug seeking behavior. This patient even sold drugs to an undercover police officer. Dr. Dahlquist was aware of that episode, yet she did not take any future measures to monitor that patient's pain medications with drug screens or to limit the number of prescriptions that that patient was given.

Dr. Egner remarked that there is no evidence in the record that Dr. Dahlquist's style of practice changed over a long period of time. ... Dr. Egner stated that unfortunately, she doesn't see that there is remediation or change in Dr. Dahlquist's future.

Mr. Browning agreed with Dr. Egner. He stated that he doesn't think that there was intent to harm the patients, but it's amazing after going through all of this that Dr. Dahlquist doesn't understand that instead of helping, she was hurting the patients. That is so fundamental in what the Board does in protecting the public

...
Dr. Steinbergh stated that ... In this particular case, the amount of narcotics prescribed, the combinations, and the danger that Dr. Dahlquist presented to her patients was so overwhelming.

Dr. Steinbergh added that ... She doesn't see remediation for Dr. Dahlquist. She understands that Dr. Dahlquist is a young physician and it's a shame, but the amount of patient harm done overwhelmingly convinces her that this needs to be a permanent revocation.

At the conclusion of the discussion, the Board voted 6 to 1 to confirm the Report and Recommendation and revoke Appellant's medical license. The doctor voting against permanent revocation supported a long suspension with the opportunity to remediate. (Minutes of meeting, pgs 3-7). The Board issued its Order of permanent revocation on January 14, 2004.

IV. LAW

When considering an appeal from an order of the Medical Board, a common pleas court must uphold the order if it is supported by reliable, probative, and substantial evidence, and is in accordance with law. R.C. 119.12. *Pons v. Ohio State Med. Bd.* (1993), 66 Ohio St. 3d 619, 621; *Landefeld v. State Med. Bd.* (2000), Tenth Appellate District No. 99AP-612, 2000 Ohio App. LEXIS 2556.

The Ohio Supreme Court has recognized that the General Assembly granted the Medical Board a broad measure of discretion. *Arlen v. State* (1980), 61 Ohio St. 2d 168, 174. In *Farrand v. State Med. Bd.* (1949), 151 Ohio St. 222, 224, the court stated:

... The purpose of the General Assembly in providing for administrative hearings in particular fields was to facilitate such matters by placing the decision on facts with boards or commissions composed of men equipped with the necessary knowledge and experience pertaining to a particular field. ...

“Accordingly, when courts review a medical board order, they are obligated to accord due deference to the board’s interpretation of the technical and ethical requirements of the medical profession.” *Landefeld, supra*, at pg. 9.

V. THE COURT’S FINDINGS AND CONCLUSIONS

Appellant contends that the Board failed to follow applicable statutes and rules regarding the treatment of intractable pain. Appellant also argues that the Board’s decision is not supported by reliable, probative and substantial evidence.

Appellant notes that in October, 1997, R.C. 4731.052, addressing management of intractable pain with dangerous drugs, became effective. Pursuant to that statute, Administrative Code chapter 4731-21 was adopted and became effective in November,

1998. Appellant objects to the fact that Dr. Shin based his testimony on prevailing standards of medical care, rather than the referenced statute and rules.

Appellee counters that Appellant was not charged with violations of the referenced statute and rules because much of the treatment at issue occurred prior to enactment of the statute and rules.

A review of the record confirms that ten of the sixteen patients were treated by Appellant prior to the effective date of the statute, and five of these ten patients were being treated in or before 1995.

Moreover, while R.C. 4731.052 became effective in October, 1997, it still required that “The physician’s diagnosis and treatment decisions shall be made according to accepted and prevailing standards for medical care.” R.C. 4731.052(C). The administrative rules similarly provided that “a practitioner shall comply with accepted and prevailing standards of care which shall include, but not be limited to” those set forth in the rules. Ohio Admin. Code 4731-21-02.

Dr. Shin testified to the accepted and prevailing standards for medical care and testified that Appellant’s treatment in the sixteen cases, both before and after October, 1997, violated those standards.

Dr. Shin testified that Appellant’s treatment of the patients failed to conform to minimal standards of care of similar practitioners under the same or similar circumstances, which constitutes a violation of R.C. 4731.22(B)(6). He further testified that Appellant failed to use reasonable care discrimination in the administration of drugs, which constitutes a violation of 4731.22(B)(2) as in effect prior to March 9, 1999, and that Appellant failed to maintain minimal standards applicable to the selection or

administration of drugs and failed to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease, which constitutes a violation of R.C. 4731.22(B)(2) as in effect March 9, 1999.

For these reasons, the Court finds Appellant's argument that the Board failed to follow applicable statutes and rules to be without merit.

Appellant also argues that the Board's decision is not supported by reliable, probative and substantial evidence. Appellant emphasizes the testimony of Dr. Blatman and Appellant that she met the standards of care. Appellant argues that the testimony of Dr. Shin should be given less weight.

The Court finds that Dr. Shin's testimony constitutes reliable, probative and substantial evidence supporting the Board's Order. The Court is to "give due deference to the administrative resolution of evidentiary conflicts" because the fact finder had the opportunity to observe the witnesses and weigh their credibility. *Univ. of Cincinnati v. Conrad* (1980), 63 Ohio St. 2d 108, 111. The Court "will not substitute its judgment for the Board's where there is some evidence supporting the Board's Order." *Harris v. Lewis* (1982), 69 Ohio St. 2d 577, 579.

Appellant argues that the Board's decision is based on its view that intractable pain should not be treated with combinations of opioids for long periods of time, and that this view is not supported by the law or by leading literature in the field. Both the Hearing Examiner and the Board expressly stated that their decisions were not based simply on the fact that Appellant used controlled substances to treat chronic pain. Rather, the decisions were based on the failure to prescribe in a safe manner and the failure to address drug abuse among patients. The Hearing Examiner stated:

At hearing, Dr. Dahlquist argued that the heart of this matter is the controversy regarding the use of controlled substances to treat chronic pain. Nevertheless, the provision of safe and effective care for chronic pain should be the true objective. (Report, p. 141).

Similarly, during the Board's discussion, it was stated as follows:

Dr. Steinbergh stated that she believes it is important that the Board encourage the appropriate management of chronic pain and make physicians aware that all modalities and pharmaceuticals may be used by law. She added, however, that physicians must be guided by the very basic medical standards (meeting minutes, p. 4).

In the reply brief, Appellant argues that the Board's decision is not supported by reliable, probative and substantial evidence because Appellant was not permitted to cross-examine Dr. Shin regarding changes to his report. During the hearing, Appellant sought to question Dr. Shin regarding any changes to his report after conversations with medical board staff members. (Tr. 618-620). The Hearing Examiner ruled that Appellant could not question Dr. Shin regarding his conversations with anyone who was involved in the Board investigation. (Tr. 620-621).

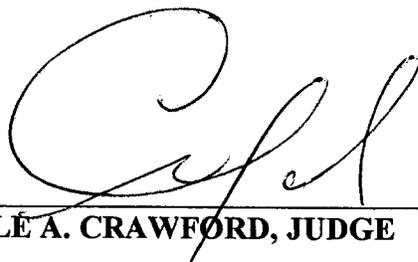
In making his ruling, the Hearing Examiner relied on R.C. 4731.22(F)(5), which provides that "Information received by the board pursuant to an investigation is confidential and not subject to discovery in any civil action" and that "The board shall conduct all investigations and proceedings in a manner that protects the confidentiality of patients and persons who file complaints with the board." Persons who are entitled to confidentiality under this statute include patients, physicians and investigation witnesses. *Wallace v. State Medical Board of Ohio* (2000), 89 Ohio St. 3d 431.

The Hearing Examiner's ruling that Dr. Shin could not be questioned about conversations with persons involved in the investigation appears consistent with the statutory provision that such investigations are confidential.

Appellant also has not shown any prejudice from any alleged error in the Hearing Examiner's ruling. Civil Rule 61 provides that "The court at every stage of the proceeding must disregard any error or defect in the proceeding which does not affect the substantial rights of the parties." *Petti v. Perna* (1993), 86 Ohio App. 3d 508 (holding that an error in the admission of evidence is not grounds for reversal unless substantial rights of the complaining party were affected or if it appears that substantial justice was not done); *Ray v. Harrisburg* (1994), Tenth Appellate District, No. 94APE04-550, 1994 Ohio App. LEXIS 5839 (holding that an evidentiary ruling in an administrative proceeding was harmless error).

Appellant cross-examined Dr. Shin extensively, for approximately one and one-half days. (Tr. Vol. 4 and 5). There is no showing as to how the refusal to permit questioning on this one narrow issue could call into question all of the voluminous evidence presented by Dr. Shin or lead to a conclusion that the Board's Order is not supported by reliable, probative and substantial evidence.

For the foregoing reasons, the Court concludes that the Board's Order in this matter is supported by reliable, probative and substantial evidence and is in accordance with law. The Board's Order is **AFFIRMED**. Within twenty-one days, counsel for Appellee shall submit an appropriate Judgment Entry reflecting this Decision pursuant to Local Rule 25.01.



DALE A. CRAWFORD, JUDGE

Copies to:
Neil F. Freund and Elizabeth Y. Collis, Counsel for Appellant
Rebecca J. Albers, Counsel for Appellee

IN THE COURT OF COMMON PLEAS STATE MEDICAL BOARD
FRANKLIN COUNTY, OHIO OF OHIO

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GLENDAM. DAHLQUIST, M.D.
369 West First Street
Dayton, Ohio 45402
Appellant,

Case No. 04CVF-02-1708

vs.

JUDGE CRAWFORD

STATE MEDICAL BOARD OF OHIO
77 South High Street, 16th floor
Columbus, Ohio 43215-6127
Appellee

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FRANKLIN COUNTY, OHIO
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Order

This matter was set for hearing on February 27, 2004, pursuant to Appellant's Motion to Stay and Memorandum in Support and Appellee's Memorandum in Opposition. It is therefore hereby Ordered, Adjudged and Decreed that Appellant, Glenda M. Dahlquist's Motion to Stay the State Medical Board of Ohio's Order ("Ohio Board") of January 14, 2004 is hereby GRANTED. The Board's Order permanently revoking Dr. Dahlquist's license is STAYED subject to the following conditions:

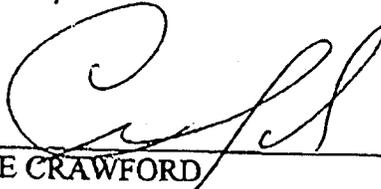
1. Dr. Dahlquist must provide a letter to all patients informing them that on January 14, 2004, the Ohio Board issued an Order which permanently revoked her license to practice medicine in Ohio based upon the Board's finding that she violated the standard of care in her treatment of sixteen (16) patients. The letter must further

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state, that the Order of the Ohio Board was stayed by Judge Crawford of the Franklin County Court pending the final decision in the Franklin County Court of Common Pleas. Dr. Dahlquist must also notify patients that they are free to seek another physician, if they choose to do so;

- 2. Dr. Dahlquist must have each patient sign a waiver acknowledging that they have been advised that Dr. Dahlquist's license to practice medicine has been permanently revoked by the Ohio Board for violating the standard of care in her treatment of sixteen patients, but that the Order of the Ohio Board has been stayed pending the final decision on her appeal before the Franklin County Court of Common Pleas. By signing the wavier, the patients consent to treatment by Dr.

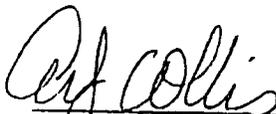
Copies of all correspondence and waivers shall be kept at the Doctor's office and shall be available for review by the Board and/or.
 IT IS SO ORDERED. *Board upon request.*

3/2/04

 JUDGE CRAWFORD

Approved:

Neil Freund (per telephone approval 3/2/04 E. Collis)
 Neil Freund, Esq.
 Counsel for Dr. Dahlquist

Rebecca Albers (per telephone approval 3/2/04 E. Collis)
 Rebecca Albers, Esq.
 Counsel for State Medical Board of Ohio


 Elizabeth Y. Collis, Esq.
 Counsel for Dr. Dahlquist

2004 MAR - 4 A 9 41

STATE MEDICAL BOARD OF OHIO

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

STATE MEDICAL BOARD
OF OHIO

2004 FEB 13 A 9 32

GLEND A M. DAHLQUIST, M.D.
369 West First Street
Dayton, Ohio 45402
Appellant,

:
: **04CVF02** 1708
: Case No. _____

vs.

: JUDGE _____
:
:

STATE MEDICAL BOARD OF OHIO
77 South High Street, 16th floor
Columbus, Ohio 43215-6127
Appellee

FILED
COMMON PLEAS COURT
FRANKLIN CO., OHIO
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NOTICE OF APPEAL

Appellant, Glenda M. Dahlquist, M.D., pursuant to Ohio Revised Code Section 119.12 hereby appeals the final decision of the Ohio State Medical Board ("Appellee"), which permanently revoked Appellant's license to practice medicine in its Adjudication Order (attached hereto) issued on January 14, 2004 and mailed to appellant on February 3, 2004.

Appellant asserts that the decision of the Ohio State Medical Board is not

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STATE MEDICAL BOARD
OF OHIO

STATE MEDICAL BOARD
OF OHIO

supported by reliable, probative and substantial evidence and is not in accordance with
2004 FEB 13 A 4 32
law.

Respectfully submitted,

Neil F. Freund (by EY Collis)

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Glenda M. Dahlquist, M.D.

2004 MAR -5 P 12:01

STATE MEDICAL BOARD
OF OHIO

Certificate of Service STATE MEDICAL BOARD
OF OHIO

I certify that the *Notice of Appeal* was served upon ~~Appellee~~, State Medical Board
of Ohio, 77 S. High Street, 17th Floor, Columbus, Ohio 43215 this 13 day of February
2004 by hand delivery, and upon Rebecca Albers, Assistant Attorney General, Office of
the Ohio Attorney General, Health and Human Services Section, 30 East Broad Street,
26th Floor, Columbus, Ohio 43215 by hand delivery this 13 day of February 2004.

Elizabeth Y. Collis

STATE MEDICAL BOARD
OF OHIO
2004 MAR -5 P 12:01



State Medical Board of Ohio

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January 14, 2004

Glenda M. Dahlquist, M.D.
369 West First Street
Dayton, OH 45402

Dear Doctor Dahlquist:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Daniel Roberts, Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on January 14, 2004, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Such an appeal must be taken to the Franklin County Court of Common Pleas.

Such an appeal setting forth the Order appealed from and the grounds of the appeal must be commenced by the filing of a Notice of Appeal with the State Medical Board of Ohio and the Franklin County Court of Common Pleas. Any such appeal must be filed within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12, Ohio Revised Code.

THE STATE MEDICAL BOARD OF OHIO

Lance A. Talmage, M.D.
Secretary

LAT:jam
Enclosures

CERTIFIED MAIL NO. 7000 0600 0024 5148 4012
RETURN RECEIPT REQUESTED

Cc: Elizabeth Y. Collis, Esq.
CERTIFIED MAIL NO. 7000 0600 0024 5148 3992
RETURN RECEIPT REQUESTED

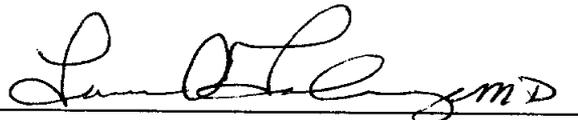
Neil F. Freund, Esq.
CERTIFIED MAIL NO. 7000 0600 0024 5148 4005
RETURN RECEIPT REQUESTED

Mailed 2-3-04

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of Daniel Roberts, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on January 14, 2004, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order; constitute a true and Glenda M. Dahlquist, M.D., as it appears in the Journal of the State Medical Board of Ohio.

This certification is made by authority of the State Medical Board of Ohio and in its behalf.



Lance A. Talmage, M.D.
Secretary

(SEAL)

January 14, 2004
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

GLEND A. DAHLQUIST, M.D.

*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on January 14, 2004.

Upon the Report and Recommendation of Daniel Roberts, State Medical Board Attorney Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the modification, approval and confirmation by vote of the Board on the above date, the following Order is hereby entered on the Journal of the State Medical Board of Ohio for the above date.

It is hereby ORDERED that:

The certificate of Glenda M. Dahlquist, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

This Order shall become effective thirty days from the date of mailing of notification of approval by the Board. In the thirty day interim, Dr. Dahlquist shall not undertake the care of any patient not already under her care.

(SEAL)



Lance A. Talmage, M.D.
Secretary

January 14, 2004

Date

**REPORT AND RECOMMENDATION
IN THE MATTER OF GLENDA M. DAHLQUIST, M.D.**

The Matter of Glenda M. Dahlquist, M.D., was heard by Daniel Roberts, Hearing Examiner for the State Medical Board of Ohio, on October 7-11, October 14-18, November 7, November 8, November 25, and November 26, 2002.

INTRODUCTION

I. Basis for Hearing

A. By letter dated February 13, 2002, the State Medical Board of Ohio [Board] notified Glenda M. Dahlquist, M.D., that it had proposed to take disciplinary action against her certificate to practice medicine and surgery in this state. The Board based its proposed action on allegations pertaining to Dr. Dahlquist's care and treatment of sixteen patients. The Board alleged that Dr. Dahlquist's conduct constitutes the following violations of law:

- “[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established,” as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.”
- “[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease,” as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code, as in effect March 9, 1999.”
- “[f]ailure to use reasonable care discrimination in the administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease,” as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code, as in effect prior to March 9, 1999.”

Accordingly, the Board advised Dr. Dahlquist of her right to request a hearing in this matter. (State's Exhibit 17A).

B. On February 27, 2002, Elizabeth Y. Collis, Esq., submitted a written hearing request on behalf of Dr. Dahlquist. (State's Exhibit 17C).

II. Appearances

- A. On behalf of the State of Ohio: Betty D. Montgomery and Jim Petro, Attorneys General, by Rebecca J. Albers and Mark A. Michael, Assistant Attorneys General.
- B. On behalf of the Respondent: Neil Freund, Esq., and Elizabeth Y. Collis, Esq.

EVIDENCE EXAMINED

I. Testimony Heard

- A. Presented by the State
 - 1. Glenda M. Dahlquist, M.D., as on cross-examination
 - 2. Paul C. Shin, M.D.
- B. Presented by the Respondent
 - 1. Glenda M. Dahlquist, M.D.
 - 2. Hal Blatman, M.D.
 - 3. Susan L. Getz, RN
 - 4. Sajona M. Weaver
 - 5. Patient C, D.O.

II. Exhibits Examined

- A. Presented by the State:
 - * 1. State's Exhibits 1-16: Confidential patient records. [Note: As presented at hearing, only patient records from Dr. Dahlquist's office contained volume numbers. The packets of records obtained directly from hospitals did not. Volume numbers were added to the hospital records post hearing.]
 - 2. State's Exhibits 17A-17Y: Procedural exhibits. [Note: Procedural exhibits 17B and 17V are sealed to protect patient privacy.]
 - * 3. State's Exhibit 18-20: Certificates of Death for Patients 2, 3, and 9, respectively.
 - * 4. State's Exhibits 21, 22 and 23: Postmortem of the bodies of Patient 16, 10 and Patient 7, respectively.

5. State's Exhibit 24: Curriculum vitae of Paul Shin, M.D.
 - * 6. State's Exhibit 25: December 6, 2001, Report of Dr. Shin.
 7. State's Exhibit 29: State's Closing Argument.
 8. State's Exhibit 30: State's Proposed Findings of Fact.
 9. State's Exhibit 31: State's Reply to Respondent's Closing Argument.
- B. Presented by the Respondent:
1. Respondent's Exhibit A: Curriculum Vitae of Hal S. Blatman, M.D.
 - * 2. Respondent's Exhibit A1: Dr. Blatman's notes concerning medical records.
 - * 3. Respondent's Exhibits B and C: Dr. Blatman's Reports.
 4. Respondent's Exhibit D: "Opioid Therapy for Chronic Nonmalignant Pain: A Review of Critical Issues," Russell K. Portenoy, M.D., Journal of Pain and Symptom Management, Vol. 11 No 4 April 1996.
 5. Respondent's Exhibit E: Educational Background and Professional Qualifications of Glenda Dahlquist, M.D.
 6. Respondent's Exhibits F-H: Copies of statutes and rules.
 - * 7. Respondent's Exhibit I: Confidential Patient Key.
 - * 8. Respondent's Exhibit J: Patient Medication Log for Patient 6.
 - * 9. Respondent's Exhibit K: MRI Report for Patient 7.
 10. Respondent's Exhibit L and M: Procedural exhibits.
 11. Respondent's Exhibit N: Respondent's Proposed Findings of Fact and Conclusions of Law.
 12. Respondent's Exhibit O: Respondent's Closing Argument.
- * Exhibits marked with an asterisk (*) are sealed to protect patient confidentiality.

PROCEDURAL MATTERS

The record in this matter was held open to allow the parties to submit closing arguments. Those were received in a timely manner and the record closed on March 31, 2003.

SUMMARY OF THE EVIDENCE

All exhibits and transcripts of testimony, even if not specifically mentioned, were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

GLENDAM. DAHLQUIST, M.D.

1. Glenda M. Dahlquist, M.D., testified that she had received her medical degree in 1987 from the University of Louisville in Louisville, Kentucky. In June 1988, Dr. Dahlquist completed a one year internship in internal medicine at Indiana University Purdue University in Indianapolis, Indiana. In June 1991, Dr. Dahlquist completed an anesthesiology residency with fellowship track in pain management at the University of Illinois in Chicago, Illinois. (Hearing Transcript [Tr.] at 15-16, 1498-1501, 2109; Respondent's Exhibit [Resp. Ex.] E).

Following her residency, Dr. Dahlquist accepted a position with Anesthesia Associates of Dayton, a general anesthesia practice involving both operating room anesthesia and pain management. In October 1996, Dr. Dahlquist opened a private office practice. (Tr. 14-16, 1501-1503, 1526, 1562, 1987, 2051; Resp. Ex. E).

Dr. Dahlquist testified that she is the only physician in her practice. Dr. Dahlquist testified that all of her active patients suffer from severe chronic pain or intractable pain.

Dr. Dahlquist further testified that she has treated about four thousand patients in the last eleven years. Dr. Dahlquist noted that she currently has between 900 and 1000 active patients and that she generally sees between fifteen and twenty-five patients per day. (Tr. 19, 24-25, 728, 1525-1527, 1564, 1987, 2051, 2227-2228).

Dr. Dahlquist testified that she had been board certified in general anesthesiology by the American Board of Anesthesiology in 1993. Dr. Dahlquist added that she had received board certification in pain management from the American Board of Pain Medicine and board certification in pain management from a sub specialty board of the American Board of Anesthesiology. (Tr. 17-19, 302-303, 1504-1506, 2254-2255; Resp. Ex. E).

Dr. Dahlquist testified that she had held privileges at Kettering Medical Center but that, in November 2001, those privileges had been suspended. She stated that she had been told that the primary reason for the suspension of her privileges was related to the amount of opioid medications she had been prescribing. Dr. Dahlquist explained that the suspension

would remain in effect at least until the completion of the Board's hearing in this matter and a separate hearing at Kettering. Dr. Dahlquist testified that she does not have privileges at any other hospital. (Tr. 20-24, 1563).

EXPERT WITNESSES

Paul C. Shin, M.D.

2. Paul C. Shin, M.D., testified as an expert witness on behalf of the State. Dr. Shin testified that he is a staff anesthesiologist with, and Director of the Pain Management Division of, the Anesthesia and Pain Center of Akron. Dr. Shin testified that he had completed medical school at the Medical College of Ohio in Toledo in 1990. Dr. Shin testified that he had completed an anesthesia residency program at the Cleveland Clinic Foundation in 1994. Dr. Shin elaborated that he had also completed a year of fellowship training in pain management. (Tr. 300-304; State's Exhibit [St. Ex.] 24).

Dr. Shin testified that, upon completing his training, he had joined Lakewood Hospital in Cleveland as a staff anesthesiologist and as Director of the Pain Care Center of Lakewood. He remained at Lakewood for about eighteen months before returning to the Cleveland Clinic Foundation where he remained until 1999. Dr. Shin left the Cleveland Clinic Foundation to join the Anesthesia and Pain Center of Akron. (Tr. 303-304, 587-590).

Dr. Shin testified that he holds "board certification in American Board of Anesthesia with qualification pain management." Dr. Shin has made numerous presentations in the field of pain management including the use of opioids and other treatments for chronic pain. (Tr. 302-304, 851; St. Ex. 24).

Hal S. Blatman, M.D.

3. Hal S. Blatman, M.D., testified at hearing as an expert witness on behalf of Dr. Dahlquist. Dr. Blatman practices medicine in Cincinnati, Ohio. Dr. Blatman further testified that he had graduated from the Medical College of Pennsylvania in 1980. Dr. Blatman also testified that he had moved to Cincinnati in 1980 to enter a residency program in orthopedic surgery. He subsequently completed PGY-2 in an orthopedic residency program. Dr. Blatman testified that he had left the orthopedic residency program for life-style reasons and had begun working in urgent care. Dr. Blatman commented that he had learned primary care on the job and had continued to work in an urgent care setting until the late 1980s. (Tr. 987-988, 122-1221, 1252-1253; Resp. Ex. A).

Dr. Blatman testified that he had returned to school for a residency in occupational and environmental medicine which he had completed in 1988. Dr. Blatman further testified that it was during this residency that he had become interested in pain management. (Tr. 988-989, 1221-1224, 1226, 1234; Resp. Ex. A).

Dr. Blatman testified that he is board certified in occupational and environmental medicine by boards recognized by the American Board of Medical Specialties. He added that he is also board certified in pain management by examination written by the American Academy of Pain Management.”¹ Dr. Blatman testified that he has published and given a series of presentations in the field of pain management. Dr. Blatman testified that he currently operates the Blatman Pain Clinic treating patients with acute and chronic pain. (Tr. 993-994, 997-99, 1226-1235; Resp. Ex. A).

GENERAL TESTIMONY REGARDING PATIENTS 1 THROUGH 16

Dr. Shin’s General Opinions Concerning Patients 1-16

4. Regarding Dr. Dahlquist’s care and treatment of Patients 1 through 16, Dr. Shin opined, in part, as follows:

The overview of the patients revealed generally a younger population with a frequent diagnosis of soft tissue pain secondary to myofascial pain, strain, sprain, and fibromyalgia. Most of the patients were disabled or unemployed. Some of the patients had a prior history of substance abuse. Most often used techniques involved trigger point injections followed by epidural steroid injections, Matrix electroceutical therapy, and massage therapy. In all the cases reviewed, opioids were the first line of medications. Consistently throughout the review of the charts, her patients did not indicate significant objective improvement of pain. Most patients frequently return to the Pain Clinic for refills of opioids. In most cases when patients requested an increase of opioids, their requests were fulfilled. In some of the cases, the patients were able to receive their choice of opioids by stating that only certain medications worked. Under her care, the patients generally required higher and higher doses of medications. In many cases, these trends of care went on for several months to years. On a consistent basis, there was a clear evidence of failure to provide pain control despite escalating doses of opioids. Many of her patients were abusing the drugs. There was no attempt at weaning the opioids, or referring to an addiction specialist or to an inpatient type of multidisciplinary rehab/pain management program.

(Tr. 574-577, 908-909; St. Ex. 25). Dr. Shin added that,

¹ Dr. Blatman’s CV lists the following information under the heading “Board Certification”:

American Board of Preventive Medicine in Occupational Medicine, January 30, 1990.
American Academy of Pain Management, in Pain Management, January 15, 1992.
Diplomat of the American Academy of Pain Management.

(Resp. Ex. A)

In many cases, patients received trigger point injections containing corticosteroids on a regular basis. These injections did not provide long term objective improvements. These injections should have been stopped. The routine office trigger point injection that only provides hours to a few days of pain reduction is unadvised in treating patients with chronic pain. The injections are costly and are not benign. The long-term use of the corticosteroids can lead to coronary atherosclerosis, osteoporosis, Cushing's syndrome, adrenal insufficiency, cataract, glaucoma, immune suppression, and tissue damage.

(St. Ex. 25 at 19). Dr. Shin further opined that,

Dr. Dahlquist failed to describe accurate pain diagnoses that justify the protracted use of multiple and high doses of opioids. As a specialist, who has a sufficient training in opioid pharmacology, Dr. Dahlquist failed to use reasonable care discrimination in administration of medications consistently. Virtually, on every case, she implemented treatments with multiple different short acting opioids that ultimately provided the same purpose. Dr. Dahlquist also failed to recognize psychological factors, secondary gains and abuse potentials affecting the treatment course.

(St. Ex. 25 at 19).

In addition, Dr. Shin testified that, in general, Dr. Dahlquist was not aware of drug-seeking behavior. However, Dr. Shin conceded that Dr. Dahlquist had ordered drug screens, urine tests, random urine tests and a pill count on at least one occasion. Nevertheless, Dr. Shin concluded that Dr. Dahlquist had failed to provide the minimal standards of care in her treatment of Patients 1 through 16. (Tr. 729-730; St. Ex. 25 at 19).

Dr. Dahlquist's General Testimony Concerning Patients 1-16

5. Dr. Dahlquist testified that the sixteen cases at issue are among the most complex cases in her practice. She added that these patients were not curable with current medical knowledge, and will likely be in pain for the rest of their lives. Dr. Dahlquist testified that she believes that she complied not only with the minimal standards of care, but also with the Board's administrative rules with respect to the treatment of patients suffering from intractable pain. (Tr. 105-1601, 2055, 2064-2065, 2135).

Dr. Dahlquist asserted that Dr. Shin was wrong to criticize her by stating that "in all cases that he reviewed, opiates were the first line of medication used." She asserted that all of the patients had been treated by other physicians and other modes of pain therapy before she treated them. (Tr. 2023-2024).

Dr. Dahlquist testified that there is controversy regarding the long term use of opiates to treat chronic pain. She added that the “controversy seems to stem mostly from the fact that physicians and patients are afraid that addiction may develop if the patient is exposed to the medication for long periods of time.” (Tr. 1762-1763, 2052-2053). Dr. Dahlquist referred to an article by Russell Portenoy, M.D., which states that

The published literature continues to be very limited, but a growing clinical experience, combined with a critical reevaluation of issues related to the efficacy, safety, and addiction or abuse, suggests that there is a subpopulation of patients with chronic pain that can achieve sustained partial analgesia from opioid therapy without the occurrence of intolerable side effects or the development of aberrant drug-related behaviors.

(Tr. 2110-2112; Resp. Ex. D).

Dr. Blatman’s General Testimony Concerning Patients 1-16

6. Regarding Dr. Dahlquist’s care and treatment of Patients 1 through 16, Dr. Blatman opined:

Dr. Dahlquist has demonstrated herself to be a conscientious and caring algologist. She has been careful and discriminating with regard to prescribing opioid medications. Her patients have typically responded with decreased pain and increased function.

(Resp. Ex. C at 21). Dr. Blatman commented that there is not always a cure for a medical condition which causes severe or intractable pain. He added that the cause of severe or intractable pain is not always identifiable. Dr. Blatman testified that in the sixteen patient charts he reviewed, Dr. Dahlquist consistently complied with the standards of care. (Tr. 1023-1030, 1280-1282; Resp. Ex. B at 3).

In his September 1, 2002, report Dr. Blatman stated:

While it can be argued that one form of medical treatment (i.e. injections of steroids) may be overutilized, that does not mean that it is a violation of [Board] standards, or that this form of treatment is dangerous to the patient. It is well recognized that injection of steroids into tendons causes weakening of the tendons, and that there is a relative 3 injection limit to such treatment. There is no such limitation known with respect to injection of steroid into muscle. It cannot be inferred from tendon injection literature that muscle injection has similar hazards. In fact, the doctor’s interim history and repeated physical examination notes do not mention any ill effects derived from these muscle injections.

(Resp. Ex. B at 1).

Dr. Blatman further opined that, although Dr. Shin had alleged that long-term use of trigger point injections with cortisone can lead to several side effects, these side effects are extremely rare with intermittent injections. Dr. Blatman concluded that Dr. Dahlquist had met scientific methods when prescribing medications. (Tr. 1389-1390; Resp. Ex. C).

Finally, Dr. Blatman noted:

Dr. Shin concludes that most of these patients were able to receive their choice of opioids by stating that only certain medications worked. These patients typically suffered from chronic pain conditions, and they had had significant experience with prior treatment. It is entirely reasonable for these patients to advise the doctor regarding which medications helped them best. While doctors are instructed in their residency training programs that this is a drug seeking behavior, it is not appropriate to assume this condition.

(Resp. Ex. C at 21).

PATIENT 1

Allegations Concerning Patient 1

7. In its February 13, 2002, Notice of Opportunity for Hearing, the Board alleged that, in her care and treatment of Patient 1, Dr. Dahlquist had prescribed medications in types, amounts and/or combinations that were inappropriate and/or for protracted periods of time that were not justified. As an example, the Board alleged that Dr. Dahlquist had prescribed various opioids to Patient 1 on a protracted basis and frequently in high or escalating doses, although Patient 1's diagnosis and/or condition did not justify such prescribing.

The Board further alleged that Dr. Dahlquist had failed to identify a reasonable pain diagnosis or differential pain diagnosis, and/or to clarify or confirm the diagnosis, and/or to identify the organic cause, mechanism, or source of the patient's pain.

Finally, the Board alleged that Dr. Dahlquist had failed to include the findings of outside specialists, including normal upper GI studies and normal sigmoidoscopy findings, in her office notes. (St. Ex. 17A).

Medical Records for Patient 1

8. Patient 1, a forty year old female, first presented to Dr. Dahlquist's office on July 11, 1998. Patient 1 complained of pain in her right abdomen, and reported that her pain was so severe that she was sometimes unable to get out of bed. She further stated that she had missed work for "months at a time" due to her pain. In addition, Patient 1 complained of

migraines and joint pain. Patient 1 also complained of diarrhea, eight to twelve episodes per day. Finally, Patient 1 reported that she had been seeing a psychiatrist and a substance abuse counselor. (St. Ex. 1 at 3a, 5-7, 8b, 10, 14, 15).

Patient 1 testified that she had been taking Darvocet without any relief. She listed the medications that she had taken in the past and which had provided relief. The list included Vicodin, Percocet, and Soma. Patient 1 further reported allergies to Morphine, Nubain, Demerol, Toradol, Compazine, and Tylenol with codeine. Patient 1 further reported that the medications she was taking were Prevacid, Asacol, Phenergan for nausea and Stadol nasal spray for migraine headaches. Patient 1 added that, due to her gastrointestinal problems, she used Stadol spray when she was unable to take in oral medications. (St. Ex. 1 at 10, 15, 73).

Dr. Dahlquist dictated a lengthy and detailed Progress Note, which included sections on history of present illness, past medical history, surgical history, social history, family history, medications, allergies, review of symptoms, physical examination, assessment and plan. In the Progress Note, Dr. Dahlquist noted that Patient 1 had been followed for fourteen years at the Grandview Hospital medical/surgical clinic, and she had been referred to a pain management specialist. Dr. Dahlquist noted that her treating physicians no longer felt comfortable treating Patient 1 with opioid medications as they feared she had become addicted. Patient 1 had been sent to an addictionologist who, Patient 1 reported, had felt that her use of pain medications was appropriate. (St. Ex. 1 at 70-75).

Patient 1 had tried numerous non-opioid medications without relief or with significant side effects. (St. Ex. 1 at 71-72).

In her Assessment/Plan, Dr. Dahlquist wrote as follows:

Crohn's disease with persistent abdominal pain and cramping / responsive to oral opioid medication. After questioning the patient, it appears that she has been given a prescription for OxyContin, but she did not have a significant response even to fairly high doses. I suspect that this is because OxyContin is a sustained release preparation and it takes quite a while to absorb this medicine once it has entered her small bowel. Because she has a fairly rapid transit time (anywhere from 15 minutes to 3-4 hours), it would make sense that she would not absorb much of this medication. Therefore it seems reasonable that she be given short acting preparations, particularly since they do give her relief. I have a bit of concern about the amount of Acetaminophen that she might be ingesting, particularly when she has flair ups of her pain, and since the exact amount of absorption is not known. Therefore, I will give her a prescription for Oxy IR to see if she will get good relief with this medication. Since Soma seems to calm down her muscle spasm as well as her cramping and diarrhea, and since she has been evaluated both by a psychiatrist and addictionologist (both of whom have felt that she used her medications

responsibly), I feel comfortable giving her a prescription for this. Will recommend that she limit it to 3 tablets per day.

Since I do not know how she will respond to the Oxy-IR, I will give her a prescription for 20 Percocet tablets to have on hand if necessary (since she does know that this medication gives her good relief of pain). She can contact my office on Monday and let us know whether or not the Oxy-IR worked or not.

History of Migraine Headaches / For now the patient is receiving medications for her migraine headaches from the medical surgical clinic at Grandview Hospital. Should the physicians there prefer that I take over care of this condition, I will be glad to do so. I will not give her any prescriptions at this time for her migraine headaches.

(St. Ex. 1 at 74-75).

Patient 1 signed a Prescription Medication Contract. In the contract, Patient 1 agreed to a number of conditions, including the following:

- Patient 1 agreed not to use any pain medications other than those prescribed by Dr. Dahlquist.
- If any other physician wrote a prescription for medication, Patient 1 would inform Dr. Dahlquist.
- Patient 1 agreed to use only one pharmacy.
- Patient 1 agreed not to share her medications.
- Patient 1 agreed to use the medications only as prescribed by Dr. Dahlquist.
- If Patient 1 violated the contract, her treatment by Dr. Dahlquist could be terminated.

(St. Ex. 1 at 51-53). Dr. Dahlquist prescribed Percocet, a maximum of eight per day; OxyIR, a maximum of twelve per day; Soma, a maximum of three per day, and Phenergan. (St. Ex. 1 at 41).

Dr. Dahlquist sent notes to Patient 1's family physician and psychologist regarding her treatment plan for Patient 1. (St. Ex. 1 at 19-21, 27). Dr. Dahlquist also sent a letter to Patient 1's pharmacist, regarding Dr. Dahlquist's treatment plan for Patient 1. Dr. Dahlquist stated in the letter that she had done so to explain the reasons that Patient 1 would require opioid medications. Dr. Dahlquist also sent notes to various physicians. (St. Ex. 1 at 18).

On August 11, 1998, Patient 1 complained that she had been having a lot of diarrhea with poor absorption of her medications. Patient 1 requested Buprenex injectable medication which she had taken before and which had provided her with pain relief. Dr. Dahlquist

prescribed Buprenex, and planned to see Patient 1 again in two months. (St. Ex. 1 at 79). Overall, Dr. Dahlquist prescribed Buprenex 0.3/cc, one to two injections every four hours as needed for severe pain; Percocet, a maximum of eight per day, Soma, a maximum of three per day; and Phenergan. (St. Ex. 1 at 41).

On October 13, 1998, Patient 1 complained that she had been vomiting and that, because of her vomiting, her Percocet had been ineffective. Patient 1 requested Vicodin HP, and Dr. Dahlquist agreed to try it. Dr. Dahlquist prescribed Vicodin HP, 120 tablets, to be taken one every six hours as needed for pain. Dr. Dahlquist planned to see Patient 1 again in two months. (St. Ex. 1 at 41, 85). Subsequently, however, Dr. Dahlquist prescribed Percocet rather than Vicodin HP. She continued to prescribe Buprenex. (St. Ex. 1 at 41).

Thereafter, Patient 1 continued to have problems with nausea and vomiting. On December 22, 1998, Patient 1 asked to discontinue oral Percocet and to increase her Buprenex injections. Dr. Dahlquist agreed, noting that Patient 1 had been taking her injectable medications reliably and had shown no signs of abuse. Later that day, Dr. Dahlquist wrote a letter to Patient 1's pharmacist. In the letter, Dr. Dahlquist explained that she had prescribed Patient 1 Buprenex injections up to two injections per day. (St. Ex. 1 at 22, 97).

In January 1999, Patient 1 reported that her GI specialist wanted Patient 1 to be admitted to the hospital for insertion of a feeding tube. Patient 1 hoped to avoid it for a while longer. (St. Ex. 1 at 103).

On February 3, 1999, Patient 1 contacted Dr. Dahlquist's office and stated that she had been hospitalized at Southview Hospital and that she had not been receiving her pain medications. Dr. Dahlquist noted that she did not have privileges at Southview Hospital. She also noted that the admitting physician had given Patient 1 OxyContin 40 mg. three times a day and that he did not "want her to have much more than that." (St. Ex. 1 at 59).

On February 19, 1999, Patient 1 reported that she had been having a lot of pain and diarrhea, and had been admitted to the hospital. Dr. Dahlquist noted that Patient 1 was developing fibrosis in the muscles due to her injections. Later that day, Dr. Dahlquist wrote to Philip Williams, M.D., requesting that he evaluate Patient 1 for a Hickman catheter placement for administration of intravenous medications. Dr. Dahlquist explained that Patient 1 had only 35-40% of her small bowel and, thus, was unable to absorb food or oral medications adequately. Dr. Dahlquist further explained that she had been prescribing Patient 1 intramuscular Buprenex and Phenergan which Patient 1 injected at home. Dr. Dahlquist stated that, because of the frequent injections, Patient 1 had developed fibrosis in the muscles used for the injections, and Patient 1 was no longer absorbing the medications well. (St. Ex. 1 at 23, 109).

On February 26, 1999, Dr. Dahlquist wrote to Dr. Bob Galor to request that he evaluate Patient 1 "to see if she would be a candidate for the new experimental therapy for Crohn's Disease. (St. Ex. 1 at 24).

On March 3, 1999, Dr. Dahlquist prescribed Roxanol, a liquid form of morphine, in addition to Buprenex. (St. Ex. 1 at 41; Tr. 1619-1620). In her progress note, Dr. Dahlquist wrote, in part, as follows:

Crohn's disease with acute exacerbation of the disease and the cramping and pain that goes along with it. The only thing that has been controlling the pain has been injectable Buprenex * * *. She is beginning to run out of places to inject herself, and now she is not absorbing the injectable as well as she used to. I am a bit concerned about giving her Duragesic patches which will last continuously since she is taking an injectable agonist/antagonist (Buprenex). The Buprenex could reverse some of the effects of the Duragesic patches. I would rather have her alternating doses of Buprenex and liquid Morphine which is short acting. The Buprenex could be warn (sic) off primarily before the Morphine would be taken orally. This way she could cut down on the amount of the injections she is getting, but she would at least have them as a back up if she did not absorb the Morphine well.

(St. Ex. 1 at 133).

On March 19, 1999, Dr. Dahlquist noted that Patient 1 had been hospitalized, but had checked out of the hospital against medical advice because she did not feel that her pain was being adequately treated. Dr. Dahlquist noted that Patient 1 had had a Groshong catheter placed by Dr. Williams, but that Patient 1 was complaining of pain at the insertion site. Dr. Dahlquist further noted that Patient 1 had been taking her pain medications intravenously through the Groshong catheter. (St. Ex. 1 at 121, 193-194).

On April 1, 1999, Patient 1 reported that she had been experiencing a reaction to the Buprenex and that her symptoms were vomiting, dizziness, dilated pupils, shakiness, and jitteriness. Patient 1 believed that she was experiencing withdrawal. Dr. Dahlquist discovered that Patient 1 had been taking Buprenex through the Hickman catheter in addition to the Roxanol. Patient 1 agreed to take the Roxanol on a regular basis and to discontinue the Buprenex (St. Ex. 1 at 125).

On April 26, 1999, Dr. Williams advised Dr. Dahlquist that he had removed Patient 1's Groshong catheter due to cyanosis and swelling in her left lower extremity. (St. Ex. 1 at 64, 140, 199).

On May 5, 1999, Patient 1 complained of epigastric pain radiating through her back. Dr. Dahlquist ordered serum amylase and lipase to rule out pancreatitis. Patient 1 also complained of pain in her left arm since removal of the Groshong catheter. Dr. Dahlquist

noted that the left arm was swollen with engorged veins. Dr. Dahlquist continued to prescribe oral liquid Roxanol. Patient 1 was also taking Soma, Norflex, Phenergan, Azulfidine, and Prevacid at that time. (St. Ex. 1 at 140, 141).

On May 25, 1999, Patient 1 continued to complain of intractable abdominal pain and requested a different type of opioid medication. In her progress notes, Dr. Dahlquist wrote that she would prescribe Duragesic patches. Nevertheless, Dr. Dahlquist's medication list indicates that Dr. Dahlquist prescribed Vicodin in addition to the Duragesic patches. (St. Ex. 1 at 42, 152).

On June 4, 1999, Patient 1 called the office to request oral Phenergan, stating that she was getting sore from the injections. She also asked for Darvocet instead of Vicodin. Dr. Dahlquist requested that Patient 1 bring in her unused Vicodin before she could get the Darvocet. (St. Ex. 1 at 65).

On June 16, 1999, Patient 1 requested to be taken off Roxanol and to receive a substitute for Vicodin as Vicodin was causing vomiting. Dr. Dahlquist prescribed Darvocet. (St. Ex. 1 at 158a).

On June 25, 1999, Patient 1 was seen by William C.M. Wilson, M.D., F.A.C.P., upon Dr. Dahlquist's request. Dr. Wilson suggested that Patient 1 be weaned from Roxanol and evaluated "as a candidate for Remicade therapy (anti-TNF antibody)." (St. Ex. 1 at 202-203).

An Upper G.I. with Air and Small Bowel Follow-Through was performed July 1, 1999, revealed the following: "1. No definite abnormalities seen in the Upper G.I. tract; 2. Status-post partial small bowel resection without definitive abnormality seen in the residual small bowel loops." (St. Ex. 1 at 36).

On July 22, 1999, Dr. Dahlquist noted that Patient 1 had seen a gastroenterologist who was evaluating Patient 1 to see if she was a candidate for experimental treatment for Crohn's Disease. Dr. Dahlquist noted that Patient 1 had not shown any signs of abusing her medications. Her medications were noted to be as follows:

- Roxanol 4-6 mg. every three hours,
- Darvocet 100 mg, 2 tablets every four hours,
- Soma 350 one to four tablets per day,
- Analgesic Patches, one patch every three days
- Phenergan 25 mg orally as needed, and
- Phenergan injectable as needed.

(St. Ex. 1 at 164).

Also on July 22, 1999, at Patient 1's request, Dr. Dahlquist wrote a note "To whom it may concern," stating that Patient 1 was totally disabled due to the severity of her Crohn's Disease and pain. Patient 1 reported that she needed the letter to further her SSI disability. (St. Ex. 1 at 28).

On August 18, 1999, Dr. Dahlquist noted that Patient 1 had been taking Roxanol, and that her abdominal pain was under better control. Dr. Dahlquist discontinued the injectable Buprenex and provided Stadol nasal spray. (St. Ex. 1 at 115).

On August 20, 1999, Patient 1 reported to Dr. Williams' office that she had been having problems with impaction and rectal bleeding. (St. Ex. 1 at 215).

On August 27, 1999, Dr. Wilson reported as follows:

Currently I find no evidence of any significant [Crohn's] activity and I suspect that a lot of her bowel complaints may well be related to the Roxanol. I have encouraged [Patient 1] to continue to taper herself off of this medication if at all possible.

(St. Ex. 1 at 207).

On October 7, 1999, Dr. Wilson performed a flexible sigmoidoscopy of Patient 1. He noted a "[n]ormal flexible sigmoidoscopy exam to 60 cm." (St. Ex. 1 at 209).

On September 21, 1999, Dr. Dahlquist noted that she would continue Patient 1 on her current medication regimen. Nevertheless, Dr. Dahlquist started prescribing MS Contin and Xanax, in addition to Roxanol. Dr. Dahlquist did not explain the addition of the new medications in her progress note. (St. Ex. 1 at, 171).

On December 15, 1999, Dr. Dahlquist noted that Patient 1 had been stable on her medications and that she had presented for refills of that medication. Dr. Dahlquist listed Patient 1's medications as follows:

- MS Contin 100 mg orally three times per day,
- Roxanol 4-6 ml. every three hours for breakthrough pain,
- Darvocet for less severe breakthrough pain,
- Soma for muscle spasms, and
- Phenergan injectable as needed.

(St. Ex. 1 at 177).

In February 2000, Patient 1 reported that she had been taking her Roxanol at 18 ml. every nine to twelve hours rather than 4-6 ml. every three hours. Dr. Dahlquist noted that Patient 1 stated that she did not get overly sedated or show signs of difficulty with

coordination or demonstrate changes in mental status when taking Roxanol at this rate. Nevertheless, Patient 1 requested to be weaned from Roxanol and to try Duragesic patches. Dr. Dahlquist set forth a schedule for weaning from Roxanol, to be implemented at a later date. (St. Ex. 1 at 180-181).

On March 27, 2000, Patient 1 had biopsies performed on her ileum and colon. Both were benign. (St. Ex. 1 at 37).

On March 31, 2000, Dr. Dahlquist noted that Patient 1 had been taking Xanax, although the note does not indicate when it was first prescribed or the reason it was prescribed. Dr. Dahlquist noted that Patient 1's mother had reported that Patient 1 functioned better with her medications than without. Dr. Dahlquist further noted that Patient 1 had been hospitalized recently for an exacerbation of Crohn's disease. Finally, Patient 1 reported that her medications had not been working well and her diarrhea had increased and her absorption decreased. She requested Duragesic patches and Dr. Dahlquist agreed to prescribe them. At that time, Patient 1 was using Roxanol, 20 mg per cc, 2 four ounce bottles, every five days. (St. Ex. 1 at 46, 187-188).

Dr. Shin's Testimony Regarding Patient 1

9. Dr. Shin testified that Dr. Dahlquist had failed "to meet the minimal standards in providing medical care." As basis for his conclusions, Dr. Shin testified that Dr. Dahlquist had prescribed two types of opioids at the same time and that Dr. Dahlquist had prescribed escalating high doses of opioid medication. Moreover, Dr. Shin testified that Patient 1 was on opioid medications for a protracted period of time. (Tr. 320-322, 327-329).

Dr. Shin further testified that, although there can be significant pain during an exacerbation of Crohn's disease, when the disease is in remission the pain may be non-existent. Dr. Shin concluded that Patient 1's pain may have been from another source. He added that, if this were the case, Patient 1 had received too much pain medication. (Tr. 329).

Dr. Shin opined that Dr. Dahlquist had not adequately determined the diagnoses for Patient 1's pain. Dr. Shin testified that the medical records for Patient 1 provided no objective evidence that Patient 1 was suffering pain related to Crohn's disease. Dr. Shin noted that the biopsies, which are the gold standard study for Crohn's disease, were negative. Moreover, the Upper GI and Sigmoidoscopy were negative. Dr. Shin testified that when Dr. Dahlquist received the results of the normal findings, she should have looked elsewhere for the cause of the pain which required increasing dose of opioids. (Tr. 330-334, 741-750).

10. Dr. Shin testified that at the time of her initial evaluation Patient 1 reported that she had been seen by a psychiatrist and an addictionologist. Dr. Shin noted he had not seen any report from either of those individuals in Dr. Dahlquist's medical record for Patient 1. (Tr. 334, 339-347, 740-741, 947-948; St. Ex. 25).

11. Dr. Shin testified that he would not quit treating Patient 1 after several years. He explained “My initial evaluation would have been I want to make sure what is causing the pain so that I can take care of the pain and identify the identifiable cause of pain and treat with a multi-disciplinary effort to get this patient better.” He added “Now, if the patient wasn’t getting better, I got to find out why the patient isn’t getting better. Is it something we can’t treat with opioids? Do we need to stop that? I would have made those determinations somewhere down the road, where the patient was taking higher doses and still having constant spasm with pain.” (Tr. 743-747).

Dr. Dahlquist’s Testimony Regarding Patient 1

12. Dr. Dahlquist testified that her care and treatment of Patient 1 had met the standard of care for treatment of intractable pain. (Tr. 1629-1630).
13. Dr. Dahlquist testified that Patient 1 had not been suffering merely from Crohn’s disease. She stated that Patient 1 had had previous abdominal surgeries which had caused abdominal adhesions and the resultant pain. (Tr. 66-67, 1046, 1053, 1603-1604, 1610-1612).
14. Dr. Dahlquist asserted that the opioids that she had prescribed for Patient 1 were “in amounts and dosages that would meet standards of care and treatment of this patient * * * because the patient had a positive response without hindrance to her function and she reported improved quality of life and weight gain with them.” (Tr. 1620).

Dr. Dahlquist agreed that Patient 1 had been on three short-acting opioids and MS Contin, a long acting opioid. Dr. Dahlquist explained that Patient 1 had taken Roxanol on a regular basis. Vicodin was to be used for a more severe break-through pain. Moreover, Darvocet was to be used for less severe break-through pain; so Patient 1 was not taking them at the same time. (Tr. 90-91).

When asked if she had prescribed “high and escalating doses of opioids” to Patient 1 Dr. Dahlquist responded that the term “high” is relative, depending on what the patient needs. She further testified that she had prescribed escalating doses because that was what kept the patient functioning and having improvement in pain and quality of life. Dr. Dahlquist testified that anytime a patient is treated with an opioid, she follows the patient on a regular basis, and “if the patient is being treated ineffectively, if they’re complaining of worsening pain, then the dose is increased until the patient either obtains adequate pain relief and improvement in function or the patient begins to show adverse side effects of the medication.” Dr. Dahlquist added that “[a]t which point, of course, we would back off slightly. But the dose is completely dependent on how the patient is responding to the medication, and it’s individual in every case.” (Tr. 91, 1608-1609).

15. Dr. Dahlquist agreed that in late September or in October 1999 she had had Patient 1 on Prevacid, Duragesic patch, Roxanol, Soma, Darvocet, Vicodin, Xanax, MS Contin, and

Phenergan. Dr. Dahlquist testified that she had not been concerned with the number of medications Patient 1 was taking because Patient 1 had been coming into her office for over a year without showing any signs of sedation, abuse of her medications, or running out early on a routine basis. Dr. Dahlquist added that Patient 1 had never given her any reason to believe that she was demonstrating any signs of aberrant behavior with her medication. Dr. Dahlquist commented that the only problem prior had been a difficulty with the medications being effective until she was placed her on the Roxanol. (Tr. 88–90).

Dr. Dahlquist testified that once Patient 1 was on the Roxanol, she had broken the cycle of not being able to absorb the medications and the pain causing more diarrhea. (Tr. 88–90).

16. Dr. Dahlquist commented that Patient 1 had reported a forty-five pound weight gain with Roxanol, a short acting opioid. Dr. Dahlquist explained that Patient 1 had previously suffered a significant unhealthy weight loss due to her illness “and with the Roxanol, she was able to gain the weight back. And she even reported feeling better than she had felt in a year at that point.” (Tr. 90, 1608).

Dr. Dahlquist testified that about twenty per cent of the time when she refers a patient to another physician, the other physician reports back to her in writing. She added that sometimes the other physician will telephone her and sometimes they are not responsive. Dr. Dahlquist noted that sometimes the physician takes over treatment for the condition which had led to the referral. Dr. Dahlquist asserted that when “it’s going to affect the pain management, I make every attempt to at least contact the other physician if I’ve not heard from the other physician.” (Tr. 2138-2139).

17. Dr. Dahlquist stated that Patient 1 had reported having undergone psychological counseling with Dr. Johnson and an addiction evaluation from Dr. Davis. Dr. Dahlquist conceded that she had not obtained Patient 1’s medical records from these treatment providers. Nevertheless, Dr. Dahlquist explained that she had called Dr. Johnson to confirm that Patient 1 had been there. Moreover, Dr. Dahlquist had sent notes to both doctors advising that she had assumed Patient 1’s pain management and asked them to contact her if they had any concerns about Patient 1 being on opioid medications. Dr. Dahlquist explained that she had faxed these notes to Dr. Davis and Dr. Johnson, and neither had expressed any concern regarding Dr. Dahlquist’s treatment. (Tr. 77-81, 339-344, 2136-2137).
18. Dr. Dahlquist noted that Patient 1 had often requested changes in her medications and had requested specific medications. Dr. Dahlquist testified that this was not a cause for concern in Patient 1 because Patient 1 had tried so many pain medications in her lifetime. Dr. Dahlquist commented that “[p]atients can develop a tolerance to one medication after they have taken it for a while. And it’s certainly reasonable to switch them back to another medication which has worked for them previously because of the incomplete cross-tolerance, at that point the patient may actually respond better to the previous medication.” Dr. Dahlquist continued, “In general, when a patient tells me that a specific medication works well, I want to know the circumstances of that; if they had taken it before, how they

responded; did they have any adverse side effects to the medication.” Dr. Dahlquist added, “[T]he majority of patients that I see have had pain for several years. And I would expect the patient to know, at least from the medications they’ve tried, which medications work well and which don’t.” Dr. Dahlquist commented, “If I’m going to believe the patient that they have pain, then I am certainly going to believe the patient when they tell me what works and what doesn’t. And then what -- what I treat them with, I will follow from that point on and evaluate the patient’s response to the therapy.” (Tr. 1623-1624).

Dr. Blatman’s Testimony Regarding Patient 1

19. Dr. Blatman opined that Dr. Dahlquist had met standards of care and treatment in her treatment of Patient 1. Dr. Blatman testified Patient 1’s condition had improved under Dr. Dahlquist’s care. Dr. Blatman noted that Patient 1 had gained weight, had been able to take nutrition orally rather than intravenously, and had visited the emergency room less often. (Tr. 1050-1051, 1055; Resp. Ex. B at 4-5; Resp. Ex. C at 2).
20. Dr. Blatman opined that Patient 1 was not prescribed medications in types or amounts or in combinations that were inappropriate or for protracted periods of time that were not justified. Dr. Blatman further opined that Patient 1 had not been prescribed various opioids on an unnecessary protracted basis of frequently high or escalating doses. (Tr. 1049-1050; Resp. Ex. B at 4-5; Resp. Ex. C at 2).
21. Dr. Blatman stated the diagnosis of Crohn’s disease for Patient 1 was well-established and reasonable as a pain diagnosis. Dr. Blatman opined that there was no need to subject Patient 1 to undergo further testing to look for organic causes or other sources of pain. (Tr. 1045-1046; Resp. Ex. B at 5).

PATIENT 2

Allegations

22. In its February 13, 2002, Notice of Opportunity for Hearing, the Board alleged that, in her care and treatment of Patient 2, Dr. Dahlquist had prescribed medications in types, amounts and/or combinations that were inappropriate and/or for protracted periods of time that were not justified. As an example, the Board alleged that Dr. Dahlquist had prescribed high doses of opioids and benzodiazepines to Patient 2—a chronic smoker with a history of emphysema—despite the unacceptable risk of cardiopulmonary failure.

The Board further alleged that Dr. Dahlquist had inappropriately administered injections or blocks to Patient 2. As an example, the Board alleged that,

- On approximately sixteen occasions, Dr. Dahlquist had administered Depo-Medrol trigger point injections to Patient 2—who had had compromised respiratory functions

due to emphysema and a history of congestive heart failure—despite the increased risk of congestive heart failure and pulmonary edema

- On approximately twenty-five occasions, Dr. Dahlquist had administered Toradol injections to Patient 2, rather than an oral anti-inflammatory, despite the risk of gastrointestinal bleeding.

Moreover, the Board alleged that, although Dr. Dahlquist had prescribed medications containing acetaminophen on a protracted basis to Patient 2, she had failed to obtain and/or document appropriate liver function studies.

Furthermore, the Board alleged that Dr. Dahlquist had failed to inform Patient 2 and/or to document having informed Patient 2, of her increased risk of cardiopulmonary failure due to the high doses of opioids, benzodiazepines and corticosteroids that Dr. Dahlquist provided her.

Finally, the Board alleged that Dr. Dahlquist also had failed to prescribe anti-depressants to Patient 2 or to refer Patient 2 to a specialist, despite her indications of depression. (St. Ex. 17A).

Dr. Dahlquist's Medical Records for Patient 2

23. Patient 2, a 52 year old permanently disabled woman, first presented to Dr. Dahlquist's office on June 3, 1997. She had been referred by Denise Griffith, M.D. Patient 2 had a history of low back pain, neck pain, and migraine headaches. More recently, Patient 2 had been diagnosed with breast cancer and had undergone a lumpectomy and was prescribed Tamoxifen and estrogen. With the initiation of estrogen therapy, Patient 1's migraine headaches had increased significantly. Moreover, Patient 2 had recently had a C.T. scan performed, but had not yet received the results. Patient 2 also reported that she had received psychological counseling for depression during the past eight years. In addition, Patient 2 reported a history of hypertension, angina, palpitations, congestive heart failure, arthritis, gout, emphysema, and cholelithiasis. She had had a coronary artery bypass graft in 1987 and a femoral artery bypass graft in 1989. (St. Ex. 2 at I: 5; St. Ex. 2 at II: 6-15).

Patient 2 stated that she had tried Ultram, Compazine, and Toradol in the past without relief of pain. She denied having tried physical therapy, specific nerve blocks, surgical procedures, or alternative medical therapies. Patient 2 was then taking imipramine, BuSpar, Zantac, Calan, K-Dur, Vasotec, Allopurinol, Imdur, furosemide, levothyroxine, Lanoxin, Prempro, Tamoxifen, Albuterol Inhaler, and Azmacort inhaler with guaifenesin. Patient 2 stated that she was allergic to Sulfa and Valium. (St. Ex. 2 at I: 5-6).

In her Assessment/Plan, Dr. Dahlquist wrote as follows:

Migraine headache which seems to have worsened since she has begun taking Tamoxifen. The patient is on no specific migraine medication, although she is on a calcium channel blocker which should keep them somewhat under control. I think it would be wise to give her a narcotic to use as an abortive medication for the migraine headaches, however, since she does not have one of these available. This could be aggravated by severe muscle spasm and bilateral occipital neuritis as evidenced by physical exam. I think that she would also benefit, therefore, with a muscle relaxant and Electroceutical therapy. I will give her an injection of Toradol, Norflex, and Phenergan to help control the nausea, pain, and muscle spasm today. I recommend that she go home and get some rest and take the oral medication specified above (Vicodin) and Flexeril. I will also give her a prescription for a Medrol Dose Pak to help decrease any inflammation in the muscles as well as Phenergan to help control the nausea. I will set her up for a series of Matrix Electroceutical neuron blockage and interferential treatments. I will see her back in 2 weeks for reevaluation of her migraine headaches.

(St. Ex. 2 at I: 6).

Patient 2 signed a detailed Prescription Medication Contract with Dr. Dahlquist. On June 20, 1997, Dr. Dahlquist wrote to Dr. Griffith regarding her plan of treatment and enclosed a copy of her dictation and the Patient 2's Prescription Medication Contract. (St. Ex. 2 at II: 24, 30-34). Thereafter, Patient 2 underwent a series of Matrix Electroceutical neuron blockage treatments without relief. (St. Ex. 2 at I: 10a, 13a, 16).

On July 21, 1997, Dr. Dahlquist performed bilateral Greater Occipital Nerve blocks with Carbocaine. She also performed six myofascial trigger point injections with Depo-Medrol, Carbocaine, and Bicarbonate. Patient 2 signed a consent form for Bilateral Greater Occipital Nerve Blocks and Myofascial Trigger Point Injections. In Dr. Dahlquist's consent form, the patient has an option to indicate either that a detailed explanation had been given regarding the procedure or that the patient had refused the explanation. Patient 2 signed the portion of the form which indicates that she had received a detailed explanation of the procedures. (St. Ex. 2 at I: 16-21).

From July through October 1997, Dr. Dahlquist performed numerous myofascial trigger point injections from which Patient 2 had obtained short term relief. Patient 2 signed a new consent form with each treatment. During that time, Patient 2 also received Toradol injections at each visit for myofascial trigger point injections. In addition, Patient 2 was taking Percocet, Vicodin, and Soma. (St. Ex. 2 at I: 23-62; St. Ex. 2 at II: 36-37).

On July 25, 1997, Patient 2 requested an injection for pain, and asked for a refill of Vicodin early. She stated that she had been limiting her use of Percocet and using the Vicodin instead. The medical record noted an “inadvertent overuse of meds.” (St. Ex. 2 at II: 43-44).

On August 1, 1997, Patient 2 stated that the Norflex had not been relieving her muscle spasms. She asked if she could use twice the amount of Norflex or try another medication. Dr. Dahlquist prescribed Soma. (St. Ex. 2 at II: 45).

On October 21, 1997, Dr. Dahlquist prescribed a sixty day supply of OxyContin and, at least, a fifteen day supply of Vicodin. She also prescribed Trazodone and Soma. One week later she prescribed Percocet. Thereafter, Dr. Dahlquist continued to prescribe OxyContin, Percocet, Vicodin, Soma, and Trazodone. (St. Ex. 2 at II: 36-38).

In December 1997, Patient 2 fell, which caused an exacerbation of the pain. Dr. Dahlquist ordered an MRI scan to rule out acute disc herniation. The MRI revealed “Overall mild diskogenic changes throughout the lumbar spine as described. No clear-cut focal or lateralizing disk herniation is detected.” Dr. Dahlquist continued the myofascial trigger point injections. Dr. Dahlquist also scheduled Patient 2 for massage and Reiki therapy. (St. Ex. 2 at I: 77, 85; St. Ex. 2 at II: 17-18).

On February 6, 1998, Dr. Dahlquist noted that Patient 2 had been taking OxyContin 40 mg. every eight hours and Percocet up to six tablets per day. Dr. Dahlquist further noted that, “This seems to be holding her pain at a relatively tolerable level in conjunction with the trigger point injections. She has been using these medications very consistently and has not shown any signs of drug abusive behavior.” (St. Ex. 2 at II: 74).

On March 13, 1998, Patient 2 reported that her husband had died unexpectedly. She stated that she was experiencing increased anxiety and pain and requested Ativan, stating that it had been effective in the past. Dr. Dahlquist prescribed a two week supply of Ativan and recommended that Patient 2 use it “sparingly.” Dr. Dahlquist continued the myofascial trigger point injections. (St. Ex. 2 at II: 67).

On March 30, 1998, Patient 2 reported to the emergency room with complaints of a migraine headache. She was dehydrated and presented with an altered mental status. Patient 2 denied taking any medication for migraine headaches. In addition, she reported that her current medications were, “Tamoxifen, Vasotec, Humibid, Albuterol, and some other medications which she cannot remember.” A urine screen revealed “no alcohol, barbiturates, or benzodiazepines.” (St. Ex. 2 at II: 77-80).

Dr. Dahlquist saw Patient 2 on April 24, 1998. She made no mention of Patient 2’s recent emergency room visit in the progress note. Dr. Dahlquist noted that Patient 2 had had an acute exacerbation of myofascial pain. She noted that Patient 2 had been taking her OxyContin, Ativan, and Percocet as written and had not shown any signs of abuse of the

medications. Dr. Dahlquist continued the myofascial trigger point injections. (St. Ex. 2 at II: 85).

On April 27, 1998, Patient 2 reported that she had lost her Percocet and Ativan. Dr. Dahlquist called in a refill for Ativan. (St. Ex. 2 at II: 46).

On May 12, 1998, Patient 2 called the office requesting something for headache. Dr. Dahlquist called in a prescription for Phrenilin Forte. Patient 2 reported that it was not effective. (St. Ex. 2 at II: 47).

On June 26, 1998, Patient 2 called the office complaining of a migraine headache not relieved by her medications. (St. Ex. 2 at II: 48).

In August 1998, Dr. Dahlquist noted that Patient 2 was experiencing increased pain and anxiety. She had recently discovered a new lump in her breast. Dr. Dahlquist increased Patient 2's Ativan to four tablets per day and continued the myofascial trigger point injections. Dr. Dahlquist noted that Patient 2 had been attending a support group for grieving and a support group for cancer survivors. (St. Ex. 2 at II: 109).

In September 1998, Dr. Dahlquist noted that she was concerned that the breakdown products of Soma can cause aplastic anemia. Dr. Dahlquist limited Patient 2's Soma to sixty tablets per month. Dr. Dahlquist added Norflex to Patient 2's medication regimen. (St. Ex. 2 at II: 117).

On October 23, 1998, Patient 2 called the office. She stated that she had spilled water into her Ativan container ruining the tablets. She requested another prescription. Dr. Dahlquist prescribed Xanax to last until her next refill was due. (St. Ex. 2 at II: 49).

On October 31, 1998, Patient 2 contacted Dr. Dahlquist's office complaining that she had not had any Ativan for eleven days. Dr. Dahlquist noted that Patient 2's speech was slurred, and she was concerned that Patient 2 may have been overmedicated, going through withdrawal, or experiencing a cerebral vascular accident [CVA]. Dr. Dahlquist advised Patient 2 to go to the emergency room. Thereafter, an emergency room physician contacted Dr. Dahlquist. The emergency room physician advised that Patient 2 was not likely suffering a CVA, did not appear to be over-medicated, and did not show signs of withdrawal. The emergency room physician gave Patient 2 enough Ativan to last until Dr. Dahlquist could see her on the following Monday morning. (St. Ex. 2 at II: 50).

On November 11, 1998, Dr. Dahlquist noted that Patient 2 had been experiencing increased depression related to her husband's death and the holidays. Dr. Dahlquist discussed counseling with Patient 2, and noted Patient 2's response as follows: "[W]ith her family's support and the use of oral medication, she can make it through the holidays. She is agreed to return to counseling in January should she not be able to wean down off the medication herself after the holidays." Dr. Dahlquist increased the Ativan to a maximum of 2 mg.

every six hours, and instructed Patient 2 to call the office if the increase in medication resulted in overmedication. (St. Ex. 2 at II: 125).

On December 10, 1998, the daughter of Patient 2 called the office to advise that Patient 2 had expired at home. (St. Ex. 2 at II: 51).

Certificate of Death for Patient 2

24. The Certificate of Death for Patient 2 indicates that the immediate cause of death was “coronary artery disease with severe left ventricular dysfunction.” Other contributing factors were, “Chronic obstructive pulmonary disease. Possible gastrointestinal bleeding (melena); substance abuse.” (Tr. 374-379, 1072-1074; St. Exs. 2, 18).

Dr. Shin’s Testimony Regarding Patient 2

25. In his December 6, 2001, report concerning Patient 2, Dr. Shin stated that,

In treating [Patient 2], there was no indication that opioids were ordered other than for legitimate therapeutic purposes and the patient was taking the medication according to Dr. Dahlquist’s directions. The patient, however, had multiple medical history including cardiac, pulmonary, peripheral vascular diseases as documented in the medical history. The patient had history of emphysema and was a chronic active smoker. A high dose opioid and benzodiazepine use is inappropriate in this patient. Using opioids and benzodiazepines in a patient with already compromised respiratory function, increases the risk of respiratory depression, which can lead to respiratory failure. Not recognizing the potential respiratory consequences in this patient, Dr. Dahlquist failed to provide the minimal standard of care.

(Tr. 353, 357-358, 363-364; St. Ex. 25 at 3).

26. Dr. Shin testified that he had concerns regarding Patient 2’s various calls for refills of medications, and lost or destroyed medications. Dr. Shin noted that,

We would consider these sort of red flags. Early refills can happen, and these are legitimate, patient being underdosed, obviously. But when they’re sort of mixed with patient lost prescription, water spilling on top, and other excuses, that doesn’t make a whole lot of sense. Then you have to say to yourself, well, is this a red flag? Is the patient abusing these medications; taking for other purposes? Is she taking more? Is she giving them to somebody else? It should come to your mind that that might be happening and appropriate steps need to be made.”

(Tr. 368-371).

Finally, Dr. Shin opined that, when there were questions regarding possible medication abuse, Dr. Dahlquist should have evaluated Patient 2 in the office. Moreover, Dr. Dahlquist should have ordered a toxicology screen to see if Patient 2 was taking too much medication and to assure that she was taking the medication at all. He added that Dr. Dahlquist also should have evaluated Patient 2 for over-sedation and depression. (Tr. 371-372).

Dr. Shin acknowledged that, although Patient 2 had been on long-term opioid therapy, there were no clear indications that Patient 2 had been over-sedated by her medications. (Tr. 765-766).

27. Dr. Shin noted that, on sixteen visits, Patient 2 received multiple trigger point injections with Depo-Medrol. Dr. Shin testified that Depo-Medrol can cause increased intravascular volume which is a strain on the heart. The heart goes into failure and ultimately cardiac failure which can result in death. Nevertheless, Dr. Shin testified that he could not say that the multiple trigger point injections of Depo-Medrol were contraindicated in Patient 2. Dr. Shin expressed concern, however, that the frequency of injections was unwarranted in a patient with coexisting cardiopulmonary history. Dr. Shin further opined that Dr. Dahlquist had not informed Patient 2 of the risks associated with injections of Depo-Medrol in light of Patient 2's coexisting diseases. (Tr. 357-358, 432-434, 768-776, 948-949; St. Exs. 18, 25).
28. Dr. Shin criticized Dr. Dahlquist's use of frequent Toradol injections. Dr. Shin stated that Patient 2 had been seen in Dr. Dahlquist's office a total of twenty-five times between June 1997 and November 1998 and that, on each visit, Dr. Dahlquist had provided Toradol injections. He stated that Toradol can lead to gastrointestinal bleeding. Dr. Shin added that the frequent use of a short acting injectable anti-inflammatory has a minimal role in treating chronic pain patients. He concluded that the frequent use of Toradol in this case had been inappropriate and that Dr. Dahlquist had failed to use reasonable care discrimination in the administration of the medications. (Tr. 357-358, 365-367, 432-434; St. Ex. 25 at 3).
29. Dr. Shin testified that Dr. Dahlquist had prescribed high doses of acetaminophen, particularly in the Percocet and Vicodin, which can lead to liver toxicity. Dr. Shin further testified that Dr. Dahlquist had not ordered liver function studies or asked Patient 2's primary care physician to do so. Dr. Shin concluded that, "Because of the patient's multiple medical history as well as pertinent social history, the patient should have been considered a risk factor. Failure to obtain and document her liver functions is below minimal standards of care." (Tr. 357-358, 364-365; St. Ex. 25 at 3).
30. Dr. Shin testified that Dr. Dahlquist had noted Patient 2's depression in the medical record. Nevertheless, he criticized Dr. Dahlquist because she had not prescribed anti-depressant therapy; moreover, she had not referred Patient 2 to an appropriate specialist for evaluation and treatment. (Tr. 357-358; St. Ex. 25 at 3).

Dr. Dahlquist's Testimony Regarding Patient 2

31. Dr. Dahlquist testified that she had conformed to standards of care and treatment for Patient 2. (Tr. 1639, 659).
32. Dr. Dahlquist acknowledged that Patient 2 had been taking high doses of short acting opioids, including Percocet and Vicodin. Dr. Dahlquist asserted there is no contraindication for using Vicodin and Percocet together. Dr. Dahlquist stated that, in some cases, she prescribes Vicodin for less severe break-through pain and Percocet for more severe break-through pain. In other cases, Vicodin and Percocet can have a synergistic effect. (Tr. 100-101, 1631-1632, 1652-1654).

Dr. Dahlquist testified that she had considered Patient 2's history when she had prescribed opioids for her. Dr. Dahlquist testified that she had never seen any indication that the opioids she had prescribed to Patient 2 had compromised Patient 2's respiratory or cardiopulmonary function. Dr. Dahlquist commented that there is no contraindication for opioid therapy in a patient who has a history of cardiopulmonary problems and who also suffers from intractable pain. (Tr. 1632-1635, 1649-1650).

Dr. Dahlquist testified that she had taken Patient 2's phone messages and statements into consideration in determining what prescriptions to issue. Regarding the July 25, 1997, reference to "inadvertent overuse of meds," Dr. Dahlquist testified that, when a patient's pain increases, the patient may inadvertently take additional medication because the pain is not getting better. Dr. Dahlquist asserted that "in and of itself" the inadvertent overuse of medication does not indicate that a patient is a drug abuser. She noted, however, that if the behavior had become a pattern of behavior, she would have been concerned. (Tr. 106-107, 1651-1652, 2042-2045).

33. Dr. Dahlquist testified that that she disagrees with Dr. Shin's opinion that she should have avoided using trigger point injections with corticosteroids in treating Patient 2. Dr. Dahlquist further testified that she had utilized trigger point injections only after other therapy had been ineffective. Dr. Dahlquist commented that the steroid medication helps to decrease inflammation, and that she believes Patient 2 received a benefit from the trigger point injections. Dr. Dahlquist testified that Patient 2 had some amount of pain relief for two to three weeks following each set of injections. (Tr. 1639-1641, 1645-1646).

Dr. Dahlquist testified that when using a series of trigger point injections she examines the patient to see if the patient is having any adverse reactions to trigger point injections, including fluid retention. (Tr. 1641-1643, 1646, 2141-2143).

Regarding informed consent, Dr. Dahlquist testified that the first time she gives trigger point injections to a patient she explains the procedure to the patient, including side effects. Dr. Dahlquist commented that she does not document all of this discussion with every

patient. She explained, however, that she uses a consent form which the patient signs, acknowledging that instructions have been given. (Tr. 1643-1646).

34. Dr. Dahlquist testified, contrary to Dr. Shin's assumption, she had not given Toradol injections to treat Patient 2's chronic pain. Dr. Dahlquist testified that she had given Toradol in conjunction with the myofascial trigger point injections because they are extremely painful. Dr. Dahlquist testified that Toradol is a nonsteroidal, anti-inflammatory agent that helps decrease the inflammation and discomfort of the needle being inserted into the tender muscle. (Tr. 37, 98-99, 663, 1067-1070, 1647).

Dr. Dahlquist testified that the risks of Toradol increase with the frequency of the injections and the amount of medication given. Dr. Dahlquist asserted that the PDR recommends that Toradol not be used for more than five consecutive days. She noted, however, that she had given Toradol as isolated injections once every several weeks. Dr. Dahlquist testified that Toradol injections were not contraindicated in Patient 2 and that Patient 2 never demonstrated any adverse effects from the Toradol injections. In addition, Dr. Dahlquist testified that she had instructed Patient 2 to be aware of the signs and symptoms of gastrointestinal bleeding, including dark, tarry stools; hematemesis; or abdominal discomfort. (Tr. 98-100, 1648).

35. Dr. Dahlquist testified that she had prescribed appropriate doses of acetaminophen and that she had not seen any evidence of liver problems with Patient 2. (Tr. 1638-1639).
36. Dr. Dahlquist testified that she had paid attention to Patient 2's psychological or psychiatric condition. Dr. Dahlquist pointed out several notations in the medical records indicating that she had received information from Patient 2 and had discussed psychological issues and treatment with her. (Tr. 1648-1649).

Dr. Dahlquist testified that Patient 2 had stated that she was continuing to see her psychiatrist during the course of her treatment by Dr. Dahlquist. Dr. Dahlquist acknowledged, however, that there was no such indication in the medical record. Dr. Dahlquist further acknowledged that, on multiple occasions, she had prescribed Trazodone, an anti-depressant, to Patient 2. Dr. Dahlquist asserted that she had not been treating Patient 2 for depression but rather was using the Trazodone to help Patient 2 sleep. (Tr. 103-10, 106).

Dr. Blatman's Testimony Regarding Patient 2

37. Dr. Blatman testified that there was no indication in the medical record that Patient 2 had suffered from any adverse consequences as a result of Dr. Dahlquist's prescription of opioids. Dr. Blatman acknowledged that Patient 2 had received high doses of medications. Nevertheless, he qualified his testimony by stating that "'high' is a relative term." Dr. Blatman testified that the doses prescribed for Patient 2 had been appropriate because

she had received the amount of medication needed to treat her pain. (Tr. 1062-1064, 1072-1074, 1298-1300).

Dr. Blatman testified that what Dr. Shin describes as “high doses” of opioids and benzodiazepines are not inappropriate for Patient 2 in spite of the patient’s alleged compromised respiratory function. Dr. Blatman explained that, “Opioid medications are not expected to cause any increase in pulmonary compromise or respiratory depression except in an opioid-naive patient.” Dr. Blatman testified that Patient 2 was not an opioid naive patient. Dr. Blatman concluded that Dr. Dahlquist had provided appropriate medications to Patient 2. (Tr. 1058-1066, 1297-1298; Resp. Ex. B at 6; Resp. Ex. C at 3).

Dr. Blatman testified that there is nothing in the medical records which would indicate that Patient 2 had abused the medications which Dr. Dahlquist was prescribing. (Tr. 1072-1074).

Dr. Blatman further testified that it is not below the standard of care to administer the combination of Vicodin and Percocet provided to Patient 2. He elaborated that they are different medications and may work on different receptor sites, thereby working synergistically. Dr. Blatman continued that Patient 2 had been receiving “a stable degree of relief from this combination of medications.” (Tr. 1071-1072).

38. Dr. Blatman testified that Dr. Dahlquist’s use of trigger point injections in Patient 2 had been appropriate. Dr. Blatman acknowledged that the trigger point injections had not obviated the need for additional pain medications. He testified, however, that they had allowed an improved quality of life and increased activity. Dr. Blatman testified that, in a patient with a myofascial pain disorder, trigger point injections are a mainstay of treatment. (Tr. 1064, 1300-1304).

Dr. Blatman testified that there was no evidence that the trigger point injections provided to Patient 2 had caused any medical problems such as muscle wasting, toxicity or cardiovascular damage. (Tr. 1064-1065; Resp. Ex. B at 6).

39. Dr. Blatman testified that Dr. Dahlquist’s use of Toradol injections with Patient 2 had not fallen below the minimal standards of care. (Tr. 1067-1070, 1304-1305; Resp. Ex. C at 3).

40. Dr. Blatman testified the dose of acetaminophen Dr. Dahlquist had prescribed to Patient 2 was no higher than that recommended in over-the-counter acetaminophen products. Dr. Blatman asserted that there was no indication to order liver function tests based only on the amount of acetaminophen prescribed by Dr. Dahlquist. Dr. Blatman added that there was no indication that Patient 2 had suffered from any liver dysfunction or any other adverse consequences caused by medications containing acetaminophen. (Tr. 1062-1064, 1072, 1298; Resp Ex. C at 3).

41. Dr. Blatman testified that Dr. Dahlquist had paid appropriate attention to Patient 2's depression, noting the November 1998 agreement for Patient 2 to return to counseling in January 1999 if she were unable to wean herself from her medications after the holidays. Dr. Blatman further stated that Dr. Dahlquist had noted that Patient 2 had seen a psychologist in the past and had undergone counseling for anxiety and depression prior to her husband's death. (Tr. 1070-1071; Resp Ex. B at 7; Resp. Ex. C at 3).

PATIENT 3

Allegations

42. In its February 13, 2002, Notice of Opportunity for Hearing, the Board alleged that, in her care and treatment of Patient 3, Dr. Dahlquist had prescribed medications in types, amounts and/or combinations that were inappropriate and/or for protracted periods of time that were not justified. As an example, the Board alleged that Dr. Dahlquist prescribed various opioids to Patient 3 on a protracted basis and frequently in high or escalating doses, although Patient 3's diagnosis and/or condition did not justify such prescribing.

The Board further alleged that Dr. Dahlquist had inappropriately administered injections or blocks. As examples, the Board alleged that,

- Dr. Dahlquist had administered Toradol injections to Patient 3 on approximately thirty-five occasions although the injections were contraindicated due to Patient 3's history of peptic ulcer disease and duodenitis.
- She also administered corticosteroid injections to Patient 3 on approximately thirty-five occasions despite the risks of steroid dependency, adrenal suppression, hyperglycemia, and fluid retention.

In addition, the Board alleged that Dr. Dahlquist had failed to adequately recognize and/or address indications of drug abuse or the increased risk of drug abuse.

The Board further alleged that Dr. Dahlquist had failed to identify a reasonable pain diagnosis or differential pain diagnosis, and/or to clarify or confirm the diagnosis, and/or to identify the organic cause, mechanism, or source of the patient's pain.

Finally, the Board alleged that, although Dr. Dahlquist had prescribed medications containing acetaminophen on a protracted basis to Patient 3—who had prior elevated liver function enzymes and a history of alcohol abuse—she failed to obtain and/or document appropriate liver function studies. (St. Ex. 17A).

Medical Records for Patient 3

43. Patient 3, a forty-three year old male and the husband of Patient 2, was admitted to an outpatient clinic at Miami Valley Hospital under the care of Dr. Dahlquist on March 22, 1994. He was admitted as a referral from Hugh Moncrief, M.D., a neurosurgeon. Patient 3 presented for lumbar epidural steroid injections due to pain of the left hip and posterior left leg, right leg cramps, lower back pain, burning, aching, sharp and shooting pain of the lower extremities. An MRI in September 1993 had revealed congenital spinal stenosis. Patient 3 had had a laminectomy in November 1993. Prior to admission, Patient 3 had been taking Darvocet and Soma. (St. Ex. 3 at I: 5-6; St. Ex. 3 at IV: 11, 82-86, 100-104).

Patient 3 reported that he was 6'7" tall and weighed 300 pounds. He smoked two packs of cigarettes per day and denied the use of alcohol. His current medications included Diabeta, Zolof, Vasotec, Zantac, Allopurinol, and Calan. (St. Ex. 3 at IV: 7).

Patient 3 had a history of "many years of alcohol abuse." He stated that he had been sober since 1988. His prior medical history also included asthma, essential hypertension, duodenal ulcer, pancreatitis, and hemorrhoids. (St. Ex. 3 at IV: 15, IV: 79; St. Ex. 3V).

On March 22, 1994, Patient 3 received lumbar epidural injections with Depo-Medrol and lidocaine, and sacroiliac joint injections with Depo-Medrol, Carbocaine and bicarbonate. Patient 3 signed a written consent for these injections. Dr. Dahlquist prescribed Darvocet. After leaving the office, Patient 3 called to request something for muscle spasms. Dr. Dahlquist prescribed Soma, ninety tablets to be taken once every eight hours as needed, with three refills. Taken around the clock, this would have been a four month supply. (St. Ex. 3 at I: 11-12; St. Ex. 3 at IV: 40-42, 44).

Patient 3 called the clinic thirteen days later. Patient 3 reported that he had filled the Darvocet prescription on March 22 and had only two tablets left. He also stated that he had refilled his Soma prescription on March 29 and had only fifty tablets left. Patient 3 reported that he had been taking Soma four to five times per day. He requested additional medications to last until the end of April because he was going on vacation. Dr. Dahlquist called in refills. (St. Ex. 3 at IV: 45).

Patient 3 next presented to the clinic on May 3, 1994. Patient 3 reported that, after the injections in March, he had obtained relief from his back pain for six weeks and from his leg pain for two days. Dr. Dahlquist repeated the trigger point injections. Her diagnoses were spinal stenosis, fibromyalgia, and bilateral sacroiliac joint inflammation. His medications were listed as Darvocet and Soma. (St. Ex. 3 at I: 16-19). On May 17, 1994, Patient 3 called requesting early refills of his Darvocet and Soma. (St. Ex. 3 at IV: 46).

On June 3 1994, Patient 3 called requesting an early refill of Darvocet, and stated that the Darvocet "doesn't 'really' help." Dr. Dahlquist prescribed Vicodin, 100 tablets, one to two tablets every four to six hours as needed for pain. (St. Ex. 3 at IV: 47).

On June 8, 1994, Patient 3 returned for additional trigger point injections. At that time his medications were listed as Vicodin and Soma, although there is no indication as to who was prescribing them. (St. Ex. 3 at I: 27).

On June 17, 1994, Patient 3 called requesting a refill of Soma. The record does not indicate whether the request was granted or denied. (St. Ex. 3 at IV: 48). On June 20, 1994, Patient 3 called requesting refills of Vicodin and Soma. The record states "written 6/22. (St. Ex. 3 at IV: 49).

On July 6, 1994, Patient 3 called requesting a refill of Vicodin. Dr. Dahlquist prescribed Vicodin, 100 tablets, one to two every six hour as needed with no refills. (St. Ex. 3 at IV: 48).

In September 1994, Patient 3 reported that he had been taking Vicodin, eight tablets per day, and Soma, three tablets per day. Dr. Dahlquist noted that she had discussed reducing Patient 3's pain meds. (St. Ex. 3 at I: 57).

In October 1994, Patient 3 reported that he had been taking Vicodin, four to six tablets per day; and Soma four to five tablets per day. Dr. Dahlquist did not discuss his pain medications in the progress note. (St. Ex. 3 at XI: 2).

In November 1994, Patient 3 reported that he had been unable to go to physical therapy due to transportation problems. (St. Ex. 3 at XIV: 2).

Dr. Dahlquist continued the trigger point, sacroiliac, and lumbar epidural steroid injections. (St. Ex. 3 at I: 57-151).

In December 1994, Patient 3 underwent a surgical repair of a deviated septum. An admission form notes history of drug abuse. An EKG at that time revealed normal sinus rhythm with left atrial enlargement. (St. Ex. 3 at XV: 2, 17). As his current medications, Patient 3 reported taking a number of non-controlled medications. He did not mention Vicodin or Soma. (St. Ex. 3 at XV: 26).

In January 1995, Dr. Dahlquist noted that Patient 3 had been suffering sacroiliac joint inflammation after three sets of sacroiliac injections since September 1994. She noted that she would refrain from further sacroiliac injections until March 1995. Patient 3 reported that he had been taking Vicodin, six to eight per day; and Soma, three per day. (St. Ex. 3 at XVI: 3).

In March 1995, Patient 3 reported that he had been taking Vicodin, six to ten per day; and Soma, three per day. (St. Ex. 3 at XVII: 2).

In June 1995, Patient 3 reported to a hospital emergency room stating that he had run out of pain medication. He was given an injection of Toradol and Norflex, and an injection of

Demerol and Vistaril. He was also given fifteen tablets of Vicodin and fifteen tablets of Soma. (St. Ex. 3 at XX: 2-4). Patient 3 saw Dr. Dahlquist the following day. There is no mention of the emergency room visit in Dr. Dahlquist's progress note. She gave Patient 3 prescriptions for Vicodin and Soma. (St. Ex. 3 at XXI: 3, 10).

In August 1995, an MRI of the lumbar spine revealed the following:

- No residual recurrent disk at the L4-5 level. There is central/left paracentral epidural scar enhancement extending from the L4-5 level superiorly to just below the L3-4 level.
- Moderate central canal stenosis at the L4-5 level due to the mild bilateral facet hypertrophy as well as the developmentally narrowed central canal.
- Lumbar spondylosis, as described above.

(St. Ex. 3 at IV: 14).

In November 1995, Dr. Dahlquist noted that Patient 3 had not had a lumbar epidural steroid injection since June. Nevertheless, he had continued to receive trigger point injections. Moreover, Patient 3 had been taking Vicodin, six tablets per day, and Soma, four tablets per day. He also reported that he had taken ten Percocet over a three day period. The record does not state where Patient 3 obtained the Percocet. Dr. Dahlquist counseled Patient 3 on "the dangers of continuing high doses of narcotics and Soma even when his pain is improved. Suggest that he change over to Norflex 100 mg po BID and Ultram 1-2 tabs po q4H prn pain. He should only take Vicodin during the times when the pain is severe." (St. Ex. 3 at I: 151, 155, 156).

On December 4, 1995, Patient 3's wife called stating that Patient 3 was in extreme pain and could "hardly walk." She stated that he had been "doubling up on Vicodin which doesn't help." The record does not indicate whether the request was granted or denied. (St. Ex. 3 at IV: 51a).

On December 14, 1995, Patient 3 reported that the pain was more severe "than ever." He added that the Ultram had not worked, so he had continued to take Vicodin and Soma. Dr. Dahlquist repeated a series of epidural injections, in addition to the trigger point injections. (St. Ex. 3 at I: 161).

In January 1996, Patient 3 reported taking Vicodin, eight per day; Soma, four per day; Ultram ten to twelve per day; and Norflex four to six per day. Dr. Dahlquist continued the injections and refilled his medications. (St. Ex. 3 at II: 5).

A myelogram performed on February 9, 1996, revealed, "Ventral impression the thecal sac at L5-transitional level with mild central canal stenosis. Further assessment will be obtained to differentiate bulging annulus versus herniated disk versus scarring." (St. Ex. 3 at IV: 18).

Upon admission to the hospital for the myelogram, Patient 3 reported the medications he was taking. He did not mention Vicodin or Soma. (St. Ex. 3 at XXVII: 8).

On February 13, 1996, nerve conduction studies revealed the following impressions:

- There is electrodiagnostic evidence for a sensorimotor axonal and demyelinating peripheral polyneuropathy with mild distal denervation and chronic reinnervation.
- A bilateral S1 radiculopathy cannot be completely excluded. The prolonged H-reflex and distal denervation could be seen with bilateral S1 radiculopathy; however, it is more likely that they are secondary to the patient's peripheral polyneuropathy, particularly since no proximal findings are noted. Correlation with recently obtained C.T. myelogram is suggested.
- No evidence for an acute lumbosacral plexopathy.
- No evidence for a left peroneal or tibial mononeuropathy.
- No evidence for a myopathic process.

(St. Ex. 3 at IV: 15).

In May 1996, Patient 3 reported taking Vicodin, five per day, and Soma three per day. Dr. Dahlquist continued the injections. (St. Ex. 3 at II: 41).

In July 1996, however, Patient 3 reported taking Vicodin, eight per day; Ultram, eight per day; and Soma, eight per day. Dr. Dahlquist did not comment in the record about the amount of medication he was taking. (St. Ex. 3 at II: 51).

In August 1996, Dr. Dahlquist started to administer Toradol injections at the time of epidural and trigger point injections. (St. Ex. 3 at II: 68).

On September 6, 1996, Patient 3 presented to the emergency room with complaints of pain. He received an injection of Toradol, Norflex, and Nubain. He was also given a prescription for Soma and Vicodin. The emergency room physician discussed the matter with Dr. Dahlquist. (St. Ex. 3 at XXXIII: 3-4).

On September 26, 1996, Patient 3 reported taking Percocet, three to four per day; Vicodin, six per day; Norflex, two per day; Soma, four per day; Ultram eight to ten per day; and Baclofen, four per day. The medications had been prescribed at a maximum of Vicodin, four

per day; and Soma, four per day. Dr. Dahlquist did not comment on the discrepancy. Nor did she mention the recent emergency room visit. (St. Ex. 3 at II: 73, 77; St. Ex. 3 at XXXIII: at 3-4). Patient 3 signed a Prescription Medication Contract. (St. Ex. 3 at IV: 35-38).

On November 5, 1996, Patient 3 reported to Miami Valley Hospital's Orthopedic Clinic complaining of left knee pain. In his list of medications, Patient 3 did not mention Vicodin or Soma. (St. Ex. 3 at XXXVI).

In November 1996, Dr. Dahlquist added Percocet to the mix of medications. (St. Ex. 3 at II: 83).

On March 5, 1997, Patient 3 stated that he had been taking Vicodin, four per day; Soma, three per day, and a few Percocet, but that his pain was unrelieved. Dr. Dahlquist told him to "double up on Vicodin next 3 days or come in and pick up #20 Percocet." (St. Ex. 3 at IV: 52).

On April 1, 1997, Patient 3 stated that he had been taking Vicodin, four per day; and Soma, four per day. He asked if he could take additional Vicodin or take a stronger medication. The record does not indicate Dr. Dahlquist's response. (St. Ex. 3 at IV: 53).

In July 1997, Dr. Dahlquist wrote that she would give Patient 3 a one month supply of Percocet "since his wife has recently had surgery and is now bed ridden, forcing him to do all of the housework and care for his wife. Due to this, his pain has increased significantly." (St. Ex. 3 at III: 37).

In October 1997, Patient 3 reported that he was leaving town for a family emergency, and he requested an early refill of his medications. Dr. Dahlquist prescribed enough Percocet, OxyContin, and Soma to last until the following week. (St. Ex. 3 at IV: 54-55).

In November 1997, Dr. Dahlquist noted that Patient 3 had been taking Percocet, one every four hours, and OxyContin 40 mg. every twelve hours. She further noted that he had "taken more Soma than was prescribed." She added that she would give him ten extra Soma tablets and "explain that he cannot continue to take more than prescribed." (St. Ex. 3 at III: 63).

Dr. Dahlquist continued to provide myofascial trigger point injections and/or lumbar epidural steroid injections throughout her care and treatment of Patient 3. (St. Ex. 3).

Certificate of Death for Patient 3

44. A Certificate of Death for Patient 3 indicates that he died on March 5, 1998. It contains a notation that the immediate cause of death was "[s]udden death due to or as a consequence of cardiopulmonary arrest." The Certificate of Death lists "Other Significant Conditions" as hypertension and diabetes mellitus.

Dr. Shin's Testimony Regarding Patient 3

45. Dr. Shin opined that Dr. Dahlquist had failed to meet the minimal standards of care by failing to use "reasonable care discrimination" in the administration of drugs or failed to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease in her care and treatment of Patient 3. (Tr. 380-381, 387-388).
46. Dr. Shin noted that Dr. Dahlquist had given Patient 3 Darvocet on his initial visit, but her prescribing had progressed over the years to include combinations of Vicodin, Percocet, OxyContin, and muscle relaxant medication including Soma, Norflex, and Baclofen. He further noted that she had prescribed these medications for a protracted time period. (Tr. 381-382, 389-390, 432-434; St. Ex. 25 at 4).

When considering the large amounts of controlled substances that Dr. Dahlquist prescribed to Patient 3, Dr. Shin testified that Patient 3's history of alcohol abuse had concerned him. Dr. Shin commented that his concern involved possible liver dysfunction and the fact that alcohol abuse is a red flag with heavy pain when opioid therapy is considered. He added that it does not mean opioid therapy is "contraindicated, but it surely is a red flag." (Tr. 386).

Dr. Shin testified that when treating a patient with prior alcohol abuse, the treatment plan must include consideration of that history. Dr. Shin added that those considerations should include potential coexisting disease, such as liver dysfunction, gastrointestinal problems and GI bleeding." Dr. Shin acknowledged that the record did not reveal any evidence of chronic liver failure, but added that Dr. Dahlquist had not ordered any objective studies to assess it. (Tr. 784, 951-952).

Dr. Shin further testified that Dr. Dahlquist had not established a diagnosis related to Patient 3's pain complaints. In his December 6, 2001, report concerning Patient 3, Dr. Shin stated:

The subjective complaints with a prior history of laminectomy do not justify the protracted use of multiple opioids. If the patient was not improving with the conventional amount of opioid, he should have been referred to identify the source of increasing pain. For instance, the patient may have instability from his prior laminectomy that may require a fusion procedure. If the findings are negative, the use of opioids should have been discouraged and an attempt at weaning the medications should have been made. The care in this case was below minimal standards.

(St. Ex. 25 at 4) (See also Tr. 390-391).

47. Dr. Shin testified that Dr. Dahlquist's frequent administration of Toradol injections concerned him because Patient 3 had a history of peptic ulcer disease, duodenitis, hiatal

hernia and alcohol abuse. He noted that, in such a patient, the physician must be concerned with the possibility of liver dysfunction. He testified that the use of Toradol with liver dysfunction could lead to “elevated liver enzymes or clotting dysfunction, which means it can lead to bleeding with liver cirrhosis.” Dr. Shin added that the use of Toradol in a patient with a history of peptic ulcers and duodenitis should be approached very carefully. He asserted that he would have avoided using the Toradol injections because there is a significant risk of bleeding. (Tr. 388-390, 785; St. Ex. 25 at 4).

48. Dr. Shin also expressed concern about Dr. Dahlquist’s use of steroid injections in Patient 3. Dr. Shin noted that Dr. Dahlquist had seen Patient 3 on thirty-five occasions and on each occasion she had administered multiple trigger point injections. In addition, she frequently administered sacroiliac joint injections and cycles of lumbar epidural steroid injections. He concluded that, at each visit, Patient 3 had received corticosteroid injections. (St. Ex. 25 at 4).
49. Dr. Shin concluded that Patient 3 had had a complicated medical history. He added that Patient 3’s cause of death was “not necessarily directly related to Dr. Dahlquist’s treatments.” (Tr. 392-395, 714, 964, 1084-1085).

Dr. Dahlquist’s Testimony Regarding Patient 3

50. Dr. Dahlquist testified that she believes that she met the “standards of care and treatment” for Patient 3. She further testified that she had not caused or contributed to the death of Patient 3 “in any way, shape or form.” (Tr. 1673-1675).
51. Dr. Dahlquist explained her rationale for prescribing increasing doses of opioids and muscle relaxants to Patient 3. Dr. Dahlquist stated that she had seen Patient 3 for several years and over the course of that time a patient will develop tolerance to an opioid analgesic, requiring some escalation of dose. She further testified that Patient 3 had suffered from spinal stenosis with arthritis and myofascial pain, which is a condition that worsens over time. She added that somebody who has that condition would need escalating doses. (Tr. 115-116, 1666).

Dr. Dahlquist testified that her decision to continue escalating doses of opioids with Patient 3 had been based a desire that he be able to live a more normal life than he would have without the medications. (Tr. 117, 1666).

Dr. Dahlquist added that there had been no other treatment options available to Patient 3. She stated that he had been through physical therapy and had undergone surgery. Moreover, Dr. Dahlquist testified that he would not have been a candidate for more invasive forms of pain management, such as an implantable spinal cord stimulator device or an implantable pump, because he had obtained “what he felt was adequate relief” with the therapy Dr. Dahlquist provided. (Tr. 1672-1673, 2148-2149).

52. Dr. Dahlquist testified that Patient 3 had not abused alcohol while she treated him. Dr. Dahlquist added that a previous history of substance abuse does not preclude somebody from being treated with opioids. She stated that it is “something to be aware of.” Moreover, Dr. Dahlquist testified that, had there been any indication of a relapse, she would have looked into the situation further, brought him in for urine screening, and more than likely sent him to an addiction medicine specialist. (Tr. 1667-1669).

Dr. Dahlquist further testified that,

Certainly abuse of any substance would have me be more concerned about the patient becoming addicted to a medication. However, alcohol and opioids react on different receptors, or they work on different receptors in the nervous system. So someone who has had a previous history of alcohol abuse is -- is not nearly as high a risk of becoming addicted to an opioid as someone who had a previous history of opioid addiction. Also, the patient appeared to still be in remission. His alcohol abuse had been in remission, and he had not continued to use alcohol.

(Tr. 116-117).

53. Regarding Dr. Shin’s opinion that she had not made an appropriate diagnosis of Patient 3’s pain, Dr. Dahlquist testified that she had had a working relationship Dr. Moncrief, and knew that when he referred a patient to her, it was because he had already evaluated the patient for neurosurgery and determined that surgery was not an option for that patient. Dr. Dahlquist testified that she had agreed with Dr. Moncrief’s evaluation. (Tr. 112-114, 542, 1307-1310, 1659-1661, 1663, 1665-1666, 2144–2146).

Dr. Dahlquist further noted that, on February 21, 1996, Dr. Moncrief had written to her, advising that he had reevaluated. Dr. Moncrief noted that Patient 3 had undergone a lumbar myelogram which demonstrated persistent stenosis at L4-5 and L3-4 and congenital spinal stenosis. Moreover, an EMG had revealed “rather severe peripheral neuropathy secondary to his diabetes.” Finally, a February 9, 1996, CT scan of the lumbar spine indicated “bilateral hypertrophic degenerative facet disease, bilateral mild foraminal narrowing.” Dr. Dahlquist commented, “there is radiographic evidence that he had things going on in his spine, arthritic changes going on in his spine, which could have caused a radiculopathy.” (Tr. 1666, 1672, 2045-2047).

54. Dr. Dahlquist testified that Toradol was not contraindicated in the care of Patient 3. She stated that she had been aware of Patient 3’s history of peptic ulcer disease. Dr. Dahlquist added that she had only used Toradol to help decrease the pain from the trigger point injections. Each injection had been given as an isolated dose, and the medication had sufficient time to be metabolized and excreted before he received a second injection. Dr. Dahlquist further testified that she had instructed Patient 3 to watch for the signs of gastrointestinal bleeding, and he had never mentioned experiencing any of those symptoms. (Tr. 118, 1670-1676).

55. Dr. Dahlquist testified that there is no indication in her records that Patient 3 had any adverse effects from the trigger point injections she had provided him. (Tr. 1671).
56. Dr. Dahlquist asserted that she had not given Patient 3 acetaminophen in doses that were above recommended levels. Dr. Dahlquist further testified that there was no indication that Patient 3 had suffered any liver dysfunction as a result of taking acetaminophen. (Tr. 117, 1666-1667).

Dr. Blatman's Testimony Regarding Patient 3

57. Dr. Blatman testified that it is his opinion that Dr. Dahlquist met "standards of care and treatment" for Patient 3. (Tr. 1084).
58. Dr. Blatman testified that it is appropriate to treat an alcoholic patient who is not currently using alcohol for intractable, severe or chronic pain with opioids or opioids containing acetaminophen. Dr. Blatman noted that the only exception he would make would be if the patient also had a liver problem. Dr. Blatman commented that there is no indication that Patient 3 had had a liver problem while being treated by Dr. Dahlquist. (Tr. 1081-1082, 1084, 1310; Resp. Ex. C at 4).
59. Dr. Blatman testified that he would "[a]bsolutely *** trust a neurosurgeon *** to make the appropriate medical determination as to whether or not further surgical care and treatment was appropriate for this particular patient." Dr. Blatman asserted that the "reasonable conclusion" he would draw if a neurosurgeon referred this patient to a pain specialist for care and treatment is that this patient is not a surgical candidate and that treatment for pain is the only option. (Tr. 1079, 1310-1311).
60. Dr. Blatman testified that he did not believe that Toradol was contraindicated in Patient 3. He elaborated that he believes that it is important for the physician who is using Toradol to be mindful of the effects of medications, but it is within the realm of that physician's judgment to be able to use these medications appropriately. Dr. Blatman added that he did not see by the record where Toradol had been harmful to Patient 3. (Tr. 1082-1084).
61. Dr. Blatman further noted that the PDR lists the contraindications for Toradol as, "patients with active or a history of active peptic ulcer disease or gastrointestinal bleeding or perforation." (Tr. 1307-1309).

PATIENT 4

Allegations

62. In its February 13, 2002, Notice of Opportunity for Hearing, the Board alleged that, in her care and treatment of Patient 4, Dr. Dahlquist had prescribed medications in types, amounts

and/or combinations that were inappropriate and/or for protracted periods of time that were not justified. As an example, the Board alleged that Dr. Dahlquist had prescribed various opioids to Patient 4, on a protracted basis and frequently in high or escalating doses, although the patient's diagnosis and/or condition did not justify such prescribing.

The Board further alleged Dr. Dahlquist had administered injections or blocks inappropriately.

Furthermore, the Board alleged that Dr. Dahlquist had failed to adequately recognize and/or address indications of drug abuse or the increased risk of drug abuse. As an example, the Board alleged that, although Patient 4 had a history of alcohol abuse and detoxification, Dr. Dahlquist had prescribed increasing doses of opioids to the patient and she failed to order a toxicology screen or to document consideration of a detoxification program as part of the patient's treatment.

Finally, the Board alleged that Dr. Dahlquist had failed to identify a reasonable pain diagnosis or differential pain diagnosis, and/or to clarify or confirm the diagnosis, and/or to identify the organic cause, mechanism, or source of the patient's pain. (St. Ex. 17A).

Medical Records for Patient 4

63. Patient 4, a thirty year old male, was first seen by Dr. Dahlquist on May 29, 1997, based on a referral from Dr. Moncrief. Patient 4 complained of neck and lumbar pain resulting from a dump truck accident in June 1996. Patient 4 had had a prior MRI, but Dr. Dahlquist stated that she did not have the results. Patient 4 reported that he had tried Vicodin and Motrin in the past without relief. He had also tried physical therapy, ultrasound, and stretching with minimal relief. He had not received therapeutic injections or undergone surgical procedures. Patient 4 denied the use of illicit drugs or alcohol. He was not taking any pain medication at that time. (St. Ex. 4 at I: 4-5).

In her Assessment/Plan, Dr. Dahlquist wrote as follows,

Neck/strain/sprain which has now become chronic. I plan to give this patient prescriptions for Norflex for muscle relaxation, Daypro to decrease inflammation, and Ultram. If he does not obtain significant relief with oral medications, I may consider ordering a T.E.N.S. unit and possibly giving him a set of trigger point injections. I will see him back in approximately 3 weeks for reevaluation.

(St. Ex. 4 at I: 5).

On June 12, 1997, Patient 4 reported that he had not had relief with oral medications. Dr. Dahlquist diagnosed cervical and thoracic strain with secondary myofascial pain. She started myofascial trigger point injections with Depo-Medrol, Carbocaine, and bicarbonate. She also prescribed Darvocet. (St. Ex. 4 at I: 9).

In July 1997, Patient 4 listed his medications as Vicodin, Ultram, Norflex, and DayPro. Trigger point injections continued. Dr. Dahlquist also administered lumbar epidural and cervical epidural steroid injections. (St. Ex. 4 at I: 31). Patient 4 signed a controlled substance contract. Dr. Dahlquist sent a copy of the contract and her dictated consultation to Dr. Moncrief. (St. Ex. 4 at III: 18).

In August 1997, Dr. Dahlquist added Fiorinal #3 for Patient 4's new complaint of headaches. She also noted that she had given him a Greater Occipital Nerve block, which "seemed to be helping his pain" in conjunction with the myofascial trigger point injections. (St. Ex. 4 at I: 60).

In September 1997, Patient 4 reported that he had lost his prescriptions. (St. Ex. 4 at III: 76).

On October 2, 1997, Patient 4 reported that Fiorinal was more effective for his headaches than Vicodin. Dr. Dahlquist administered myofascial trigger point injections and a Greater Occipital Nerve block. She also ordered a TENS unit. (St. Ex. 4 at I: 69).

On November 21, 1997, Patient 4 complained of increasing pain. Dr. Dahlquist ordered an MRI scan to rule out a new or worsening disc herniation and nerve root compression. The MRI revealed the following:

- a small broad-based disc bulge with associated uncovertebral hypertrophic changes and ventral spondylitic spurring at C5-6.
- minimal multi-level spondylitic ridges as described above.
- no focal disc herniations.

(St. Ex. 4 at III: 28). Dr. Dahlquist continued to administer myofascial trigger point injections and lumbar epidural and cervical epidural steroid injections. (St. Ex. 4 at I: 44, 50).

On February 2, 1998, Dr. Dahlquist noted that Patient 4 had been participating in a work reconditioning program, and had been experiencing increased pain and muscle spasm. Dr. Dahlquist administered additional epidural steroid injections and myofascial trigger point injections. She also ordered an MRI scan of the spine. (St. Ex. 4 at II: 12).

On March 3, 1998, Patient 4 reported that his pain relief had lasted only 2½ weeks after the epidural steroid injections. The MRI scan had revealed, "at the L5-S1 level, grade 1 anterior listhesis of L5 on S1 with pseudo-bulge present at that level." There was also "severe stenosis both centrally and within the lateral recess region" and "a severe left and moderate to severe right neural foraminal narrowing." Dr. Dahlquist referred Patient 4 to Dr. Amongero for a surgical consultation. Dr. Dahlquist was prescribing Percocet, Fiorinal, Vicodin, Norflex, and Phrenilin Forte at that time. (St. Ex. 4 at II: 22; St. Ex. 4 at III: 23-24, 32-33).

Dr. Dahlquist also noted that Patient 4 had been experiencing “intermittent spells of passing out” and had been evaluated by Evelyn Brown, M.D. Dr. Brown had ordered an EEG which had not shown any abnormalities. She discovered, however, a heart dysrhythmia during sleep, and ordered a Holter monitor and an MRI scan of the brain. In addition, Dr. Brown had prescribed Elavil. (St. Ex. 4 at II: 22; St. Ex. 4 at III: 31).

On April 14, 1998, Dr. Dahlquist noted that Dr. Amongero planned to perform a posterolateral fusion with instrumentation, decompression, and ICBG. Patient 4 stated that his pain was “worse than it ha[d] ever been,” and he requested additional pain medication. Dr. Dahlquist noted that Patient 4 had not shown signs of medication abuse and had always taken his medications as prescribed. Dr. Dahlquist increased his Vicodin to a maximum of six per day, and noted that he was aware that he should not take Percocet on the same days that he took Vicodin. (St. Ex. 4 at II: 30).

On May 12, 1998, Patient 4 reported that Dr. Amongero had performed the surgery. Patient 4 added that, in the hospital, he had been taking a long acting narcotic with better relief. Dr. Dahlquist prescribed Oramorph 60 mg. every six to eight hours. (St. Ex. 4 at II: 38).

On June 23, 1998, Patient 4 complained of increasing headaches, and stated that Norflex and Toradol injections had helped him in the past. Dr. Dahlquist gave him a prescription for Norflex and Toradol injections to be used at home. She noted that she would continue his oral medications as he had shown no signs of abuse. (St. Ex. 4 at II: 46).

In August 1998, Dr. Dahlquist administered caudal epidural injections with the myofascial trigger point injections. In September 1998, Dr. Dahlquist noted that a physical medicine and rehabilitation specialist had stated that Patient 4 had likely “reached a plateau” with steroid injections. Dr. Dahlquist wrote that she had switched Patient 4 from Oramorph to OxyContin, and “to one short acting narcotic as opposed to 2.” Nevertheless, in September 1998, Dr. Dahlquist prescribed Oramorph or OxyContin, Vicodin ES, Percocet, Fiorinal #3, Toradol, Norflex, and Pamelor. (St. Ex. 4 at III: 54-63).

On November 6, 1998, Dr. Dahlquist administered an additional caudal epidural steroid injections in addition to the myofascial trigger point injections. She noted that Patient 4 had been having more anxiety and difficulty sleeping due to pain, and she added Xanax to his medication regimen. In his list of medications, Patient 4 continued to note two short acting opioids, Percocet and Vicodin ES, in addition to OxyContin, Fiorinal, and Restoril. Dr. Dahlquist also administered intramuscular injections of Toradol and Norflex. (St. Ex. 4 at II: 72, 75, 76).

In February 1999, Patient 4 reported that his pain medications were no longer giving him adequate relief, and he requested something stronger. Dr. Dahlquist prescribed OxyIR and MSIR. (St. Ex. 4 at II: 90, 99).

In March 1999, Patient 4 complained that his medications were not controlling his pain. He asked to “switch back to Percocet” and to increase the amount of Xanax he was taking. Dr. Dahlquist noted that she would consider a spinal cord stimulator unit. (St. Ex. 4 at II: 99).

Dr. Dahlquist continued lumbar, cervical, and caudal epidural steroid injections; sacroiliac joint injections; myofascial trigger point injections; and oral and injectable medications. Patient 4 also continued to use a TENS unit. (St. Ex. 4 at II: 110, 118, 119-120, 125).

In June 1999, Dr. Dahlquist increased Patient 4’s OxyContin from one tablet every six hours to one or two tablets every six hours. (St. Ex. 4 at III: 84).

In September 1999, Dr. Dahlquist counseled Patient 4 on limiting the amount of acetaminophen in Percocet and Vicodin. (St. Ex. 4 at III: 97). Moreover, Dr. Dahlquist noted that Patient 4 had been taking Vicodin ES, Elavil, Flexeril, Toradol, Norflex, Percocet, OxyContin, Fiorinal #3, Xanax, and Phrenilin. She further noted that she had increased his OxyContin from 40 to 80 mg. In addition, Dr. Dahlquist stated that Patient 4 would discontinue Vicodin ES, Toradol, Norflex, Phrenilin and Fiorinal #3. Overall, her medication regimen for Patient 4 was reduced to the following:

Drug	Mg.	Directions	Max/Day
OxyContin	80	1-2 po q. 6 hrs	6
Percocet		1-2 po q. 6 hrs	8
Xanax	2	1 po q. 6 hrs	4
Elavil		1-2 po at bedtime	2
Flexeril		1-2 po q. 6 hrs	8

Finally, Dr. Dahlquist instructed that no medications other than the five listed above should be filled, and that she had instructed Patient 4 to have blood drawn for liver function studies. The liver function studies were normal. (St. Ex. 4 at III: 66, 98).

Patient 4 called the office stating that he “ he did not understand why he could not continue with his meds as have been given previously.” Patient 4 added that, ““No one else has ever questioned me about how I take the medications. Why now?”” (St. Ex. 4 at III: 86).

In December 1999, Dr. Dahlquist increased the dosage of Elavil from 150 mg. to 200 mg. nightly. (St. Ex. 4 at III: 116).

64. At hearing, Dr. Dahlquist testified that she is no longer treating Patient 4. She explained that he had been discharged for nonpayment of services sometime after December 16, 1999. (Tr. 1682-1683).

Dr. Shin's Testimony Regarding Patient 4

65. Dr. Shin testified that Dr. Dahlquist had failed to meet the minimal standards in providing medical care for Patient 4. Moreover, Dr. Shin testified that Dr. Dahlquist had “failed to use reasonable care discrimination in the administration of drugs or failed to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease in her care and treatment of Patient 4.” Dr. Shin further testified that Patient 4 had not suffered from intractable pain, and the combination and increasing amounts of drugs that Dr. Dahlquist prescribed for diagnoses of neck pain and lumbar pain, with no improvement, was below the standard of care. (Tr. 395, 399, 797).
66. Dr. Shin testified that diagnoses of sprain and strain did not justify the prescribing of opioids in the amounts Dr. Dahlquist prescribed. Dr. Shin testified that Dr. Dahlquist had prescribed Patient 4 large amounts of controlled substances, at rapidly increasing dosages, without resolution of Patient 4’s pain. He added that Dr. Dahlquist should have been considering whether Patient 4 was overdosing on his medication, and should have ordered a toxicology screen or considered a detoxification program for Patient 4. He added that Dr. Dahlquist should also have paid more attention to determining the cause of the pain. Moreover, Dr. Shin testified that, when Dr. Dahlquist realized that high doses of opioids were not effective, she should have referred Patient 4 immediately to a specialist to identify the source of increasing pain. Dr. Shin noted that Dr. Dahlquist had not done so until more than two years after the initial presentation. Dr. Shin concluded that Dr. Dahlquist’s care was far below the minimal standards. (Tr. 400-405, 796-798, 952, 1090-1092, 1899-1900; St. Ex. 25 at 5).

Dr. Shin conceded that there was no evidence of over-sedation in Dr. Dahlquist’s medical records for Patient 4. Dr. Shin further conceded that there is no evidence in the medical records that Patient 4 had a recurrence of his alcohol abuse while being treated by Dr. Dahlquist . (Tr. 395-397, 399-40, 797-798).

67. Dr. Shin testified that he has concerns with a patient self-injecting medications such as Toradol. He explained that self-injection might be justified in some illnesses such as metastatic cancer if the patient is in significant pain and needs an immediate injection to stop it. Dr. Shin continued that Patient 4 had a sprain and strain diagnosis and injecting himself with Toradol and Norflex was inappropriate. In addition, Dr. Shin testified that frequent use of Toradol is contraindicated, whether used orally or intramuscularly. (Tr. 403).
68. In his December 6, 2001, report concerning Patient 4, Dr. Shin stated:

The patient received injections containing corticosteroid mixture on a regular basis. The physician is very conscientious of not providing more than required epidural steroid injections, however the patient seemed to be receiving

injections on a routine basis that contain corticosteroids. These injections did not provide a long-term pain relief and should have been stopped.

(Tr. 398-399; St. Ex. 25 at 5). Nevertheless, Dr. Shin agreed that there was no evidence of steroid toxicity in Dr. Dahlquist's medical records for Patient 4. On the other hand, Dr. Shin stated that the use of a combination of steroid and trigger point injections and opioids did not provide long term improvement in Patient 4's pain condition. (Tr. 798-799).

Dr. Dahlquist's Testimony Regarding Patient 4

69. Dr. Dahlquist testified that Patient 4's diagnosis was posttraumatic arthritis in the lumbar spine which had developed from the initial sprain strain injury. She stated that she had continued to use Patient 4's previously assigned Workers' Compensation diagnosis of neck sprain and strain, in order to ensure that Workers' Compensation would continue to authorize treatment for Patient 4. (Tr. 127-129, 131, 1088, 1321, 1377, 1678-1680, 1801-1802).

Dr. Dahlquist testified that, in March 1998, she had referred Patient 4 to Dr. Amongero, a spine surgeon, requesting that he evaluate Patient 4 for possible lumbar surgery. She explained that she had been exploring the possibility that Patient 4's condition could be surgically corrected. Dr. Dahlquist commented that, at that point in her management of Patient 4, Patient 4 had been through physical therapy, epidural injections and all the modalities of pain management that she had to offer him. (Tr. 1090-1092, 1683-1684, 2048-2049).

70. Dr. Dahlquist testified that she makes the determination to provide escalating doses of opioids to a patient who is reporting improved pain relief depending on the total circumstances of the patient. She explained that it may be appropriate to use an increasing dose if the current dose is reducing pain but not reducing it enough. She added that it would be appropriate to increase the dose to try to get the pain level down to whatever seems to be tolerable for the patient without hindering function or without causing adverse side effects. (Tr. 126-127).
71. Dr. Dahlquist testified that she "seem[s] to recall" that Patient 4 had a history of alcohol abuse, but that he had denied use of alcohol or illicit drugs at the time of his initial visit on May 29, 1997. Dr. Dahlquist noted that, over the years that she treated Patient 4, there had been only one occasion in which he claimed to have lost his prescriptions. She further testified that there had been no evidence of drug-seeking behavior. Finally, Dr. Dahlquist testified that there had been no reason to send Patient 4 to a detoxification program. (Tr. 120-126, 1682, 2047-2048).
72. Dr. Dahlquist testified that she had provided Patient 4 with trigger point injections, which had improved his condition. Dr. Dahlquist testified that multiple trigger point injections can keep oral doses of opioids lower. She added that Patient 4 had reported relief from

pain with the injections. She elaborated that with most of these patients, had the patients not been receiving the trigger point injections, the patients would have required higher doses of opioid medications. (Tr. 167-180, 2154).

Dr. Blatman's Testimony Regarding Patient 4

73. Dr. Blatman testified that, in her care and treatment of Patient 4, Dr. Dahlquist had complied with the standards of care. (Tr. 1092; St. Ex. C at 7).

74. In his September 1, 2002, report concerning Patient 4, Dr. Blatman stated:

Dr. Dahlquist did as much as possible to identify a reasonable pain diagnosis and the source of the patient's pain. In fact, myofascial pain is an adequate diagnosis. The myofascial pain was further complicated by the neurosurgically related diagnoses and surgery.

(Resp Ex. B at 10).

75. In his September 23, 2002, report concerning Patient 4, Dr. Blatman stated:

Doctors who treat chronic pain patients after failed low back surgery understand the futility of further diagnostic procedures and the danger of additional surgery for these desperate patients. Waiting 2 years is not unreasonable, as there were no significant new medical findings that would have required more immediate referral. The concept is underscored by the patient undergoing a second surgery, and this procedure also failing to provide pain relief.

(Resp Ex. C at 6). Dr. Blatman further noted that, under the care of Dr. Dahlquist, Patient 4 had participated in a work-hardening program and underwent lumbar spinal fusion with instrumentation, which did not improve his pain or functional status. It was eventually opined by the surgeons that the patient had reached maximum medical improvement. Dr. Blatman added that the patient had "continued to obtain his best relief and treatment with intermittent injections and oral medications." (Tr. 1085-1087).

76. In his September 1, 2002, report concerning Patient 4, Dr. Blatman stated:

Previous alcohol detoxification does not preclude a patient from taking opioid pain medication. Additionally, previous alcohol detoxification does not absolutely require toxicology screening or a detoxification program as part of a patient's treatment. The treating doctor felt that this patient had obvious sources for pain, was obviously in severe pain, and therefore required this level of medication for treatment.

(Resp Ex. B at 11; Resp. Ex. C at 6-7). Dr. Blatman added that there is no indication in Dr. Dahlquist's medical records for Patient 4 that Patient 4 used alcohol while being treated by Dr. Dahlquist. (Tr. 1090).

77. Dr. Blatman testified that the frequency of trigger point injections depends upon the effectiveness of the injection and how they fit into the total treatment plan and the patient's clinical course. He added that there are no specific regulations for "how often" or "how many." Dr. Blatman testified that epidural steroid injections and trigger point injections had been effective for Patient 4. In addition, Dr. Blatman noted that these injections are painful; therefore, patients who are merely drug-seeking are not willing to undergo these injections. Finally, Dr. Blatman noted that Patient 4 had never demonstrated any signs of steroid toxicity. (Tr. 1093-1095; Resp Ex. C at 7).

PATIENT 5

Allegations

78. In its February 13, 2002, Notice of Opportunity for Hearing, the Board alleged that, in her care and treatment of Patient 5, Dr. Dahlquist had prescribed medications in types, amounts and/or combinations that were inappropriate and/or for protracted periods of time that were not justified.

The Board further alleged that Dr. Dahlquist had failed to obtain records of prior or concurrent medical treatment, including studies performed, and/or failed to refer the patient for additional, necessary consultations, evaluations, studies, or treatment. As examples, the Board alleged that, although Patient 5's pain had not been relieved by high doses of opioids and other procedures offered by Dr. Dahlquist, and despite the possibility of psychological factors in this case, Dr. Dahlquist had failed to refer Patient 5 to a tertiary pain center with an inpatient pain rehabilitation and detoxification program for treatment.

Moreover, the Board alleged that Dr. Dahlquist had failed to appropriately consider and/or address whether psychological factors were affecting Patient 5's pain. (St. Ex. 17A).

Medical Records for Patient 5

79. Patient 5, a twenty-eight year old female, was first seen by Dr. Dahlquist on March 25, 1997, based on a referral from Pietro Seni, M.D., an orthopedic surgeon. Patient 5 complained of left leg pain resulting from injuries sustained in a motor vehicle accident in 1988. The injuries included a fractured femur, a comminuted fracture of the left acetabulum, transverse fractures of both columns of the acetabulum, and disruption of the pelvic rim and left sacroiliac joint. (St. Ex. 5 at I: 4).

Since the accident, Patient 5 had been treated in a multi-disciplinary pain center with little relief. She had also participated in psychological counseling, relaxation techniques, and

biofeedback. She had undergone electrical stimulation, massage, and multiple therapeutic nerve blocks. Furthermore, Patient 5 had undergone surgeries in May 1988, March 1989, June 1989, September 1989, January 1995, and October 1996. Patient 5's diagnoses included "mononeuritis of the lower extremity, deformity of left ankle and foot, fractured pelvis (closed), [and] late effect fracture of the lower extremity on the left." (St. Ex. 5 at I: 4; St. Ex. 5 at III: 250; St. Ex. 5 at V: 4). (See Patient 5's previous medical records at St. Ex. 5 at III: 231-247; St. Ex. 5 at IV; St. Ex. 5 at V).

At the time of her first visit to Dr. Dahlquist, Patient 5 had been taking M.S. Contin, 60 mg every eight hours, and Morphine, 10 mg po every four hours. Medications that she had tried in the past, but which were ineffective, included Vicodin ES, Neurontin, Pamelor, Tegretol, Dilantin, Amitriptyline, and Desyrel. Patient 5 admitted to drinking wine occasionally and denied any illicit drug use. (St. Ex. 5 at I: 4-6, St. Ex. 5 at III: 2-15).

In her assessment/plan, Dr. Dahlquist diagnosed post-traumatic neuropathic pain. Although Dr. Dahlquist did not prescribe any medications at that time, she noted that the use of a long acting opioid with a short acting opioid for breakthrough pain would be appropriate for Patient 5's condition. Dr. Dahlquist also considered placement of a dorsal column stimulator or an implantable narcotics pump. (St. Ex. 5 at I: 5; St. Ex. 5 at III: 39).

Patient 5 returned on April 24, 1997, requesting adjustment of her oral medications. Dr. Dahlquist prescribed methadone instead of M.S. Contin, Demerol 50 mg tablets for breakthrough pain, and Neurontin. Patient 5 signed a Prescription Medication Contract. (St. Ex. 5 at I: 10; St. Ex. 5 at II: 3-5).

On May 8, 1997, Patient 5 called the office and requested an increase in her daily medications. Dr. Dahlquist authorized an increase of methadone. (St. Ex. 5 at II: 7).

On May 12, 1997, Patient 5 reported doing well on methadone, four tablets in the morning and three tablets in the evening. She was also taking Demerol 30 mg daily and Neurontin. The following month, she was taking methadone, four tablets in the morning and four tablets in the evening. She was also taking Demerol 100 mg every four hours for pain. Dr. Dahlquist recommended that Patient 5 hold her Demerol dosage to less than 400 mg per day. (St. Ex. 5 at I: 15, 20).

On July 18, 1997, Patient 5 reported itching with Demerol. She requested a prescription for Tylox. Dr. Dahlquist agreed. (St. Ex. 5 at II: 9).

On July 22, 1997, an MRI of the lumbar spine revealed:

- No evidence of disc herniation or focal disc protrusion.
- Bilateral facet joint sclerosis and hypertrophy at L5-S1, especially prominent on the right. Other than this, the lumbar spine is within normal limits.

(St. Ex. 5 at III: 30).

On July 25, 1997, Patient 5 reported taking methadone, four tablets in the morning and four tablets in the evening; Tylox, one to two tablets every six hours, and Neurontin 300 mg every twelve hours. Dr. Dahlquist noted that Patient 5 had had “itching” with Demerol and prescribed OxyIR instead. Dr. Dahlquist administered a left sacroiliac joint injection of Depo-Medrol, Carbocaine, and bicarbonate. (St. Ex. 5 at I: 31-32).

On October 13, 1997, Patient 5 reported that she had had to increase her methadone to five tablets three times daily due to increased stress and pain. Patient 5 reported “I’ve been taking more than prescribed due to the intensity of pain.” She was also taking Flexeril for spasms and Phenergan for nausea. Dr. Dahlquist scheduled Patient 5 for a spinal cord stimulator. (St. Ex. 5 at I: 44-46).

Patient 5 had a temporary spinal cord stimulator inserted on October 24, 1997. A permanent spinal cord stimulator with lead wire and pulse generator was inserted on October 30, 1997. (St. Ex. 5 at I: 50-53, 56, 62; St. Ex. 5 at III: 23-24).

On November 11, 1997, Patient 5 reported at least 50% relief of pain with the spinal cord stimulator. She stated that she had weaned herself from all Demerol, and was taking methadone, four to five tablets three times per day. She reported that she would try to wean herself from methadone as well. (St. Ex. 5 at I: 67).

On December 1, 1997, Patient 5’s family contacted Dr. Dahlquist’s office with concerns for Patient 5. Patient 5’s mother reported that Patient 5 was withdrawn, had been calling in sick to work, isolating herself, and had let her personal grooming deteriorate. Patient 5’s mother further asked for a referral to a counselor, if not for Patient 5, than for the rest of the family. Dr. Dahlquist contacted Dr. Welty and obtained the name of a counselor for Patient 5’s family. (St. Ex. 5 at II: 12).

In February 1998, Patient 5 was admitted to the Psychiatric Unit at Miami Valley Hospital. Her diagnoses were,

Diagnosis: Axis	I	Major depressive disorder with anxiety acute and suicidal ideation
	II	Deferred
	III	Severe nerve damage left lower back and pelvic area, chronic pain, pelvic nerves radiating to left leg
	IV	Stressors, chronic pain
	V	GAF 20-30

(St. Ex. 5 at V: 3). In the reason for admission, Dr. Welty wrote that Patient 5 had been to the Cleveland Clinic for a procedure that she had hoped would relieve her pain. It had not

worked. She had also lost a job. Dr. Welty stated that, after these two disappointments, Patient 5 had become depressed and withdrawn. Dr. Welty further wrote as follows:

During this period of time one of the neighbors close to her was evidently into drugs, got her involved and this young lady sold some of her drugs to an undercover policeman. It was following this that she did become suicidal and it was felt that hospitalization was necessary.

(St. Ex. 5 at III). Dr. Dahlquist did not mention this incident in her progress notes regarding Patient 5. (St. Ex. 5 at II).

During her hospitalization, Patient 5 was treated by a psychologist. The psychologist administered an MMPI to Patient 5. He commented that Patient 5's profile was highly defensive, bordering on "faking good." The psychologist continued that patients with this profile have little insight into themselves and may often react to stress or avoid responsibility by developing symptoms. He added that such persons tend to be very immature and egocentric and their relationships tend to be shallow and superficial. In addition, the psychologist noted that it did not appear that Patient 5 had "yet come to terms with the seriousness of her actions or her situation. [Patient 5] may be used to having others 'bail her out' and/or using others to get what she wants/needs. She needs psychotherapy but her prognosis for being able to benefit from it is guarded at best." (St. Ex. 5 at V: 11-12).

Dr. Dahlquist did not mention this hospitalization in her progress notes regarding Patient 5; nor did she discuss the recommendation for psychotherapy. (St. Ex. 5 at II).

On October 1, 1998, Dr. Dahlquist prescribed methadone 10 mg., five to six tablets every eight hours, and Demerol 50 mg., one to two tablets every three to four hours as needed for pain, with a maximum of six per day. (St. Ex. 5 at II: 31).

On March 3, 1998, Dr. Dahlquist noted that Patient 5 was doing well with the spinal cord stimulator and methadone, four to five tablets, four times a day, and no Demerol. Patient 5's parents reported that Patient 5 was doing better on methadone alone. (St. Ex. 5 at II: 47). On March 21, 1997, Dr. Dahlquist noted that Patient 5 had been using Dilaudid for breakthrough pain. (St. Ex. 5 at II: 53).

On May 8, 1998, Dr. Dahlquist noted her impressions of "Neuropathic pain of the [left lower extremity] thought to be due primarily to a combination of causalgia (CRPS-II) and RSD (CRPS-I)." Dr. Dahlquist further noted that Patient 5 had weaned herself from pain medication "as far as she possibly can" and suggested a trial of intrathecal injections of Dilaudid. (St. Ex. 5 at II: 56).

On June 26, 1998, Patient 5 called the office requesting additional pain medication. Dr. Dahlquist increased her methadone from a maximum of 70 mg per week to a maximum of 90 mg per week for one week. (St. Ex. 5 at III: 49).

On July 2, 1998, Patient 5 was admitted to the hospital for insertion of a subcutaneous narcotics pump and intrathecal catheter. The pump was filled with Dilaudid and programmed to give Patient 5 a continuous infusion of Dilaudid 0.4 mg per day. By the second day, the Dilaudid infusion had been increased to 0.6 mg per day, without relief of pain. Dr. Dahlquist added an intravenous PCA pump to deliver Demerol. Patient 5 was having difficulty urinating due to the large amount of narcotics, but this resolved. On the third day, Patient 5 was discharged with a Dilaudid infusion of 0.6 mg per day. (St. Ex. 5 at II: 65-66).

On July 13, 1998, Patient 5 requested an increase in the Dilaudid infusion. Dr. Dahlquist declined due to Patient 5's problems with urinary retention. Patient 5 continued to take methadone, eighteen to twenty tablets per day. (St. Ex. 5 at II: 74, 79).

On August 4, 1998, Dr. Dahlquist increased the infusion to 0.75 mg per day. Dr. Dahlquist instructed Patient 5 to decrease her methadone intake to sixteen pills per day. Patient 5 was also taking Demerol 50 to 100 mg every three to four hours for incisional pain. (St. Ex. 5 at II: 85).

On October 8, 1998, Dr. Dahlquist noted that Patient 5 had been taking methadone, as many as sixty tablets per day, in addition to the Dilaudid infusion of 0.75 mg. Dr. Dahlquist increased the Dilaudid infusion to 1 mg per day, and instructed Patient 5 to decrease her methadone intake to twelve or fourteen tablets per day. Patient 5 continued to take Demerol. (St. Ex. 5 at II: 94-97).

On December 8, 1998, Dr. Dahlquist increased the Dilaudid infusion to 1.3 mg per day, and added Bupivacaine. Patient 5 was taking methadone at a maximum of twenty per day, with Phenergan 25 mg each time she took methadone. (St. Ex. 5 at II: 106).

On January 22, 1999, Dr. Dahlquist increased the Dilaudid infusion to 1.5 mg per day. (St. Ex. 5 at III: 61).

Later that month, Patient 5 was again hospitalized for anxiety and depression. (St. Ex. 5 at III: 52). Dr. Dahlquist did not comment on the hospitalization in her progress notes. (St. Ex. 5 at III).

On March 4, 1999, Dr. Dahlquist increased the Dilaudid infusion to 1.9 mg per day. Patient 5 reported taking fourteen to fifteen methadone per day; she was instructed to decrease to twelve per day. Dr. Dahlquist also prescribed Soma, one every six hours for muscle spasms. Patient 5 was also taking Lorazepam and Phenergan. (St. Ex. 5 at III: 61, 73).

On March 11, 1999, Dr. Dahlquist increased the Dilaudid infusion to 2.3 mg per day. Patient 5 reported taking eight to ten methadone per day; she was "very proud and happy" that she had been able to do so. (St. Ex. 5 at III: 79).

On April 27, 1999, Dr. Dahlquist increased the Dilaudid infusion to 3.1 mg per day. Patient 5 reported taking methadone five to eight per day; Soma, three to four daily; Lorazepam, 2 mg four times daily; Phenergan; and Klonopin. (St. Ex. 5 at III: 92, 95).

On June 25, 1999, Dr. Welty advised that Patient 5 had been a long time patient of his and that he was retiring. Dr. Welty requested that Dr. Dahlquist take over prescribing Phenergan, Lorazepam, and Klonopin for Patient 5. (St. Ex. 5 at III: 38).

On July 2, 1999, Dr. Dahlquist increased the Dilaudid infusion to 5.3 mg per day. On July 12, 1999, she increased it to 6.7 mg per day. (St. Ex. 5 at III: 129, 138-139).

On August 26, 1999, Patient 5 reported that she had been stopped by the police for “not driving straight.” Patient 5 explained that she had been tired. Dr. Dahlquist increased the Dilaudid infusion to 9.0 mg per day. (St. Ex. 5 at III: 149-148).

On September 30, 1999, Patient 5 reported that her pain had increased. She stated that she had been taking between twelve and twenty-one methadone per day. Dr. Dahlquist increased the Dilaudid infusion to 12.5 mg per day. (St. Ex. 5 at III: 155).

On December 7, 1999, Patient 5 again reported that her pain had increased. Dr. Dahlquist increased the Dilaudid infusion to 17 mg per day. Patient 5 stated that she had been taking seven to eight methadone every eight hours. (St. Ex. 5 at III: 184, 188).

On December 28, 1999, Patient 5 reported that her pain had increased. Dr. Dahlquist increased the Dilaudid infusion to 19 mg per day. Patient 5 stated that she had been taking six methadone every six hours. (St. Ex. 5 at III: 193-194, 196).

On January 17, 2000, Patient 5 called the office complaining of paralysis on the right side and muscles spasms. Patient 5’s parents expressed concern. (St. Ex. 5 at III: 57). Patient 5 was seen in the emergency room and was discharged in good condition with a diagnosis of right sided weakness. (St. Ex. 5 at VI: 1-3). Dr. Dahlquist saw Patient 5 on January 21, 2000, but did not mention the complaints of paralysis. (St. Ex. 5 at III: 202).

On March 3, 2000, Dr. Dahlquist increased the Dilaudid infusion to 21 mg per day. Patient 5 stated that she had been taking six to seven methadone every eight hours, in addition to Lorazepam, Klonopin, and Phenergan. (St. Ex. 5 at III: 214, 217).

On April 6, 2000, Patient 5 reported that she had been needing “more and more” methadone, and that she had been having problems with urinary incontinence. Dr. Dahlquist referred Patient 5 to a urologist. Dr. Dahlquist increased the Dilaudid infusion to 23 mg per day. (St. Ex. 5 at III: 223-2, 226).

80. Dr. Dahlquist testified that she continues to treat Patient 5. (Tr. 1689).

Dr. Shin's Testimony Regarding Patient 5

81. Dr. Shin testified that Dr. Dahlquist had failed to provide the minimal standards of care in her treatment of Patient 5. Dr. Shin further testified that he does not believe that Patient 5 suffered from intractable pain, in part, because, despite escalating doses of opioids and the intrathecal pump, Patient 5 had not received any pain relief. Dr. Shin asserted that Patient 5 may have been opioid resistant. He further asserted that there may have been psychological issues, psychosocial issues, behavioral issues, and environmental issues affecting Patient 5's treatment. In that case, Dr. Shin asserted, no amount of medication would have helped Patient 5. (Tr. 409-413, 805; St. Ex. 25 at 6-7).
82. Dr. Shin opined that Dr. Dahlquist had "failed to use reasonable care discrimination in the administration of drugs or failed to employ accepted scientific methods in the selection of drugs or other modalities for treatment of disease in her care and treatment of Patient 5." He elaborated that the use and combination of medication was inappropriate despite the intrathecal pump and high dosage of opioids. Dr. Shin testified that in his experience as a pain specialist neuropathic pain does not respond well to treatment with high doses of opioid medication. (Tr. 408-409, 413-414).
83. Dr. Shin testified that psychological factors can contribute to a patient's pain and should be considered by a pain specialist in treating a patient. He further testified that it does not appear that Dr. Dahlquist had considered Patient 5's psychiatric or psychological factors. (Tr. 424, 802, 805-806).
84. Dr. Shin testified that he had concerns regarding the fact that Patient 5 had been working when she first came to Dr. Dahlquist and that, as of September 8, 1998, Patient 5 had applied for disability. He elaborated that Patient 5 was only thirty years old, and there were so many other factors involved, including her suicidal ideation and isolation, that Dr. Dahlquist should have explored other avenues or referred Patient 5 to another pain care specialist. Dr. Shin commented "I think it's important to understand your limitations as a physician as to what you can do and what you cannot do. As I said, some people are resistant to your treatments, and if they would have a better chemistry with somebody else, they may do better." (Tr. 425-426).
85. Dr. Shin testified that he had also been concerned regarding the fact that Patient 5 had sold some of her medications to an undercover police officer. He explained that Dr. Dahlquist should have considered that event in her treatment of Patient 5. (Tr. 418-419).

Dr. Dahlquist's Testimony Regarding Patient 5

86. Dr. Dahlquist testified that she does not believe that she breached the standards of care by prescribing opioids for Patient 5. Dr. Dahlquist further testified that, prior to seeing Dr. Dahlquist, Patient 5 had already been tried on antidepressant and anti-seizure medications. She added that Patient 5 had been tried on various opioids and, by the time she

came to see Dr. Dahlquist, Patient 5 had been receiving both a long-acting opioid for baseline pain management and a short-acting agent for break-through pain. Nevertheless, Patient 5 had been having significant pain and had not felt that her medication regimen provided sufficient relief. (Tr. 140, 1691-1692).

Dr. Dahlquist testified that she had initially given Patient 5 methadone to control the baseline pain and Demerol as a short-acting agent. She chose these two opioids because methadone, unlike the other opioids, has some action on the NMDA receptor. Dr. Dahlquist elaborated that, if the patient can tolerate it, methadone often times is more effective for neuropathic pain than other long-acting opioids. She added that Demerol also tends to be more effective for neuropathic pain than some of the other opioids. (Tr. 140-141; St. Ex. 5 at III: 39).

87. Dr. Dahlquist testified that she had placed Patient 5 on an intrathecal pump because Patient 5 had been complaining of significant pain even with the use of the spinal cord stimulator and opioids. Dr. Dahlquist testified that neuropathic pain is very difficult to control on minimal doses of oral analgesics, and that she had been unable to increase the dose of methadone without causing sedation. Therefore, Dr. Dahlquist had chosen an intrathecal opioid infusion system because it can deliver much lower doses of opioid medication with fewer side effects. (Tr. 147-148, 1695; St. Ex. 5 at II: 64-65).
88. Dr. Dahlquist testified that the source of Patient 5's pain was physical. Dr. Dahlquist added that she had taken into consideration that there could be other psychological factors related to that pain. (Tr. 156-158).
89. Dr. Dahlquist testified that she had been aware of Patient 5's psychological and psychiatric status, in part, because she had communicated with Patient 5's parents regarding Patient 5's situation. Dr. Dahlquist testified that when Patient 5's parents reported that Patient 5 was withdrawn and would not work, Dr. Dahlquist had considered it to be a manifestation of depression. Nevertheless, Dr. Dahlquist admitted that they could have been symptoms of oversedation. (Tr. 1702-1703).

Dr. Dahlquist further testified that she had been aware of Patient 5's psychiatric status because she had communicated with Dr. Welty. Moreover, Dr. Dahlquist testified that she had seen Patient 5 at the hospital during her February 1998 psychiatric hospitalization. (Tr. 144-145, 1097-1098, 1693-1694, 2159-2162).

When asked why she had not documented conversations with other treating physicians in her progress notes, Dr. Dahlquist testified that if she spoke to another treating physician about a patient's medical condition and the discussion suggested a change in treatment, she would document that discussion in the record. However, if the discussion "took the path of it's okay to continue the current therapy, then I would not necessarily document that in the record." (Tr. 146-147).

90. Dr. Dahlquist testified that she had concluded that Patient 5 had not abused medications in any way. She stated that she held this opinion because Patient 5 had not routinely called for early refills and because Dr. Dahlquist had not received phone calls from family members or a pharmacist claiming that Patient 5 had been abusing her medications. (Tr. 139-140, 147).

Dr. Dahlquist acknowledged that Patient 5 had reported being stopped by police for “not being able to drive straight.” Dr. Dahlquist testified that that had “not necessarily” been an indication that Patient 5 had been oversedated. Dr. Dahlquist added Patient 5 had had a neurologic problem in both of her lower extremities which may have caused spasms, resulting in difficulty driving. (Tr. 154-155).

Regarding Patient 5’s selling narcotics to undercover police officers, Dr. Dahlquist testified that both Patient 5 and Patient 5’s father had represented to her that this conduct was out of character for Patient 5 and that if pain management was not continued Patient 5 would likely commit suicide. Dr. Dahlquist commented that she was “reasonably convinced that this was the truth.” Dr. Dahlquist testified that she had not had any further problems from Patient 5 since that time. (Tr. 1709-1711, 2159-2162, 2236).

91. Dr. Dahlquist testified that she does not agree with Dr. Shin’s concern that Patient 5 had been working full time when she had first been seen by Dr. Dahlquist and subsequently became totally disabled. Dr. Dahlquist explained that Patient 5 had reported at her initial visit that she had worked intermittently, and that it was just a coincidence that Patient 5 had been working full time at the time she came to see her. Dr. Dahlquist asserted that Patient 5’s work had been so intermittent to that point because of the severity of her illness that it had not surprised Dr. Dahlquist that Patient 5 had eventually applied for disability. Moreover, Dr. Dahlquist asserted that Patient 5’s application for disability had been based on her physical condition not Dr. Dahlquist’s prescribing excessive medications. (Tr. 1713-1714).
92. Dr. Dahlquist testified that, while the treatment she had provided to Patient 5 “didn’t cure her underlying problem, it certainly did improve the pain.” Dr. Dahlquist further testified that it is possible that she had saved Patient 5 from suicide by maintaining her on her pain medications. She explained that Patient 5 had told her on various occasions that if she could not be treated with pain medication, she would have to consider suicide because she could not live with her pain. (Tr. 1706, 1715-1716, 2163).

Dr. Blatman’s Testimony Regarding Patient 5

93. Dr. Blatman asserted that Dr. Dahlquist had met the standards of care in treating Patient 5. Dr. Blatman asserted that Dr. Dahlquist had prescribed medications in types, amounts, and/or combinations that were appropriate, and for periods of time that were justified. With the caveat that intrathecal Dilaudid is outside the scope of his practice because he does not administer intrathecal Dilaudid, Dr. Blatman testified that the dosages of

methadone and of intrathecal Dilaudid had been appropriate for Patient 5 and met standards of care. (Tr. 1099-1103, 1321-1324; Resp. Ex. B at 1; Resp Ex. C at 8).

94. Dr. Blatman testified that there is no limit to the length of time Patient 5 can be treated with methadone. Dr. Blatman added that he would expect Patient 5 to require pain treatment for the rest of her life. Dr. Blatman added that he believes that it would be unethical and inappropriate to stop treating Patient 5 for her chronic or intractable pain. (Tr. 1100-1101).

Dr. Blatman further testified that the dose of methadone prescribed to Patient 5 by Dr. Dahlquist was high in comparison to what many physicians will prescribe. He added, however, it was below the dose that would be expected to cause toxicity. Dr. Blatman added that Patient 5 had exhibited no signs of toxicity. (Tr. 1102; Resp. Ex. C at 8).

95. Dr. Blatman opined that "[o]ne of the responsibilities of the pain practitioner is to make responsible choices to avoid diversion of potentially abused or abusable substances." The pain practitioner also needs to decide how to handle "behaviors that can be explained but may not be always justifiable in the eyes of the law or in the eyes of society." Dr. Blatman continued that there is a whole spectrum of how various practitioners will handle the problem of a patient giving or selling medication to an undercover police officer. (Tr. 1106-1108).

96. Dr. Blatman opined that Dr. Dahlquist's medical records reflect that Dr. Dahlquist had taken into account Patient 5's psychological factors when treating Patient 5's pain. Dr. Blatman noted that, when Dr. Welty retired, Dr. Dahlquist had assumed responsibility for Patient 5's psychiatric medications. Moreover, Dr. Dahlquist's medical record contained an April 19, 1997, letter from Dr. Dahlquist to Dr. Charles Demirjian advising him that Dr. Dahlquist had evaluated Patient 5 on March 25, 1997. Dr. Blatman commented that this document shows that Dr. Shin's assertions that Dr. Dahlquist had failed to consider Patient 5's psychological factors is inaccurate. (Tr. 1098-1099; Resp. Ex. B at 13; Resp Ex. C at 8).

PATIENT 6

Allegations

97. In its February 13, 2002, Notice of Opportunity for Hearing, the Board alleged that, in her care and treatment of Patient 6, Dr. Dahlquist had prescribed medications in types, amounts and/or combinations that were inappropriate and/or for protracted periods of time that were not justified.

The Board further alleged that Dr. Dahlquist had inappropriately administered injections or blocks. As examples, the board alleged that Dr. Dahlquist had continued to administer lumbar epidural blocks to Patient 6 on a regular basis over a period of more than three

years although the blocks were not clearly providing Patient 6 with adequate long-term pain relief.

In addition, the Board alleged that Dr. Dahlquist had failed to identify a reasonable pain diagnosis or differential pain diagnosis, and/or to clarify or confirm the diagnosis, and/or to identify the organic cause, mechanism, or source of the patient's pain.

Furthermore, the Board alleged that Dr. Dahlquist had failed to obtain records of prior or concurrent medical treatment, including studies performed, and/or she failed to refer the patient for additional, necessary consultations, evaluations, studies, or treatment. As an example of such failures, the Board alleged that Dr. Dahlquist had failed to obtain appropriate neurological studies such as an MRI, an electromyographic study, and/or a nerve conduction study.

Finally, the Board alleged that Dr. Dahlquist had failed to appropriately consider and/or address whether psychological factors were affecting the Patient 6's pain. (St. Ex. 17A).

Medical Records for Patient 6

98. Patient 6, a thirty year old female, first presented to Dr. Dahlquist on October 19, 1994. Patient 6 had been referred by Walter Broadnax, Jr., M.D. Patient 6 had reported having congenital hip problems with bilateral total hip replacements in 1991, with resultant injury to her sciatic nerve and reflex sympathetic dystrophy. Subsequently, Patient 6 had undergone two additional surgeries on her left hip, and a series of lumbar sympathetic blocks. Dr. Dahlquist planned to perform a series of lumbar sympathetic blocks because Patient 6 had responded well to such treatment in the past. Patient 6 was taking Baclofen, Triavil, and Lorazepam at that time. (St. Ex. 6 at II: 9, 15-16, 24; St. Ex. 6 at IV: 3; St. Ex. 6 at IV: 108-110).

In November 1994, Dr. Dahlquist prescribed Oxycodone, every six hours as needed; Triavil at night; and Baclofen, twice daily. In February 1995, Dr. Dahlquist prescribed Tylenol #3 and Flexeril rather than Oxycodone. (St. Ex. 6 at II: 33, 43). Dr. Dahlquist continued to administer lumbar sympathetic blocks and lumbar sympathetic neurolytic blocks. (St. Ex. 6 at II: 24-101).

On July 9, 1995, Dr. Dahlquist reported to Dr. Broadnax that, since he had referred Patient 6 to her, Dr. Dahlquist had administered repeat lumbar sympathetic blocks for Patient 6's diagnosed reflex sympathetic dystrophy. Dr. Dahlquist further noted that, at Dr. Broadnax' request, she had also administered epidural local anesthetic blocks. Dr. Dahlquist noted that Patient 6 had been getting "fairly good relief, which [was] surprising given the length of time [Patient 6] had had this condition." Finally, Dr. Dahlquist noted that Patient 6's area of pain seemed to be increasing, and Dr. Dahlquist recommended a trial of physical therapy. (St. Ex. 6 at II: 7).

In August 1995, Patient 6 started physical therapy at home. Dr. Dahlquist continued epidural local anesthetic blocks on a regular basis. Dr. Dahlquist added Percocet, Trazodone, and Ativan to Patient 6's medication regimen. (St. Ex. 6 at I: 7-8, 14; St. Ex. 6 at II: 101, 128).

On February 28, 1996, Dr. Dahlquist reported that Patient 6 had made significant improvement since starting treatment. Dr. Dahlquist stated that Patient 6 had first presented primarily wheelchair bound, and now was able to walk around the house without crutches. Dr. Dahlquist credited intermittent epidural local anesthetic blocks and Patient 6's persistence with physical therapy. (St. Ex. 6 at I: 17).

In June 1996, Dr. Dahlquist started prescribing Vicodin, two to three tablets per day, in addition to Patient 6's other medications. (St. Ex. 6 at I: 37). From March through December 1996, Dr. Dahlquist administered monthly lumbar sympathetic blocks. (St. Ex. 6 at I: 27-124).

In February 1997, Patient 6 reported that she had "accidentally" taken one of her boyfriend's Ritalin tablets. Thereafter, Patient 6 requested Ritalin for pain. Dr. Dahlquist complied. (St. Ex. 6 at III: 10, 13).

On March 19, 1997, Patient 6 called the office to state that Ritalin was not effective, and requested Percocet. Dr. Dahlquist complied. (St. Ex. 6 at IV: 41).

In April 1997, Dr. Dahlquist was prescribing Vicodin, one every six hours as needed for pain; Ativan 1 mg, one to two every six hours for anxiety, with a maximum of four per day; Flexeril 10 mg, one every six hours as needed for muscle spasm; Ritalin 10 mg, two daily; and Phenergan 25 mg, one every six hours as needed for nausea. Dr. Dahlquist recommended massage therapy and Reiki. In May 1997, Patient 6 requested Talwin rather than Percocet. Dr. Dahlquist complied. (St. Ex. 6 at III: 18, 36). Dr. Dahlquist continued epidural local anesthetic blocks on a regular basis. (St. Ex. 6 at III: 18-53).

In May 1997, Dr. Dahlquist ordered a C.T. scan of the lumbar spine and left hip to rule out nerve root compression or hip dislocation. The C.T. scan revealed, "Osteoarthritis of facet joint at L4-5 and L5-S1 encroaching upon the right neural foramina." (St. Ex. 6 at IV: 15, 17).

On June 20, 1997, Patient 6 reported to the emergency room complaining that she was experiencing a "nervous breakdown." She also complained of pain. The emergency room physician ordered a mental health evaluation. The diagnosis was acute pain secondary to RSD and depression. Dr. Dahlquist did not mention the emergency room visit in her progress notes. (St. Ex. 6 at III: 54a, 54b).

On September 24, 1997, Patient 6 called for an increase in her Ritalin. Dr. Dahlquist refused. (St. Ex. 6 at IV: 44).

In October 1997, a pharmacy called to advised that Dr. Broadnax had been prescribing Depakote, Ultram, and Baclofen. (St. Ex. 6 at IV: 45).

On December 1, 1997, Patient 6 reported to the emergency room for complaints of pain. The emergency room physician consulted with Dr. Dahlquist and administered an injection of Demerol and Phenergan. (St. Ex. 6 at III: 80-81).

On January 2, 1998, Patient 6 called the office to report that she had fallen and had increased pain. She requested permission to go to the emergency room or for additional Demerol. Dr. Dahlquist refused to provide additional pain medication. (St. Ex. 6 at IV: 47).

On January 22, 1998, Patient 6 called the office to report that her injections had not helped her pain. Dr. Dahlquist refused to provide additional pain medication, stating that Patient 6 was "already on max medications." (St. Ex. 6 at IV: 48).

On February 11, 1998, Patient 6 called the office to report that her Vicodin was not helping to relieve her pain. She requested Percocet. Dr. Dahlquist advised that she would give her one Percocet for each Vicodin tablet Patient 6 returned. (St. Ex. 6 at IV: 49).

On March 16, 1998, Patient 6 filed a police report stating that her medications had been stolen. (St. Ex. 6 at IV: 50).

In approximately mid-June 1998, Dr. Dahlquist's office received information that that Patient 6 had been selling her OxyContin to earn money to purchase cocaine. Dr. Dahlquist ordered a random urine specimen for toxicology. (St. Ex. 6 at IV: 54).

On June 30, 1998, a urine drug screen tested positive for cannabinoids and benzodiazepines. Opiates, lorazepam, and cocaine were not detected. (St. Ex. 6 at IV: 19). At that time, Patient 6's medications included lorazepam, Roxicodone, Vicodin, Demerol, and Ritalin. (St. Ex. 3 at IV: 29-30). Patient 6 signed a statement acknowledging that the urine test had revealed the presence of cocaine and the absence of prescribed medications. Patient 6 agreed to comply with monitoring terms and limited prescriptions. (St. Ex. 6 at IV: 53).

On July 16, 1998, Patient 6 appeared for treatment. Dr. Dahlquist confronted her with the results of the urine screen. Patient 6 stated that she believed that her boyfriend had altered her medications. In response to the positive results and Patient 6's explanation, Dr. Dahlquist offered two options to Patient 6, as follows:

The first option is to receive her medications only on a weekly basis, and give a urine specimen every week (randomly) in other words, one of our office staff will contact her any day of the week in the morning, and she needs to make it into the office by the end of the business day (5:00 p.m.) on that same day to give urine specimen. This will be done for 8 weeks in a row. She will only receive one weeks worth of medications each

week during this time. If she fails to show up for urinalysis to be performed, or if her urine results are not in compliance with what we are prescribing her, she will be given two options at that time. The first will be to go through a formal drug rehabilitation program, and the second will be to be discharged from the practice and be turned into the proper authorities. She has fully agreed to this.

(St. Ex. 6 at IV: 1020103).

On July 29, 1998, a urine drug screen tested positive for cannabinoids and cocaine metabolites. Opiates and benzodiazepines were not detected. (St. Ex. 6 at IV: 19). Dr. Dahlquist issued prescriptions for Demerol, Ativan, Roxicodone, and Ritalin. (St. Ex. 6 at IV: 30).

On August 11, 1998, Patient 6 did not appear for a scheduled appointment and did not call. Dr. Dahlquist wrote that no medications would be prescribed to Patient 6 until she was seen. There are no further entries in the medication sheets. (St. Ex. 6 at IV: 30).

On December 8, 1998, Patient 6 called the office requesting an appointment. Office staff advised Patient 6 that, because she had violated the monitoring contract that she had signed in June, she was no longer a patient of Dr. Dahlquist. (St. Ex. 6 at IV: 56).

Dr. Shin's Testimony Regarding Patient 6

99. Dr. Shin testified that Dr. Dahlquist had "failed to provide at least minimum standards of care" to Patient 6, in part, because Patient 6's diagnosis did not justify the use of combinations of high-dose opioids, muscle relaxers and benzodiazepines. Dr. Shin testified that Dr. Dahlquist had failed to use "reasonable care discrimination" in the administration of drugs because Dr. Dahlquist had continued to administer injections and a wide variety of controlled substances despite the fact that Patient 6's condition did not improve. Dr. Shin testified that this was a deviation from the standards of care. (Tr. 430-434, 440-441; St. Ex. 25 at 8).
100. Dr. Shin testified that Dr. Dahlquist had not identified or confirmed a reasonable diagnosis or a differential diagnosis as the cause of Patient 6's pain. Dr. Shin explained that the appropriate approach would have been to establish that there was a neuropathic component involved. He commented that "[j]ust because the patient has pain does not mean that it is a pain arising from the neuropathic component or sympathetic component of the injury directly related to that particular nerve." Dr. Shin commented that Dr. Dahlquist had made no real attempt at diagnosis. He continued that there should have been a diagnosis more specific than RSD, such as a causalgia or CRPS Type I. Dr. Shin further testified that, without a more specific diagnosis, Dr. Dahlquist should have ordered studies to indicate whether the patient may have had some other component of pain. As examples, Dr. Shin suggested an EMG to rule out damage to the nerve, or an MRI "to rule out any occult

findings in the spine that may be compressing on that nerve.” (Tr. 438-440, 818-819; St. Ex. 25 at 8).

Dr. Shin further testified that Dr. Dahlquist should have used more caution after Patient 6 reported that she had “accidentally” taken her boyfriend’s Ritalin. Dr. Shin testified that Ritalin is not “a common medication to be prescribed for someone with pain.” Dr. Shin explained that Ritalin is a stimulant, adding that he had never seen Ritalin used to treat chronic pain. (Tr. 441-446; St. Ex. 25 at 8).

101. Dr. Shin further testified that he had concerns regarding Dr. Dahlquist’s prescribing to Patient 6 despite the positive findings of a drug screen for marijuana and cocaine while being negative for medications Dr. Dahlquist prescribed. (Tr. 430-434, 443-444; St. Ex. 25 at 8).

Dr. Shin testified that if he learned that a patient was using cocaine in addition to the medications he had prescribed, he would set forth specific guidelines without immediately changing the current treatment. The specific guidelines would include measures to assist the patient in obtaining an evaluation and treatment for his cocaine use. Thereafter, he would adjust his treatment based on the evaluation. Dr. Shin noted that if the patient did not comply with those guidelines he would discharge the patient from his practice, after a proper tapering of the medications he had been prescribing. (Tr. 685-687).

Dr. Shin testified that if he had a patient whose drug screen did not reflect the drugs he was prescribing he would confront the patient and get an answer from that patient as to what the patient has been doing with those medications. He added that it is difficult to trust a patient after such a violation. (Tr. 444-445).

102. Dr. Shin testified that he does not believe that Dr. Dahlquist appropriately considered or addressed whether Patient 6 had had psychological factors that were effecting her pain. Dr. Shin explained that there is no mention of a possibility of psychological factors affecting pain in the records he reviewed. (Tr. 445-446; St. Ex. 25 at 8).

Dr. Dahlquist’s Testimony Regarding Patient 6

103. Dr. Dahlquist testified that Patient 6 had intractable pain and that she had attempted to relieve that pain using opioids and various other methods. Dr. Dahlquist further testified that she believes that she had met the appropriate “standards of medical care” in her treatment of Patient 6. (Tr. 1765-1767).
104. Dr. Dahlquist testified that “eventually” she had prescribed opioids for Patient 6 because Patient 6 had had severe pain because of her RSD and causalgia, because of her neuropathic pain. Dr. Dahlquist asserted that, although the blocks were giving Patient 6 relief, “it was just temporary relief and it was not complete relief.” Dr. Dahlquist explained that she had provided opioids to Patient 6 to help improve the pain to the point that she could have an improved quality of life. (Tr. 1738-1739).

Dr. Dahlquist testified that the levels of opioids she had prescribed to Patient 6 were not too high because she had followed Patient 6 on a regular basis. Moreover, she had had input from a significant other that the patient was functioning appropriately. Dr. Dahlquist added that Patient 6 had improved significantly from Dr. Dahlquist's therapy in that she had progressed from a wheelchair to a point where she could walk short distances in her house without crutches. Dr. Dahlquist added that, until the very end of her treatment, Patient 6 had not shown any indication of medication abuse. Therefore, Dr. Dahlquist concluded that the amount of medication she prescribed had been appropriate. Dr. Dahlquist further concluded that discontinuing Patient 6's medications would have been a breach of the standards of care. (Tr. 172-177, 1744-1745, 1749-1750, 1760-1761, 1766).

105. Dr. Dahlquist testified that the fact that Patient 6 had taken one of her boyfriend's Ritalin had concerned her. Nevertheless, Dr. Dahlquist noted that the boyfriend had been with Patient 6 for almost every office visit and had corroborated the story that the taking of Ritalin had been an accident. Dr. Dahlquist commented that she had looked for other signs of aberrant behavior and had not found any. (Tr. 173-174, 1757-1759).

Dr. Dahlquist testified that she had subsequently prescribed Ritalin for Patient 6. Dr. Dahlquist explained that Ritalin had had a different effect on Patient 6 than it does in normal adults. Dr. Dahlquist elaborated that Patient 6 had responded more like a child in that the Ritalin calmed her. Dr. Dahlquist added that, when someone is anxious and high strung, pain can be worsened. Dr. Dahlquist testified that it is very possible that the calming effect had decreased the sympathetic nervous system stimulation giving improvement in her pain without having to add additional opioids. Dr. Dahlquist concluded that Patient 6 had appeared to use her Ritalin appropriately. (Tr. 173-174).

106. Dr. Dahlquist asserted that Patient 6 had been referred to her by a neurologist. She added that it had been reasonable to assume that Dr. Broadnax had done a prior workup of this patient and had determined that Patient 6 did not need further diagnostic testing. Dr. Dahlquist testified that her medical records for Patient 6 contain documentation of her communications with Dr. Broadnax. (Tr. 1728-1735).

107. Dr. Dahlquist testified that Patient 6 had responded well to the lumbar sympathetic blocks. Dr. Dahlquist explained that the lumbar sympathetic blocks are only local blocks and are expected to wear off after about twelve hours. She added that people with sympathetic pain sometimes obtain prolonged relief extending out several days or several weeks, because the cycle of pain is broken. (Tr. 179-180).

Dr. Dahlquist testified that she had not expected that Patient 6 would be cured by epidural blocks. She explained that, since Patient 6 had had permanent damage to her sciatic nerve, it was unlikely that she would ever get better. (Tr. 1742-1744; St. Ex. 6 at I: 7, 17).

108. Dr. Dahlquist testified that she had considered Patient 6's psychological or psychiatric issues. Dr. Dahlquist testified that she had not seen any evidence of psychological issues before August 1997, when an emergency room physician had referred Patient 6 for a mental health evaluation. Dr. Dahlquist commented that, after the mental health evaluation, Patient 6 had established a doctor-patient relationship with a psychiatrist. Therefore, Dr. Dahlquist had felt that "the psychiatrist was the best qualified to determine whether the patient needed follow-up or not. So I left it up to the psychiatrist and the patient as to what to do from that point on psychiatrically." (Tr. 1759-1760; St. Ex. 6 at III: 55).

Dr. Blatman's Testimony Regarding Patient 6

109. Dr. Blatman testified that Dr. Dahlquist had met the standards of care in treating Patient 6. Dr. Blatman further testified that the medications prescribed to Patient 6 by Dr. Dahlquist were appropriate and met the standards of care. Dr. Blatman added that pain from RSD is "so strong and so bizarre that high-dose opioids are certainly indicated." Moreover, Dr. Blatman testified that he generally prescribes opioids and muscle relaxants for RSD patients, and he will prescribe benzodiazepines depending on the patient. Dr. Blatman commented that the primary treatments available to pain practitioners, especially anesthesiologists, for RSD are regional sympathetic blocks and opioid medication. He opined that those are among the most effective treatments for RSD. (Tr. 1112, 1114-1117; Resp. Ex. B at 14; Resp Ex. C at 9).
110. Dr. Blatman testified that there had been no reason for Dr. Dahlquist to obtain medical records for Patient 6's prior treatment or to obtain additional testing. Dr. Blatman noted that Patient 6 had been referred by Dr. Broadnax who had summarized the case for Dr. Dahlquist. He added that Dr. Dahlquist's physical findings had been consistent with the summary provided by Dr. Broadnax. (Tr. 1112-1113; Resp Ex. B at 14).

Dr. Blatman further testified that he does not normally conduct nerve conduction studies on patients with RSD. He elaborated that EMGs with needle nerve conduction involves sticking needles into the skin and muscle. Dr. Blatman commented that the area of the body to be tested is already hypersensitive to pain. He opined that an EMG in an RSD patient can be cruel. (Tr. 1113-1114; Resp. Ex. C at 9).

111. Dr. Blatman testified that the fact that lumbar sympathetic and epidural blocks do not provide long term relief is not an indication that the blocks should not be given at all. He added that even temporary relief is desirable for a patient such as Patient 6. Dr. Blatman testified that he could see no reason for Dr. Dahlquist to have discontinued the blocks. (Tr. 1117-1118; Resp Ex. B at 15; Resp. Ex. C at 9).
112. Dr. Blatman testified that chronic pain patients frequently tell the physician which medications are effective in controlling their pain. Dr. Blatman continued, "Unfortunately, we are raised in our medical career with the concept that a patient who comes in and says, 'Doc, this is the only drug that works for me, these other ones don't work for me,' that is

pathognomonic for a drug-seeking patient. That's what we're taught, that's what we're bred with." Dr. Blatman added, "In patients with legitimate pain, they're telling you because they honestly tell you, "This drug works, these other drugs don't work, don't waste my time and don't waste my money." (Tr. 1118-1119).

113. Dr. Blatman testified that Dr. Dahlquist's handling of the positive drug screen for Patient 6 was appropriate. (Tr. 1121-1126).
114. Dr. Blatman testified he would be concerned if a patient reported that she had taken someone else's prescribed controlled substance. He stated that, if that should happen, he would counsel the patient regarding the dangers of taking other people's medication and remind the patient that taking another's prescription medication is illegal. (Tr. 1330-1331).
115. Dr. Blatman opined that Dr. Dahlquist had considered Patient 6's psychological factors. Dr. Blatman stated that Dr. Dahlquist had noted the patient's "more positive outlook on life" on one occasion. He noted that Dr. Dahlquist had also addressed psychological factors when she encouraged Patient 6 to participate in Reiki treatment. He noted that, "While unconventional, this is a respected choice for a pain practitioner." (Resp Ex. B at 14; Resp Ex. C at 9).

PATIENT 7

Allegations

116. In its February 13, 2002, Notice of Opportunity for Hearing, the Board alleged that, in her care and treatment of Patient 7, Dr. Dahlquist had prescribed medications in types, amounts and/or combinations that were inappropriate and/or for protracted periods of time that were not justified.

The Board further alleged that Dr. Dahlquist had failed to obtain records of prior or concurrent medical treatment, including studies performed, and/or she failed to refer Patient 7 for additional, necessary consultations, evaluations, studies, or treatment. As an example, the Board alleged that Dr. Dahlquist had failed to obtain a neurological consult or records of a prior neurological consult for Patient 7. (St. Ex. 17A).

Medical Records for Patient 7

117. Patient 7, a twenty-nine year old female, first presented to Dr. Dahlquist on June 30, 1999. Patient 7 was 5'7" and weighed approximately 340 pounds. She complained of chronic migraine and tension headaches and neck spasms. Patient 7 stated that she had fallen from her crib when she was eighteen months old. Patient 7 reported that her headaches occurred approximately once per week, and lasted from a few hours to a week. Patient 7 had been referred by her family physician. Dr. Dahlquist noted that she did not have

Patient 7's prior treatment records; therefore, she would rely on Patient 7's oral history. (St. Ex. 7 at I: 6-17, 31).

Nevertheless, previous medical records for Patient 7 would have revealed the following:

- In November 1987, Patient 7 had been treated in the emergency room after presenting to an appointment with her psychiatrist "somewhat lethargic with slurred speech and difficult to awaken." She had been diagnosed with chemical dependency, acute drug overdose (unintentional), and episodic marijuana and alcohol abuse. The emergency room physician had ordered a psychiatric evaluation. (St. Ex. 7 at III: 1, 6).

Patient 7 had been hospitalized for six days at Greene Hall in Xenia, Ohio. A psychiatric evaluation had noted that Patient 7 had been abusing her prescription Flexeril. During the evaluation, Patient 7 had appeared "drug affected and lethargic." The evaluation noted that Patient 7 had started abusing alcohol and marijuana at age fourteen, and that she had abused prescription medications, including diet pills. Moreover, Patient 7 had had a history of suicidal ideation. (St. Ex. 7 at II: 2-7).

- In July 1993, Patient 7 had been treated in the emergency room with a diagnosis of "nontoxic ingestion, illegal ingestion of another person's prescription medication [Soma]." The emergency room physician had diagnosed polysubstance abuse and noted that Patient 7 was, at that time, a patient in an outpatient drug treatment program. (St. Ex. 7 at II: 46-51).
- On June 27, 1998, Patient 7 had presented to the emergency room after taking ten Tylox and ten Xanax. She had been admitted to Greene Memorial Hospital for drug detoxification, with diagnoses that included continuous poly-chemical dependency (benzodiazepines, opiates and Soma), acute mild drug withdrawal, insomnia, personality disorder with dependent and borderline features, major depression, and possible anxiety disorder with panic attacks. (St. Ex. 7 at IV: 1-2).

In the History of Present Illness, it had been noted that, "This is a 28-year-old female who has been taking Xanax on a daily basis for about 10 years. When she gets a prescription, she takes it until it is all gone. She is also snorting Tylox. She gets Tylox about once a month, it lasts 4-5 days and then it's gone." (St. Ex. 7 at IV: 6).

Upon her initial evaluation by Dr. Dahlquist in June 1999, Patient 7 did not reveal her history of chemical dependency and drug abuse. She did report that she had attended a multidisciplinary pain center in the past, but had not "attended very long." Patient 7 had stated that she had used a TENS Unit, a Matrix Unit, and electrical stimulation, and had had traction, myofascial trigger point injections, and chiropractic manipulations. (St. Ex. 7 at I: 6-7).

At that time, Patient 7 stated that she had not been taking any medications for pain. Patient 7 reported that medications that had been effective in the past included OxyContin, Tylox, Soma, and Xanax. She further reported that medications which had been ineffective in the past included Vicodin, Lorcet, Ultram, Toradol, Midrin, calcium channel blockers, and beta-blockers. (St. Ex. 7 at I: 10, 19-20).

Patient 7 signed a Prescription Medication Contract. Dr. Dahlquist prescribed OxyContin, 20 mg, one to two tablets every eight to twelve hours. Dr. Dahlquist explained the risks associated with opioid medications. One week later, Dr. Dahlquist prescribed OxyContin and methadone. On July 30, 1999, Dr. Dahlquist prescribed OxyContin and Ambien. (St. Ex. 7 at I: 18, 23-25).

Patient 7 missed her next appointment in October 1999. She appeared for an appointment in November 1999, and Dr. Dahlquist explained that she must be seen every three months or Dr. Dahlquist would not continue to prescribe medication for her. Patient 7 apologized and agreed to keep her appointments. (St. Ex. 7 at I: 45).

Patient 7 reported significant improvement in her headaches. She added that she had been taking OxyContin 40 mg three times a day, and Ambien for sleep. In addition, Patient 7 reported, for the first time, that she had had a history of panic attacks, and requested Xanax. Dr. Dahlquist gave her a prescription for Xanax, and stated that it did not appear that Patient 7 needed a psychological evaluation since she had good coping skills, practiced relaxation, and used good breathing skills during panic attacks. (St. Ex. 6 at I: 45-46).

On February 11, 2000, Patient 7 reported that her pain had been stable with her medication, but noted a new complaint of low back pain. She further reported that she would be out of town for one month, and asked for prescriptions to cover that period. Dr. Dahlquist noted that Patient 7 had not shown any signs of abuse, and acquiesced. (St. Ex. 7 at I: 52-53).
Dr. Dahlquist diagnosed,

Probable early degenerative disc disease in the lumbar spine causing back pain. Since this does not seem to be causing her a great deal of difficulty, and since it does not have any radicular symptoms, I do not plan to work this up further at this time. Will simply continue to treat her with medications as above.

(St. Ex. 7 at I: 53).

118. On February 18, 2000, Patient 7 suffered a cardiopulmonary arrest and died. The emergency room records noted a history of migraine headaches, chemical dependency, and low back pain. (St. Ex. 7 at II: 4-19).
119. A postmortem examination was conducted on the body of Patient 7 which revealed the cause of death as "acute bronchopneumonia" with a contributing condition of "morbid

obesity.” The report further noted a “[c]linical history of prescription drug abuse” and “[s]lightly elevated levels of alprazolam (Xanax) and oxycodone (Percodan) in the blood.” (St. Ex. 23).

Dr. Shin’s Testimony Regarding Patient 7

120. Dr. Shin testified that Dr. Dahlquist had departed from or failed to conform to minimal standards of care in her treatment of Patient 7. (Tr. 447-449; St. Exs. 17B, 23; St. Ex. 25 at 9).

121. Dr. Shin noted that initially Dr. Dahlquist had prescribed OxyContin, and one week later added methadone while maintaining Patient 7 on OxyContin. Subsequently, Dr. Dahlquist added Ambien and increased the dosage of OxyContin. Dr. Shin opined that these medications were prescribed “in types, amounts or combinations that were inappropriate or were for protracted periods of time that might not be justified based upon the patient’s diagnosis or condition.” (Tr. 453-454).

Dr. Shin testified that headaches can be managed with anti-inflammatory medication instead of narcotic medication. Dr. Shin opined that an anti-inflammatory should have been prescribed prior to prescribing OxyContin for Patient 7. Dr. Shin acknowledged that Patient 7 had tried Motrin and Naprosyn, but added that there are other anti-inflammatories that should have been tried, including Daypro, Arthrotec, Oruvail or Voltaren. Moreover, Dr. Shin added that Patient 7 had reported that Motrin and Naprosyn had provided a fair amount of relief. (Tr. 456-457).

122. Dr. Shin testified that he had been concerned, also, that Dr. Dahlquist had prescribed Ambien and Xanax in combination with the OxyContin, as they are all central nervous system depressants and cause mental status changes. Dr. Shin added that his concerns were compounded by the fact that Patient 7 had a history of chemical dependency, inpatient treatment for drug abuse, and other social behavioral issues. Dr. Shin concluded that treating Patient 7 with this combination of medications had been unwarranted. (Tr. 457-460).

123. Dr. Shin testified that Dr. Dahlquist’s medical records for Patient 7 reflect that Patient 7 had been treated by other physicians. Dr. Shin opined that it is important for a pain specialist to get records from prior and concurrent treating physicians. Dr. Shin explained that pain patients are typically very difficult to assess and that it is difficult to formulate an appropriate diagnosis when the physician is relying on subjective information from patients. (Tr. 450-453, 820-821, 953-954; St. Ex. 25 at 9).

124. Dr. Shin acknowledged that Patient 7 would have elevated levels of alprazolam and oxycodone, as noted in her post-mortem report, based on the medications Dr. Dahlquist had prescribed. (Tr. 461 and 822-823; St. Ex. 23).

Dr. Dahlquist's Testimony Regarding Patient 7

125. Dr. Dahlquist testified that she had “conformed to the standards of care and treatment of this patient in the prescription of medications.” Dr. Dahlquist testified that initially she had prescribed OxyContin for Patient 7. Dr. Dahlquist added that Patient 7 had received six tablets of methadone on July 7, 1999, as a trial to see if methadone would give her any better relief of the neuropathic symptoms. Dr. Dahlquist commented that the OxyContin alone had been more effective, so the methadone was not continued. (Tr. 1769-1770, 1774-1775, 1795).

Dr. Dahlquist testified that she had prescribed Ambien for Patient 7 for insomnia and that Patient 7's insomnia had been well controlled by the Ambien. Dr. Dahlquist continued that a lack of sleep can set up a vicious cycle which causes increased pain and other medical complications. (Tr. 1776-1777).

Dr. Dahlquist further testified that she had prescribed Xanax for Patient 7 to help with panic attacks. Dr. Dahlquist added that Patient 7 had not been overusing the Xanax or reporting lost or stolen pills. Dr. Dahlquist felt that it had been appropriate to continue treating her with Xanax since it relieved her symptoms. (Tr. 1777-1778).

Dr. Dahlquist testified that Patient 7 had reported improvement in function with the medications. Dr. Dahlquist explained that to control the headaches with medication that did not itself inhibit her mental status had been a significant improvement for Patient 7. (Tr. 1778-1779).

126. Dr. Dahlquist testified that Patient 7 had never reported to Dr. Dahlquist that she had been treated at Greene Memorial Hospital. (Tr. 1794-1795).

127. Dr. Dahlquist testified that in her initial diagnosis of Patient 7 she had believed that Patient 7 had muscle tension headaches, migraine headache, and myofascial pain. Dr. Dahlquist commented that she had not ordered testing for Patient 7 at her initial visit because she had had an MRI scan in January 1996. Dr. Dahlquist testified that the MRI scan had been normal, which is to be expected for patients with migraine headaches. (Tr. 185-187, 1769, 1773-1778).

Dr. Dahlquist testified that she had spoken with a prior treating physician concerning Patient 7 and that the prior treating physician had confirmed Patient 7's story. Dr. Dahlquist conceded, however, that she had not documented this conversation in Patient 7's medical record. Dr. Dahlquist stated that if the prior treating physician had given her a story different than what the patient was reporting, she would have documented it. (Tr. 191, 1778, 2185-2186).

128. Dr. Dahlquist testified that she does not believe that the care she provided to Patient 7 contributed to Patient 7's death. (Tr. 1794).

Dr. Blatman's Testimony Regarding Patient 7

129. Dr. Blatman asserted that Dr. Dahlquist had met the standards of care in treating Patient 7. Dr. Blatman noted several occasions on which Patient 7 reported improvement in pain scores as a result of the medications provided by Dr. Dahlquist. (Tr. 1134-1135; Resp Ex. B at 16; Resp Ex. C at 10).

130. In his September 23, 2002, report concerning Patient 7, Dr. Blatman stated:

Dr. Dahlquist was not aware that this patient had been seen at Greene Memorial Hospital, and cannot be held responsible for not having copies of the studies performed in that facility. Physicians do not have the staff to be detectives at that level, blindly calling area hospitals to see if patients have prior records.

(Resp Ex. C at 10).

131. Dr. Blatman testified that he is not aware of any reason that Dr. Dahlquist should have had a neurologic consultation for Patient 7. Dr. Blatman added that Dr. Dahlquist has shown herself to be a competent physician who can perform a basic neurological examination. He added that Dr. Dahlquist had not recorded any findings that indicated that such a consult would have been helpful. Dr. Blatman continued that "we are in an unfortunate situation these days where we need to consider the patient's pocketbook. And a consult that is * * * not going to be necessary or important, we have to be careful how we spend our patients' money." (Tr. 1133-1134).

132. Dr. Blatman testified that, from the postmortem of Patient 7, it is not reasonable to draw any adverse inference against Dr. Dahlquist that she somehow deviated from standards of care in her treatment of Patient 7. (Tr. 1129-1131; St. Ex. 23).

PATIENT 8

Allegations

133. In its February 13, 2002, Notice of Opportunity for Hearing, the Board alleged that, in her care and treatment of Patient 8, Dr. Dahlquist had prescribed medications in types, amounts and/or combinations that were inappropriate and/or for protracted periods of time that were not justified.

The Board further alleged that Dr. Dahlquist had failed to identify a reasonable pain diagnosis or differential pain diagnosis, and/or to clarify or confirm the diagnosis, and/or to identify the organic cause, mechanism, or source of Patient 8's pain. (St. Ex. 17A).

Medical Records for Patient 8

134. Patient 8, a thirty-two year old male, first presented to Dr. Dahlquist on May 9, 1998. Patient 8 complained of low back pain radiating into the right leg in a posterolateral distribution. Patient 8 also complained of right knee pain as a result of his right knee having been “shattered” in an automobile accident in 1989. Dr. Dahlquist noted that Patient 8 had metal rods in his knee as a consequence of that injury. Patient 8 reported that he had been instructed to wear a brace, but that the brace no longer fit him. (St. Ex. 8 at 6-10, 39-42).

Patient 8 also reported a history of alcohol abuse eight to ten years earlier. He stated that, at the time of the initial visit, he rarely drank alcohol. Moreover, he denied ever having abused drugs. (St. Ex. 8 at 40).

Patient 8 report that he had not been taking any medication for pain at that time, but that drugs which had worked in the past were Vicodin, Percocet, Soma, and Xanax. He added that drugs which had been ineffective included Tylenol #3, Tylenol #4, Flexeril, Relafen, Motrin, Norflex, Robaxin, Skelaxin, DayPro, Neurontin, Arthrotec, and Ultram. (St. Ex. 8 at 11, 40).

Dr. Dahlquist diagnosed bilateral lumbar facet joint arthritis, right lumbar radiculopathy possibly secondary to bulging lumbar disc or nerve root compression from facet disease, and bilateral sacroiliac joint inflammation. Dr. Dahlquist prescribed Vicodin ES, one every six hours as needed; Soma, one every six hours as needed; and Neurontin. Patient 8 signed a Prescription Medication Contract. (St. Ex. 8 at 26, 31-33, 42).

Dr. Dahlquist referred Patient 8 to Dr. Daugherty, a Dayton psychologist, for an evaluation due to depression and anxiety associated with his pain syndrome, and because she had initiated opioid therapy. There is no further discussion of the referral in Dr. Dahlquist’s records. (St. Ex. 8 at I: 21).

Dr. Dahlquist also referred Patient 8 for physical therapy. On May 22, 1998, the physical therapists advised Dr. Dahlquist that they had attempted to contact Patient 8 on seven occasions. They further advised that, if Dr. Dahlquist desired to schedule Patient 8 for physical therapy in the future, a new prescription would be required. There are no new prescriptions in the record. (St. Ex. 8 at 22, 23).

On June 19, 1998, Patient 8 called the office for early refills on his prescriptions. He stated that he was going out of town. Dr. Dahlquist complied. (St. Ex. 8 at 26, 34).

Patient 8 did not return to Dr. Dahlquist’s office until November 1998. Despite not seeing him for six months, Dr. Dahlquist had continued to refill his prescriptions for Vicodin ES and Soma. (St. Ex. 8 at 26, 46).

Patient 8 returned to Dr. Dahlquist's office on November 6, 1998. At that time, Patient 8 reported that Neurontin had caused side effects which he had been unable to tolerate. Dr. Dahlquist added Flexeril and decreased the amount of Soma. Dr. Dahlquist continued to prescribe Vicodin ES. Dr. Dahlquist did not address the reason for Patient 8's failure to report to physical therapy as recommended. (St. Ex. 8 at 26, 31-33, 46).

Patient 8 cancelled his appointment in February 1999 due to illness. (St. Ex. 8 at 52).

On March 15, 1999, Patient 8 called the office and stated that, since Dr. Dahlquist had decreased his Soma to four per day, he had had to increase his other medications. Moreover, although Dr. Dahlquist had prescribed Flexeril, Patient 8 had not filled the prescription because it was too expensive. Patient 8 stated that the pharmacist had suggested Valium instead of Flexeril because it was less expensive. Dr. Dahlquist advised Patient 8 that he would have to be seen before she could alter his medications. Patient 8 presented later that day and Dr. Dahlquist prescribed Valium. (St. Ex. 8 at 35, 52).

At his next appointment, in June 1999, Patient 8 reported that his medications had been effective in controlling his pain, but stated that he had been having difficulty sleeping. Patient 8 requested medication for sleep, but stated that his insomnia was not severe enough to require psychological counseling. Dr. Dahlquist noted Patient 8 had "never used his medications to drown his emotional pain and he does not intend to do that. He has always taken them in compliance with the way they are written and has never shown any signs of the medications before." Dr. Dahlquist added Halcion to his medication regimen. (St. Ex. 8 at 27, 55).

At his next visit, in September 1999, Patient 8 reported that he was doing well. He did not request any additional medications. (St. Ex. 8 at 61).

On December 22, 1999, Patient 8 called the office requesting a refill on his medications. Dr. Dahlquist informed him that, because he had not been seen in three months, he would need to be seen as soon as possible. Dr. Dahlquist scheduled an appointment one month later but refilled his prescriptions to avoid withdrawal. (St. Ex. 8 at 36).

On January 21, 2000, Patient 8 reported for an office visit. Dr. Dahlquist noted that he was stable on his medications. (St. Ex. 8 at 67). Nevertheless, at his next visit, in April 2000, Patient 8 reported that his medications had been less effective, and he thought he was developing tolerance. Dr. Dahlquist increased his Vicodin to five tablets per day. (St. Ex. 8 at 72).

Dr. Shin's Testimony Regarding Patient 8

135. Dr. Shin opined that Dr. Dahlquist had failed to conform to the minimal standards of care in her treatment of Patient 8. Dr. Shin stated that Dr. Dahlquist had not had a reasonable pain diagnosis or a differential pain diagnosis for Patient 8. Dr. Shin added that, in order to make

an assessment, a physician should rely on objective studies rather than the patient's oral history. Dr. Shin testified that this was particularly true in regard to Dr. Dahlquist's diagnoses for Patient 8, facet joint arthritis, and the right lumbar radiculopathy secondary to bulging lumbar disc on nerve root compression from facet disease. Dr. Shin added x-rays or an MRI would have been helpful in making that diagnosis. (Tr. 475-477).

Dr. Shin testified that Patient 8 had reported to Dr. Dahlquist that he had undergone multiple x-rays at St. Elizabeth's Hospital, but he did not bring the results of those tests with him. Dr. Shin added that Dr. Dahlquist should have obtained these records, but did not. (Tr. 476-477, 1333-1334).

136. Dr. Shin opined that Dr. Dahlquist had failed to maintain minimal standards applicable in the selection or administration of drugs or failed to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease in rendering treatment to Patient 8. Dr. Shin explained that, "without having specific diagnosis and without having objective studies to identify the diagnosis, the protracted course of use of opioids was unwarranted." (Tr. 476, 478; St. Ex. 8).
137. Dr. Shin testified that in the medical records for Patient 8 there appears to be a psychological consultation referral from Dr. Dahlquist to Dr. Daugherty. Dr. Shin asserted that there is no documentation in Dr. Dahlquist's records for Patient 8 of any feedback from Dr. Daugherty. (Tr. 477-478).

Dr. Dahlquist's Testimony Concerning Patient 8

138. Dr. Dahlquist testified that she believes that she had conformed to applicable standards of pain management in her care and treatment of Patient 8. (Tr. 1803, 1808).
139. Dr. Dahlquist testified that Patient 8's complaints had been consistent with her physical findings. Dr. Dahlquist acknowledged, however, that she had not ordered any tests for Patient 8 at his initial office visit. (Tr. 192-194, 473-475, 838-842, 1135-1138, 1797-1798, 1800, 1808-1809, 2188).

Nevertheless, Dr. Dahlquist testified that she believes that her evaluation and diagnosis of Patient 8 had been "adequate." She stated that, "We see patients develop spinal arthritis and facet joint problems frequently when they have lower extremity pain because the patient will oftentimes limp on -- on the leg that hurts. And this unbalanced walking can actually lead to low-back problems and unequal wear and tear of the spine." Dr. Dahlquist continued, "Which that's how the spine tends to heal itself, is by building up calcium deposits. Just like the skin is scratched, we form a scar. Well, if -- if the spine has unequal pressure on it, it will build up calcium deposits and form arthritis." Dr. Dahlquist added, "So the treatment would not have been any different whether he just had inflammation or calcium buildup; I still would have treated him the same. So it doesn't seem like it would be cost effective to get a test just to show that he had arthritis." (Tr. 1804-1805).

140. Dr. Dahlquist asserted that the medications she had prescribed for Patient 8 had caused a reduction of his pain. Dr. Dahlquist testified that Patient 8 had stated that he would not have been able to continue working twelve to fourteen hours per day if he had not been able to take the medications Dr. Dahlquist prescribed. Dr. Dahlquist added that Patient 8 had indicated that he had been functioning better with the medications than he had without the medications. (Tr. 1805-1808).
141. Dr. Dahlquist testified that she had referred Patient 8 to Dr. Daugherty, a Dayton psychologist. Dr. Dahlquist further testified that Patient 8 had not kept his appointment with Dr. Daugherty. Dr. Dahlquist testified that the fact that Patient 8 had not seen Dr. Daugherty had caused her some concern and was one of the reasons she had discharged Patient 8 from her practice. (Tr. 194-198, 477-478, 1140-1141, 1803-1809, 2187-2188).

Dr. Blatman's Testimony Regarding Patient 8

142. Dr. Blatman testified that Dr. Dahlquist's treatment of Patient 8 had not fallen below the standards of care and that the medications she prescribed had been appropriate. Dr. Blatman further testified that he had reached these conclusions because Patient 8 had had a history of trauma and pain. Dr. Blatman added that the physical examination of Patient 8 supported the diagnosis of myofascial pain and that Patient 8's self-report of his pain pattern was consistent with the physical examination findings. Dr. Blatman continued that the level of medication prescribed for this patient is relatively low. He commented that it is "certainly within the realm of reason to prescribe this level of medicine with this history and this physical exam." (Tr. 1139-1140; St. Ex. 8 at I: 26-28).
143. Dr. Blatman testified that Patient 8 had not needed further workup or diagnostic testing to support Dr. Dahlquist's diagnosis. Dr. Blatman testified that x-rays would have been of no value in either confirming or denying a diagnosis of myofascial pain or lumbar radiculopathy. (Tr. 1137-1141; St. Ex. 8; Resp. Ex. C at 11).

PATIENT 9

Allegations

144. In its February 13, 2002, Notice of Opportunity for Hearing, the Board alleged that, in her care and treatment of Patient 9, Dr. Dahlquist had prescribed medications in types, amounts and/or combinations that were inappropriate and/or for protracted periods of time that were not justified.

The Board further alleged that Dr. Dahlquist had failed to obtain records of prior or concurrent medical treatment, including studies performed, and/or she had failed to refer the patient for additional, necessary consultations, evaluations, studies, or treatment. As examples, the Board alleged that, although Patient 9 had reported being hospitalized for

three weeks and on life support for four days due to a severe sickle cell crisis, Dr. Dahlquist had failed to obtain any medical records regarding this hospitalization.

Medical Records for Patient 9

145. Patient 9, a forty-seven year old male, first presented to Dr. Dahlquist on August 4, 1997. Patient 9 had been referred by Gary Nicholson, M.D., a hematologist and oncologist in the Dayton area. Patient 9 had a history of sickle cell disease and complained of chronic thoracic pain. Patient 9 reported that he was permanently disabled due to sickle cell disease and that he had received physical therapy “off and on for 20 years.” He had tried numerous medications for his pain. He claimed that, among other things, OxyContin and M.S. Contin had not relieved his pain. (St. Ex. 9 at 5-6, 43-44).

In an intake form completed by the patient, Patient 9 reported that he had been taking Vicodin, eight to ten daily, and Percocet, two to four, “not every day.” In Dr. Dahlquist’s progress note, however, she stated that he had been taking Vicodin, four to eight daily, and Percocet, two to three every other day. Patient 9 signed a Prescription Medication Contract. (St. Ex. 9 at 8, 29-34, 43-44).

In her progress note, Dr. Dahlquist wrote,

Of note, according to Dr. Nicholson’s notes, this patient has on previous occasions lied to Dr. Nicholson regarding visits to the E.R. and prescriptions that had been given to him in the E.R., presumably in an attempt to obtain more medications. When questioned whether he was selling medications on the street, the patient denied this, according to Dr. Nicholson. Apparently, Dr. Nicholson has become frustrated with what has gone on in the past, and he would like to have someone else manage this patient’s pain medication.

(St. Ex. 9 at 43). (See Dr. Nicholson’s notes, St. Ex. 9 at 98-104).

Dr. Dahlquist diagnosed, “Persistent thoracic spine pain most likely due to thoracic facet joint arthritis and degenerative disc disease.” She further noted that, because his pain was “fairly constant,” a long acting narcotic agent would be more appropriate than Vicodin. Dr. Dahlquist prescribed methadone, “starting at 5 mg. po. q. 12 hours increasing up to 20 mg. po. q. 12 hours if necessary.” She also prescribed Vicodin for “flare-ups.” Dr. Dahlquist added that, if Patient 9 still needed large amounts of Vicodin, she could consider adjunctive medications such as anti-inflammatory, anti-depressant, or anti-seizure medications. (St. Ex. 9 at 44-45). In addition, Dr. Dahlquist noted that,

Although normally, we would start with adjunctive medication and work up to narcotic medication, I have found in sickle cell disease, patients quite frequently need to have narcotic medication added to their regimen anyway. Since he is used to taking this, and since he does not seem to be open to starting with

adjunctive medication, I feel that a compromise can be met by starting him at a very low dose of a long acting narcotic and then adding adjunctive medications before increasing the narcotic to a higher level.

(St. Ex. 9 at 44-45).

Furthermore, Dr. Dahlquist ordered PA, lateral, and oblique x-rays of the thoracic spine to rule out degenerative disc disease and facet arthritis. The x-rays revealed no acute abnormalities and findings consistent with sickle cell anemia. Dr. Dahlquist also ordered an MRI of the thoracic spine to rule out disc herniation, facet arthritis, and nerve root compression. The MRI was normal. (St. Ex. 9 at 18-20, 45).

On August 18, 1997, Patient 9 reported that methadone and Vicodin were not effective in controlling his pain, and he requested Percocet. He further reported that he had gone to the emergency room the evening before. Dr. Dahlquist doubled the dose of methadone and allowed him to supplement with either Vicodin or Percocet, although “not both at the same time.” She also prescribed Demerol in injectable syringes and DayPro. (St. Ex. 9 at 49, 51).

On August 25, 1997, Patient 9 called Dr. Dahlquist’s office stating that methadone was not covered by his insurance. He stated that the pharmacist had suggested Talwin NX. Dr. Dahlquist prescribed Talwin NX, one to two every six hours. (St. Ex. 9 at 27).

On September 15, 1997, Patient 9 reported having had good relief of his pain, although he requested to take methadone instead of Talwin. Dr. Dahlquist complied. (St. Ex. 9 at 54).

On September 30, 1997, Patient 9 called Dr. Dahlquist’s office stating that he had just left the hospital “for pain” and was out of pain medications. He stated that the hospital was not giving him any pain medications. He requested Percocet and injectable Demerol. Dr. Dahlquist complied with his request. (St. Ex. 9 at 28).

On October 10, 1997, Patient 9 called Dr. Dahlquist’s office stating that he was going out of town and requested early refills. Dr. Dahlquist prescribed enough medications to last until his next appointment. (St. Ex. 9 at 35).

On October 16, 1997, Patient 9 called Dr. Dahlquist’s office requesting early refills on his methadone, Demerol, Vicodin, and Percocet. He complained of being jittery and nervous. Dr. Dahlquist scheduled an office visit for October 24, 1997, and refilled the methadone to last until then. (St. Ex. 9 at 36).

On October 23, 1997, another physician notified Dr. Dahlquist’s office that Patient 9 had called to request Phenergan. A staff member in Dr. Dahlquist’s office advised the other physician’s office that Dr. Dahlquist was responsible for Patient 9’s medications. The other physician agreed to refrain from prescribing for Patient 9. (St. Ex. 9 at 37).

Patient 9 missed an appointment on October 24, 1997. He did not call the office to cancel. (St. Ex. 9 at 39).

On December 8, 1997, Patient 9 reported that he had lost his methadone prescription. Patient 9 reported the loss to the police and provided Dr. Dahlquist with a copy of the report. Dr. Dahlquist refilled his prescriptions. Dr. Dahlquist also noted that Patient 9 had refused to take anti-inflammatory medications since he had tried two and they had not helped. Dr. Dahlquist agreed to discontinue DayPro, reasoning that the risk of bleeding is greater in a patient who is anemic with sickle cell disease. (St. Ex. 9 at 67).

On December 22, 1997, Patient 9 reported that he had been taking methadone, 40 mg twice daily, supplementing with Vicodin, up to four tablets daily for breakthrough pain. For more severe pain, he supplemented with Percocet instead of Vicodin. Finally, during a sickle cell crisis, Patient 9 used injectable Demerol. Dr. Dahlquist added Elavil at bedtime, in an attempt to improve his sleep, decrease his pain, and eventually decrease the amount of narcotic medication he was taking. (St. Ex. 9 at 70).

On January 15, 1998, Patient 9 called Dr. Dahlquist's office stating that he had been taking Percocet for pain, but that he wanted Demerol. Dr. Dahlquist prescribed Demerol 100 mg, to be injected every six hours as needed for pain. She also advised Patient 9 to increase his methadone to three tablets every morning and two every evening. She noted that she would start prescribing his opioids in amounts to last two weeks. (St. Ex. 9 at 23, 40).

On February 13, 1997, the Medication Sheet indicates that Patient 9 would be out of the state for two to three weeks. During the time that Patient 9 was out of the state, Dr. Dahlquist refilled his prescriptions for Demerol syringes, methadone, Vicodin, and Phenergan. Moreover, Dr. Dahlquist released the medications to another person during Patient 9's absence. (St. Ex. 9 at 24).

On April 22, 1998, Patient 9 reported that he had been in Tennessee and suffered a severe sickle cell crisis. He stated that he had been taken to a hospital intensive care unit in a coma, and had required life support for four days. He further stated that he had been hospitalized for three weeks. Patient 9 complained that his pain had worsened; Dr. Dahlquist increased his methadone to three times per day. (St. Ex. 9 at 82).

During the time of Patient 9's three week hospitalization in Tennessee, Dr. Dahlquist had continued to prescribe methadone, Demerol syringes, Vicodin and Phenergan. (St. Ex. 9 at 24).

In late April 1998, Patient 9 was hospitalized at Kettering Memorial Hospital with a sickle cell crisis. (St. Ex. 9 at 87, 90).

On May 6, 1998, Dr. Dahlquist noted that Patient 9's pain had been much worse since his hospitalization and that he had been requiring Demerol and Phenergan injections "fairly

frequently.” In addition, Dr. Dahlquist referred Patient 9 to Dr. Brown for “new neurological symptoms which sound like rather atypical transient ischemic attacks.” Dr. Dahlquist described the attacks as episodes that the patient likened to seizures, although he did not lose consciousness. He stated that he had felt that he could not talk, could not move, and had difficulty seeing. Each episode lasted a few minutes, and Dr. Dahlquist was concerned that “he may have some clogging going on of sickled red blood cells in his cerebral vasculature.” (St. Ex. 9 at 16, 90).

146. Patient 9 expired on June 30, 1998. The Certificate of Death notes cocaine intoxication as the immediate cause of his death. (St. Ex. 20 at 2)

Dr. Shin’s Testimony Regarding Patient 9

147. Dr. Shin testified that Dr. Dahlquist had failed to provide minimal standards in providing treatment for Patient 9, in part, for her failure to obtain objective studies to support her findings and for her inappropriate prescribing of medications. (Tr. 480-482; St. Ex. 25 at 11)

148. In his December 6, 2001, report concerning Patient 9, Dr. Shin stated:

Although the medical diagnosis is established, the attempt to treat intractable pain purely with increasing the dose or mixing of opioids is inappropriate. The injectable Demerol should have been used for acute situations. These injections should have been carefully monitored as quick and immediate euphoric effects have stronger impact on developing psychological dependence. In severe painful crisis, the patient should have been admitted to the hospital and treated accordingly. It is obvious that the patient had a polysubstance abuse problem. Dr. Dahlquist failed to use reasonable discrimination in administration of medications. Dr. Dahlquist should have obtained pertinent outside records and laboratory results, and should have provided inpatient hospital care for increasingly uncontrolled pain. The care provided was below the minimal standards.

(St. Ex. 25 at 11)

149. Dr. Shin noted that Dr. Dahlquist had continued to prescribe narcotics and other medications to Patient 9 despite the fact that he had been in an intensive care unit in Tennessee. Dr. Shin testified that it would be unusual for a patient hospitalized in an intensive care unit to continue taking prescription medications prescribed by an outside physician located in a different state. Dr. Shin testified that, while the patient was in the hospital, the hospital would have been responsible for providing pain care for that patient. (Tr. 482-485)

Dr. Shin further stated that Patient 9 had been on a respirator while hospitalized. Dr. Shin explained that a patient on a respirator cannot take oral medications. (Tr. 482-485)

150. Dr. Shin testified that Dr. Dahlquist should have obtained Patient 9's Tennessee hospital records. He explained that there needs to be some continuity of care, to determine if there were any changes in medications, new findings, or new development that would dictate a change in treatment. Dr. Shin added that the records were important to confirm the patient was telling the truth. (Tr. 482-484)
151. Dr. Shin noted that Dr. Dahlquist had increased Patient 9's pain medication on April 22, 1998, despite the fact that the physical examination on that date merely states "[b]asically unchanged with tenderness to palpation in the thoracic paraspinous muscles." (Tr. 482; St. Ex. 9 at I: 82)

Dr. Dahlquist's Testimony Regarding Patient 9

152. Dr. Dahlquist testified that she had met the standards of care in her treatment of Patient 9. (Tr. 1821)
153. Dr. Dahlquist testified that Patient 9 had not demonstrated to her any aberrant behavior as far as his medications were concerned. Dr. Dahlquist further testified that Patient 9 had required these medications because sickle cell disease can be very painful. Dr. Dahlquist explained that sickle cell disease is a disease of the blood, where the red blood cells accumulate in the small arterials and cause extreme joint pain. Dr. Dahlquist added that if it happens on a protracted basis, it can lead to small infarctions of bone. (Tr. 200-201, 842-843, 1141, 1344-1345, 1811-1818). Dr. Dahlquist testified that Patient 9 had had an infarction of the vertebrae and the spine. She added that, "He had a reason to have pain [twenty-four] hours a day. It seemed to make sense that he needed adequate pain treatment." (Tr. 204-205)
154. Dr. Dahlquist testified that she had not made referrals for consultations because Dr. Nicholson had given her his diagnosis and Patient 9 had had x-ray studies consistent with that diagnosis. She added that there had not been any change in Patient 9's pain and Patient 9 had continued to follow with Dr. Nicholson for his sickle cell disease. Dr. Dahlquist concluded that she had not seen a need to send Patient 9 for any other consultations. (Tr. 205-206)
155. Regarding Dr. Nicholson's report that Patient 9 had not been honest with him about visits to the emergency room, Dr. Dahlquist testified that she had considered the possibility that Patient 9's trips to the emergency room had been caused by Dr. Nicholson's not prescribing adequate medications to treat Patient 9's pain. Dr. Dahlquist further testified, if so, Patient 9 had "an incentive to obtain the medication and not be honest with Dr. Nicholson." Dr. Dahlquist testified that this is a frequent occurrence, and is defined as "pseudoaddiction" in the administrative rules. (Tr. 202-203)

Dr. Dahlquist testified that, “The way to determine then whether the patient is abusing the medications or not is to give the patient an adequate dose of medication which will control the pain. If the aberrant behaviors then cease or seem to cease, then, more than likely, it was pseudoaddiction.” Dr. Dahlquist added that if there is true addiction, the patient’s functioning will decrease. Moreover, family, friends, and pharmacists call to report signs of abuse. Dr. Dahlquist noted that that had not happened in this case. (Tr. 203-204, 479-480, 1809-1811)

156. Dr. Dahlquist testified that she did not believe that the Tennessee medical records for Patient 9 would have contained information beneficial to her. She explained that, by the time she saw the patient, the crisis was over, and Patient 9 had already returned to his baseline level of functioning and pain. She added that he had not appeared to have suffered any major medical episode that had not already been reversed. Therefore, she had seen no reason to obtain the records. (Tr. 206-213, 1816-1817, 2191-2192)
157. Dr. Dahlquist testified that there are situations in which it is appropriate for patients to take medications from home while they are hospitalized. She stated, for example, that the primary care physician may not feel comfortable prescribing the medications that Dr. Dahlquist prescribes. In such cases, the primary care physician will allow medications from home, which will be monitored by a nurse. (Tr. 2236-2239)

Dr. Blatman’s Testimony Regarding Patient 9

158. Dr. Blatman testified that Dr. Dahlquist had not deviated from the standards of care when she treated Patient 9 with increasing doses of opioids. Dr. Blatman explained that it is appropriate to treat sickle cell patients with opioid medications. Dr. Blatman further explained that it is appropriate as a patient develops tolerance to increase the dosage of the opioid. (Tr. 1142-1143; Resp. Ex. C at 12)
159. Dr. Blatman testified that it had not been below the standard of care to treat Patient 9 as an outpatient as opposed to admitting him to the hospital. Dr. Blatman added that generally it is preferable to keep patients out of the hospital. He commented that compromised patients tend to get sick in the hospital; therefore, it can be reasonably argued that the hospital was not best place for Patient 9 if the only problem he had was pain. (Tr. 1143-1144)
160. Dr. Blatman asserted it did not appear from the medication sheets that Patient 9 had had a polysubstance abuse problem. Dr. Blatman commented that patients with a polysubstance abuse problems do not take their medications as prescribed and may use street drugs in addition to their prescribed medications. He asserted that it did not appear that Patient 9 ever misused his prescribed medications. (Tr. 1144-1145; Resp. Ex. C at 12)
161. Dr. Blatman testified that there is no evidence that Dr. Dahlquist was aware, prior to the death of Patient 9, that he had been ingesting cocaine. Dr. Blatman further testified that he

can not infer anything about Dr. Dahlquist's treatment of Patient 9 based on Patient 9's death from cocaine ingestion. (Tr. 851-852, 1146-1147; Resp. Ex. C at 12)

PATIENT 10

Allegations

162. In its February 13, 2002, Notice of Opportunity for Hearing, the Board alleged that, in her care and treatment of Patient 10, Dr. Dahlquist had prescribed medications in types, amounts and/or combinations that were inappropriate and/or for protracted periods of time that were not justified. As examples, the Board alleged the following:

- Dr. Dahlquist had prescribed various opioids to Patient 10, on a protracted basis and frequently in high or escalating doses, although Patient 10's diagnosis and/or condition had not justified such prescribing; and
- Dr. Dahlquist had prescribed to Patient 10 a combination of medications including opioids, anti-depressants, anxiolytics and benzodiazepines, without attempting to identify the reason for Patient 10's declining function and increased sedation, and despite the risk of respiratory depression.

The Board further alleged that Dr. Dahlquist had inappropriately administered injections or blocks. As examples, the Board alleged that Dr. Dahlquist had administered multiple trigger point injections using a corticosteroid to Patient 10 on approximately fifty-six occasions over a period of almost five years although Patient 10 had not responded significantly to the injections and although frequently injecting corticosteroids into the same area can cause skin irritation, muscle wasting and sloughing, and can increase pain.

The Board further alleged that Dr. Dahlquist had failed to identify a reasonable pain diagnosis or differential pain diagnosis, to clarify or confirm the diagnosis, and/or to identify the organic cause, mechanism, or source of the patient's pain. (St. Ex. 17A).

Medical Records for Patient 10

163. Patient 10, a forty-four year old female, first presented to Dr. Dahlquist on March 13, 1995. She was 5'4" tall and weighed 240 pounds. Patient 10 had been referred by Dr. Moncrief with complaints of neck and left-sided head pain. She also reported having had this pain for several years, following a series of motor vehicle accidents. Patient 10 stated that Vicodin and Valium provided effective relief from her pain. She further stated that the medications she was taking at that time were Vicodin, Valium, Ambien, Klonopin, Slow-K, and Lasix. (St. Ex. 10 at IV: 4, 6).

Patient 10 reported having a history of depression, which included having had fifteen electroconvulsive therapy treatments three to four months earlier. She stated that she had been seeing Dr. Welty on a frequent basis. (St. Ex. 10 at IV: 6, 8-9).

Dr. Dahlquist diagnosed myofascial syndrome and left greater occipital neuritis. Dr. Dahlquist administered myofascial trigger point injections and a left greater occipital nerve block with local anesthetic and steroids. In addition, Dr. Dahlquist prescribed Vicodin. (St. Ex. 10 at I: 19; St. Ex. 10 at IV: 7, 72a).

On April 10, 1995, Dr. Dahlquist noted that Patient 10 had had four days of relief following the injections in March. Dr. Dahlquist further noted that Patient 10 had been involved in two additional motor vehicle accidents since March and that her pain was “excruciating.” Moreover, Dr. Dahlquist noted that Patient 10 had recently switched to butalbital from Vicodin. Dr. Dahlquist repeated the myofascial trigger point injections and a left greater occipital nerve block with local anesthetic and steroids. (St. Ex. 10 at I: 10-11).

An MRI performed on May 12, 1995, revealed the following:

- At C5-6 a small focal soft disk protrusion is noted centrally and to the left. There is some uncovertebral joint disease present bilaterally. There is only mild central canal compromise and cord effacement mainly left sided and the neuroforamina are patent. The findings here appear slightly more prominent than on the previous exam.
- A tiny focal soft disk protrusion is seen left paracentral at C6-7 producing no neural compression. The neuroforamina are patent.
- Minimal spur across the posterior disk margin at C4-5.

(St. Ex. 10 at I: 5).

In June 1995, Patient 10’s medications were Vicodin, butalbital, Parnate, and Xanax. (St. Ex. 10 at I: 44).

On September 15, 1995, Patient 10 reported that her pain medications had not been working and/or caused side effects. Patient 10 suggested trying Percocet. Patient 10 also stated that she had been getting more depressed, and had started seeing Dr. Welty again. On September 18, 1995, Patient 10 called Dr. Dahlquist’s office to advise that Dr. Welty had given her “a few” Percocet and that the Percocet had completely relieved her headache. (St. Ex. 10 at IV: 72a; St. Ex. 10 at I: 78).

On October 21, 1995, Dr. Dahlquist administered an injection of Demerol with Phenergan. On November 11, 1995, Patient 10 reported to the emergency room with complaints of headaches. She received an injection of Nubain and Phenergan. (St. Ex. 10 at VI: 81-87).

On November 30, 1995, Patient 10 reported that she had had an MRI. The MRI revealed “mild degenerative discogenic changes.” (St. Ex. 10 at I: 7). The following day, Patient 10 reported to the emergency room with complaints of headaches. She received an injection of Nubain and Phenergan. (St. Ex. 10 at VI: 76-78).

On January 28, 1996, Patient 10 reported to the emergency room with complaints of migraine headache. She received injections of Toradol, Norflex, Nubain, and Phenergan. In February 1996, Dr. Dahlquist referred Patient 10 for physical therapy. (St. Ex. 10 at IV: 16a, 1, 70-75).

On February 22, 1996, Patient 10 reported to the emergency room with complaints of vomiting and migraine headaches. She received two injections of Nubain and Vistaril. On April 21, 1996, Patient 10 reported to the emergency room with complaints of migraine headache. She received an injection of Nubain and Vistaril and an injection of Toradol and Phenergan. On May 2, 1996, Dr. Dahlquist prescribed Tylenol #2 for pain, noting that Tylenol #3 was too strong. (St. Ex. 10 at IV: 25, 59-69).

On June 10, 1996, Patient 10 reported to the emergency room with complaints of abdominal pain. The emergency room physician noted the following:

We scheduled the patient for an abdominal x-ray, as well as an ultrasound, and the patient refused, stating that she would prefer to follow up with her doctor tomorrow. * * * [T]he patient had requested pain medication multiple times. She was given a shot of Toradol and Compazine. Upon repeat examination the patient was noted to be resting quietly and appeared to be having no discomfort, although when aroused she did complain severely of discomfort and requested more pain medication.

(St. Ex. 10 at VI: 55). Patient 10 left the emergency room after signing out against medical advice. (St. Ex. 10 at IV: 56).

On July 3, 1996, Dr. Dahlquist noted that Patient 10 had seen an orthodontist who recommended that she wear a retainer for several months. The orthodontist stated that, if the retainer did not relieve her jaw pain, he would considerer TMJ surgery. (St. Ex. 10 at II: 64).

On July 13, 1997, Patient 10 reported to the emergency room with complaints of headache. She received injections of Nubain, Phenergan, and Toradol. (St. Ex. 10 at VI: 41-54). On July 25, 1996, Patient 10 presented to the emergency room for complaints of pain, headache, and suicidal ideation which was frightening her. Patient 10 was admitted to the hospital. Dr. Dahlquist did not comment on Patient 10’s emergency room visit or hospitalization in her progress notes. (St. Ex. 10 at III: 5-6; St. Ex. 10 at IV: 73, 80).

On August 2, 1996, Dr. Dahlquist prescribed Duragesic patches 100 mcg, one patch to the chest wall every third day. (St. Ex. 10 at IV: 25, St. Ex. 10 at II: 84).

On October 17, 1996, Dr. Dahlquist noted that Patient 10 had been using Duragesic patches, Depakote, Xanax, Fioricet, Effexor, Baclofen, and Lasix. (St. Ex. 10 at II: 99). On November 5, 1996, Patient 10 reported to the emergency room. She stated that she had seen her family physician for a headache earlier in the day, and her family physician had given her an injection of Nubain and Vistaril. She reported to have had an adverse drug reaction. The emergency room physician administered two injections of Demerol, two injections of Valium and oral medications. (St. Ex. 10 at VI: 35-40).

On December 30, 1996, Patient 10 advised that she had been alternating between 25 and 50 mcg Duragesic patches daily. She was also using Baclofen and an Alpha-Stimulator. Dr. Dahlquist continued to administer myofascial trigger point injections. (St. Ex. 10 at II: 115).

On February 19, 1997, Patient 10 reported to the emergency room with complaints of headache. She received an injection of Toradol and Phenergan. (St. Ex. 10 at VI: 23-33).

On March 20, 1997, Patient 10 called Dr. Dahlquist's office stating that she had tried to wean herself from her medications by changing her Duragesic patch every four days instead of every three days. Patient 10 stated that, after two days, she had experienced shakes, chills, and sweats. Dr. Dahlquist told Patient 10 to continue to change the Duragesic patches every three days. She added that, if that did not help, she would try methadone. Patient 10 was also taking Soma and Fioricet. (St. Ex. 10 at IV: 39; St. Ex. 10 at III: 14, 17).

On March 23, 1997, Patient 10 reported to the emergency room with complaints of headache. She received an injection of Demerol and Phenergan. (St. Ex. 10 at VI: 20-23).

On June 5, 1997, Patient 10 called Dr. Dahlquist's office stating that her pain had increased and that nothing helped. (St. Ex. 10 at IV: 40).

On June 27, 1997, Patient 10 advised that she had spent eight inpatient days at the Miami Valley Hospital Psychiatric Center under the care of Dr. Welty. Dr. Dahlquist did not make any further reference to the hospitalization in her progress notes. (St. Ex. 10 at III: 37, 41).

On July 21, 1997, Patient 10 called Dr. Dahlquist's office complaining of headache and swollen neck. She requested stronger Duragesic patches. Dr. Dahlquist prescribed five 50 mcg patches. (St. Ex. 10 at IV: 41).

On August 11, 1997, Patient 10 called Dr. Dahlquist's office stating that the Duragesic patch was not helping. She requested something stronger. Dr. Dahlquist advised Patient 10 to place two patches on her chest wall for one week, then resume one patch every two to three days. On August 31, 1997, Patient 10 reported to the emergency room

with complaints of headache. She received an injection of Toradol and Phenergan. (St. Ex. 10 at VI: 1, 1, 42).

On September 15, 1997, Patient 10 was evaluated by Joseph S. Casaly, M.D., of the Midwest Center for Head Pain Management. Dr. Casaly recommended that Patient 10 be admitted to his inpatient treatment program “for sequential dosing of intravenous DHE to attempt to break the headache cycle and to lessen withdrawal headaches coming off daily narcotic maintenance therapy and butalbital.” (St. Ex. 10 at IV: 220-222).

On September 29, 1997, Dr. Dahlquist recommended that Patient 10 continue with massage and Reiki therapy. Patient 1 was using the Duragesic patch, butalbital and Soma at that time. (St. Ex. 10 at III: 7, 76).

On October 10, 1997, Patient 10 called Dr. Dahlquist’s office requesting permission to enter the Midwest head and Neck Pain clinic. She stated that she would be hospitalized for five days in an attempt to withdraw from narcotic medications. Dr. Dahlquist advised her that it was a good idea. Dr. Dahlquist noted that Dr. Casaly had discontinued Patient 10’s Duragesic patches, and had prescribed Verelan, MS Contin, and Clonidine instead. (St. Ex. 10 at III: 87; St. Ex. 10 at IV: 43, 44).

On November 14, 1997, Patient 10 reported that she had been taking only Prozac, Zyprexa, Lithium and Lasix. (St. Ex. 10 at III: 95). Nevertheless, on November 26, 1997, Dr. Dahlquist wrote as follows:

Patient underwent [myofascial trigger point injections] on 11/14/97 with 20-40% relief of her pain for one week. Unfortunately, she ran out of her Duragesic patches, and she was given oral medication by her family physician. Unfortunately, the oral medication made her sick to her stomach, and she strained neck muscles while vomiting. She is having an acute exacerbation of her pain and requesting repeat injections.

Dr. Dahlquist renewed prescribing of Duragesic patches. (St. Ex. 10 at III: 101; St. Ex. 10 at III: 26).

On December 4, 1997, Patient 10 called Dr. Dahlquist’s office to request three or four 50 mcg Duragesic patches. Dr. Dahlquist prescribed three. (St. Ex. 10 at IV: 41). On January 28, 1998, Dr. Dahlquist noted that Patient 10 was also receiving treatment at a pain center in Troy, Ohio. (St. Ex. 10 at IV: 79-158).

On March 3, 1998, Patient 10 called Dr. Dahlquist’s office to request three or four 50 mcg Duragesic patches for a migraine headache. Dr. Dahlquist prescribed three. Patient 10 stated that she would pick them up the next day. (St. Ex. 10 at IV: 27, 41).

On March 21, 1998, Patient 10 noted that she had been using Duragesic patches, 25 mcg every two to three days, and Butalbital, two to four per day. Dr. Dahlquist was not prescribing butalbital, and the progress note does not indicate who did. (St. Ex. 10 at IV: 96).

On March 31, 1998, Patient 10 called Dr. Dahlquist's office requesting approval to continue wearing 50 mcg Duragesic patches. Dr. Dahlquist prescribed 50 mcg patches every two to three days. (St. Ex. 10 at IV: 48).

On June 1, 1998, Dr. Dahlquist noted that Patient 10's other caregivers reported that Patient 10 "did better" with myofascial trigger point injections. (St. Ex. 10 at IV: 109).

On June 9, 1998, Patient 10 reported to the emergency room. Patient 10's daughter stated that Patient 10 "seems unable to speak and seem to be in a daze." Patient 10 was discharged after the emergency room physician spoke with Dr. Welty. The diagnosis was depression. (St. Ex. 10 at VI: 99-113).

On June 22, 1998, Patient 10's daughter called Dr. Dahlquist's office. She stated that Patient 10 had been discharged from the hospital and had been having "mini strokes." She stated that Patient 10's other physicians had concerns regarding Patient 10's Duragesic patches. Dr. Dahlquist decreased the dose to 25 mcg every two to three days. (St. Ex. 10 at IV: 27, 49).

On August 20, 1998, Patient 10's daughter called Dr. Dahlquist's office to report that Patient 10 had been tapering off patches, and was having withdrawal symptoms. Patient 10 requested something to replace them. Dr. Dahlquist prescribed Clonidine patches, one patch per week, and methadone. She instructed Patient 10 to change her Duragesic patch every three days. (St. Ex. 10 at IV: 27, 50).

On September 2, 1998, Patient 10 called Dr. Dahlquist's office to advise that Dr. Goldstick, her neurologist, "want[ed] her off Duragesic Patch ASAP." Dr. Dahlquist stopped prescribing Duragesic patches for the time being. On September 11, 1998, Dr. Dahlquist added methadone to Patient 10's medication regimen. (St. Ex. 10 at IV: 27, 51).

On September 21, 1998, Dr. Dahlquist noted that Patient 10 had suffered a cerebral vascular accident. Dr. Dahlquist noted that Dr. Goldstick had requested that Patient 10 refrain from using any opioid medications. Dr. Dahlquist noted that Patient 10 had been off opioid therapy for two weeks, but had been suffering nausea. Dr. Dahlquist attributed the nausea to pain rather than to withdrawal. Dr. Dahlquist further noted that she would try to discuss the issue with Dr. Goldstick to see if he would object to maintaining Patient 10 on low-dose opioid therapy. Dr. Dahlquist prescribed Fioricet. (St. Ex. 10 at IV: 27, 117, 120).

On September 24, 1998, Patient 10 called Dr. Dahlquist's office to state that the methadone was making her ill and Phenergan was not helping. On September 29, 1998, Dr. Dahlquist prescribed methadone. (St. Ex. 10 at IV: 27, 52).

On October 12, 1998, Dr. Dahlquist noted that Patient 10 had started using Percodan that she had had at home and that the Percodan was effective. Dr. Dahlquist prescribed Percodan. (St. Ex. 10 at IV: 27, 125).

On October 26, 1998, Patient 10 called Dr. Dahlquist's office to state that she was going through withdrawal due to not taking Duragesic patches. On October 27, 1998, Patient 10 called Dr. Dahlquist's office asking for MS Contin. The following day, Dr. Dahlquist prescribed MS Contin. (St. Ex. 10 at IV: 2, 52, 53).

On March 4, 1999, Patient 10 called to state that she had been hospitalized after suffering a "stroke." Patient 10 asked for Percodan for headaches. Dr. Dahlquist prescribed Percodan. (St. Ex. 10 at IV: 56).

On March 29, 1999, Patient 10 presented with complaints of pain in her neck and head, and a new complaint of pain in her low back radiating to her right hip and leg. Dr. Dahlquist prescribed OxyContin, Percodan, and a Medrol Dose Pak. (St. Ex. 10 at IV: 27, 149).

Electrodiagnostic studies in March 1999 revealed "normal findings. There [was] no evidence of a lumbosacral radiculopathy or peripheral polyneuropathy." (St. Ex. 10 at IV: 24).

On April 1, 1999, Dr. Dahlquist prescribed a thirty day supply of OxyContin. On April 8, 1999, Patient 10 requested to go back on Duragesic patches for one month. Dr. Dahlquist prescribed a thirty day supply of Duragesic patches. On April 16, 1999, Patient 10 called to state that her chest had "broken out" from the Duragesic patches. She asked to go back on Percodan. Dr. Dahlquist prescribed a thirty-day supply of Percodan. (St. Ex. 10 at IV: 27, 57).

On April 26, 1999, Dr. Dahlquist added lumbar epidural steroid injections to the myofascial trigger point injections. Dr. Dahlquist also prescribed Dilaudid, although her progress note states that she would prescribe Duragesic patches because Dilaudid had caused a rash. Dr. Dahlquist continued to prescribe Dilaudid through June 1999. (St. Ex. 10 at IV: 27, 158).

On June 23, 1999, Dr. Dahlquist noted that Patient 10 had been taking Celexa and Serzone prescribed by Dr. Welty, and that Patient 10 had been much improved functionally since taking Celexa. Dr. Dahlquist further noted, however, that Patient 10's daughter reported that Patient 10 was occasionally "drowsy" when taking Dilaudid. Dr. Dahlquist opined that the drowsiness was due to the combination of Dilaudid and Celexa. She noted that she had been "hesitant" to ask Dr. Welty to discontinue the Celexa since Patient 10 had been doing so well since taking Celexa. Dr. Dahlquist prescribed 150 Dilaudid and 150 Oxy IR. (St. Ex. 10 at IV: 27, 174).

On June 25, 1999, Patient 10 called Dr. Dahlquist's office and stated that she was suffering side effects from OxyIR. Dr. Dahlquist instructed her to take Dilaudid instead. The Medication Sheet notes that Patient 10 had returned 106 Oxy IR. The record does not address the fact that forty-four pills had been used over a two day period. (St. Ex. 10 at IV: 58).

On July 13, 1999, Patient 10 called Dr. Dahlquist's office and stated that a doctor had told her "to get off the Dilaudid." Dr. Dahlquist wanted to know who the doctor was, but the record does not indicate if Dr. Dahlquist received an answer. (St. Ex. 10 at IV: 59).

On July 21, 1999, Patient 10's daughter reported that she had taken Patient 10's Dilaudid away from her because the medication was making her overly sedated and she had been falling asleep. Instead, Dr. Dahlquist prescribed Duragesic patches, Clonidine patches, and MSIR. She suggested that Patient 10 could also use the Dilaudid at night before bedtime. (St. Ex. 10 at IV: 2, 182).

On August 11, 1999, Dr. Dahlquist prescribed Talwin. On August 27, 1999, Dr. Dahlquist added Zydone. (St. Ex. 10 at IV: 28).

On September 1, 1999, Dr. Dahlquist noted the following:

There have been some difficulties with getting [Patient 10] on an oral medication regimen that gives her good pain relief without causing too much sedation. Apparently, when the patient thought she was not sedated, her family ended up telling her that she was. Her daughter is with her today stating that there have been many medications, particularly when she had been given medications in combination with each other that cause her to be overly sedated and have a much lower level of functioning than the patient realized. Apparently, there was a report from some physician recommending not to give [Patient 10] morphine combinations, but when I spoke with the patient's daughter, she stated that it was not specifically morphine, but it was a combination of medications that caused the problem. The patient seems to think that M.S. Contin gave her reasonably good relief without excessive sedation when she took it by itself. She would like to try this again.

(St. Ex. 10 at IV: 190).

On September 13, 1999, Dr. Dahlquist prescribed a five to seven day supply of MS Contin. Two days later, Dr. Dahlquist prescribed another five to seven day supply of MS Contin. (St. Ex. 10 at IV: 28).

On September 8, 1999, Patient 10 called Dr. Dahlquist's office and stated that she had been taking Xanax and other medications prescribed by another physician. (St. Ex. 10 at IV: 61).

On September 12, 1999, Patient 10 reported to the emergency room with complaints of severe headaches. Patient 10 reported that she had not had a headache of similar intensity in the past. Patient 10 further reported that the only medications she was taking were Tylenol, Excedrin Migraine, Celexa, and Zyprexa. She received injections of Benadryl, Toradol, and Compazine. A C.T. of the head revealed minimal focal cerebral atrophic changes and no acute abnormalities. The emergency room physician offered further evaluation with a lumbar puncture, but Patient 10 declined. (St. Ex. 10 at VI: 114-123).

On September 13, 1999, Dr. Dahlquist prescribed a six to seven day supply of OxyContin. Three days later, Dr. Dahlquist prescribed another six to seven day supply of OxyContin. (St. Ex. 10 at IV: 28).

On September 30, 1999, Patient 10 called Dr. Dahlquist's office and stated that the OxyContin was making her "drowsy and out of it" and was not relieving her headache. She requested to go back on Zydone. Dr. Dahlquist instructed Patient 10 to bring in her unused OxyContin and then use no more than six Zydone per day. (St. Ex. 10 at IV: 58).

On October 1, 1999, Dr. Dahlquist prescribed Zydone. Dr. Dahlquist noted that she had destroyed thirty tablets of OxyContin. She advised that Patient 10 would have no more refills until her next appointment. (St. Ex. 10 at IV: 28).

On October 7, 1999, Dr. Dahlquist noted that Patient 10 had become overly sedated on her medication. Patient 10 had gone to the emergency room, where Narcan was administered and Patient 10 "awakened easily." Dr. Dahlquist prescribed Demerol and Phenergan injections. (St. Ex. 10 at IV: 28, 198).

On October 13, 1999, Patient 10 reported to the emergency room with complaints of headaches. She received injections of Benadryl, Toradol, and Compazine. (St. Ex. 10 at VI: 124-131).

On October 14, 1999, Patient 10 called Dr. Dahlquist's office and stated that she was suffering side effects from Demerol. Patient 10 requested Zydone and Clonidine. Dr. Dahlquist instructed her to bring in her excess Demerol. (St. Ex. 10 at IV: 64).

On December 19, 1999, Patient 10 reported to the emergency room with complaints of headaches. She received injections of Benadryl, Toradol, and Compazine. (St. Ex. 10 at VI: 132-140).

On January 10, 2000, Patient 10 called Dr. Dahlquist's office and stated that she had obtained a prescription for Zydone from another physician because Dr. Dahlquist's office was "too slow." (St. Ex. 10 at IV: 58).

On February 1, 2000, Patient 10 called Dr. Dahlquist's office and stated that she had gone to the emergency room for headaches and had received Demerol. Dr. Dahlquist noted

that Patient 10's pain had been worsening. She further noted that Patient 10 had been seen by her family doctor who reported that Patient 10 had lost twenty pounds over a 2½ week period. Dr. Dahlquist prescribed methadone, noting that, "[Patient 10's] daughter has been with her long enough and knows that it is important to watch [Patient 10] when she takes new medication, because she does have a tendency to become a bit sedated on opioid medications." (St. Ex. 10 at IV: 69).

Patient 10 passed away on February 2, 2000. On February 3, 2000, the Greene County Coroner advised Dr. Dahlquist that the Coroner's office was investigating the death of Patient 10. They requested Dr. Dahlquist's medical records for Patient 10. (St. Ex. 10 at IV: 71).

164. The postmortem report regarding Patient 10 indicates that the cause of death was primarily "alprazolam and methadone intoxication." Secondary causes were noted as pulmonary edema and generalized congestion. A toxicology report included the following: Alprazolam 0.075 mcg/mL, with a therapeutic level of 0.025-0.061 mcg/mL; and methadone, 0.671 mcg/mL, with a therapeutic level of 0.006-0.099; and citalopram, 2.27 mcg/mL; with no therapeutic level noted. (St. Ex. 22).

Dr. Shin's Testimony Regarding Patient 10

165. Dr. Shin testified that, in her treatment of Patient 10, Dr. Dahlquist had failed to meet the minimal standards of care, in part, because she had failed to identify a reasonable pain diagnosis or a differential pain diagnosis. Dr. Shin noted that Dr. Dahlquist had initially diagnosed myofascial pain and greater occipital neuritis. Dr. Shin testified that, based on that diagnosis, Dr. Dahlquist had prescribed various opioids in increasing amounts and had administered injections without objective improvement. Dr. Shin further noted that Patient 10 had experienced declining function and increased sedation during her treatment by Dr. Dahlquist. (Tr. 491-492, 498).

Moreover, Dr. Shin testified that Patient 10 had had a history of depression which may have been a component in her pain. He added that Dr. Dahlquist should have obtained consultation to evaluate it and she should have incorporated the evaluation in her treatment plan. Dr. Shin asserted that, in the case of Patient 10, there had been complaints from the family stating that Patient 10 had been overly sedated and asking Dr. Dahlquist to decrease the amount of medicine she was prescribing. He noted that, at a certain point, opioids will not work and it is necessary to identify why the pain has not gotten better for someone who is increasingly sedated without pain control. Dr. Shin testified that it is important to identify whether psychosocial issues or social behavioral issues have led to the use of pain medication for the wrong reason, which can be very dangerous. (Tr. 492-496, 499-500; St. Ex. 25 at 12).

166. Dr. Shin testified that in addition to opioids, Patient 10 had received multiple trigger point injections from Dr. Dahlquist on every visit and multiple greater occipital nerve blocks, as

well as steroid injections. Dr. Shin further testified that there had been no objective improvement of pain. Dr. Shin explained that there are risks associated with injections. He added that the injections may provide temporary relief, but when the local anesthetic wears off, the pain may be worsened due to damage in sensitive tissue caused by the injection itself. Dr. Shin concluded that frequent injections are not advised unless they provide a lengthy relief. (Tr. 496-498, 859).

Dr. Dahlquist's Testimony Regarding Patient 10

167. Dr. Dahlquist asserted that she had complied with the applicable standards of care in her management of Patient 10, in the prescription of opioids or a combination of opioids, and in the administration of trigger point injections. Dr. Dahlquist testified that almost every non-opioid modality of pain therapy that was available had been tried on Patient 10. Patient 10 had been given migraine medications, anti-inflammatory agents, massage therapy and Reiki. Moreover, Dr. Dahlquist testified that Patient 10 had been adequately controlled on antidepressant medications and had been followed by her psychiatrist. Dr. Dahlquist continued that Patient 10 had been treated by another pain management specialist who had had nothing else to offer and had suggested that Dr. Dahlquist continue giving medications and the trigger point injections. Dr. Dahlquist asserted that the opioid medications and trigger point injections she had provided to Patient 10 had been the only treatments that had given Patient 10 adequate relief, improved quality of life, and improved functioning. (Tr. 1838, 1845).
168. Dr. Dahlquist testified that Patient 10 had not been at risk of respiratory depression as the result of the medications Dr. Dahlquist had prescribed. Dr. Dahlquist testified that the risk of respiratory depression is usually seen in opioid-naive patients receiving opioid medication for the first time or in sudden substantial increases in doses of opioid medication in somebody who is already tolerant to opioid medication. She further noted that respiratory depression will be preceded by sedation. Dr. Dahlquist continued that she had responded appropriately when Patient 10 experienced an episode of sedation. (Tr. 1838-1839).
169. Dr. Dahlquist testified that curing the patient is not the purpose of trigger point injections. Dr. Dahlquist commented that trigger point injections are given to maintain the pain at a more tolerable level, to help the patient be more functional, and to decrease the requirements for oral medications. (Tr. 1824-1825).

Dr. Dahlquist further testified that the amount of Depo-Medrol she had administered in the trigger point injections had not been a problem for Patient 10 because Depo-Medrol lasts in the body for about four to six weeks. Therefore, it is dangerous to administer injections more often than that. Nevertheless, Dr. Dahlquist testified that she had only administered subsequent sets of injections after the previously administered Depo-Medrol had been metabolized and excreted from Patient 10's body. Dr. Dahlquist added that there is nothing

in the literature that states that there is a limit on the number of trigger point injections that can be performed in a muscle. (Tr. 217-220).

Dr. Blatman's Testimony Regarding Patient 10

170. Dr. Blatman testified that Dr. Dahlquist had met the standards of care in her treatment of Patient 10. Moreover, Dr. Blatman opined that Dr. Dahlquist had done "as much as possible to identify a reasonable pain diagnosis." He added that, "Myofascial pain syndrome is a primary diagnosis, it underlies migraine headache and the other pain area problems this patient complained of. This diagnosis was repeatedly confirmed by physical examination findings, and the patient's response to treatment." (Tr. 1148, 1152, 1158; Resp Ex. B at 20; Resp. Ex. C at 13-14).
171. Dr. Blatman testified that his review of the medication records for Patient 10 had led him to conclude that it appears that the prescribed medications and combinations of medications were appropriate for the care and treatment of Patient 10's myofascial pain syndrome and occipital neuritis. Dr. Blatman further testified that a diagnosis of myofascial pain syndrome supports the protracted use of opioids or combination of opioids. He commented that myofascial pain is detected by physical examination. He added, "It's its own cause for pain. It's as organic as we get." (Tr. 1151, 1157-1158; Resp. Ex. B at 19; Resp. Ex. C at 13).
172. Dr. Blatman testified that Dr. Dahlquist had met the standard of care in relation to oversedation or decline of function with Patient 10. Dr. Shin noted that Dr. Dahlquist had reviewed this with the patient, examined the patient, appropriately documented it in the chart, and made adjustments to medication to effect a change in the problem. (Tr. 1151-1154; Resp. Ex. C at 13).
173. Dr. Blatman testified that trigger point injections are the standard of care for myofascial pain disorder. Dr. Blatman commented that the physical modalities that treat it best are trigger point injections, massage therapy and myofascial release. (Tr. 1150; St. Ex. C at 13).

Dr. Blatman testified that Patient 10 had received pain relief from trigger point injections. Dr. Blatman elaborated that Patient 10 had obtained twenty-five to eighty percent of relief of pain following each set of injections. He added that each set of injections had lessened the pain to a more manageable level where oral analgesics could work more effectively. Dr. Blatman concluded that there was no indication in the record that Patient 10 had suffered an adverse result from the trigger point injections. (Tr. 1150-1152; Resp. Ex. B at 20; Resp. Ex. C at 13).

174. In his September 23, 2002, report concerning Patient 10, Dr. Blatman stated:

The autopsy report did not reveal evidence of peripheral edema. Additionally, the patient reported a [twenty] pound weight loss during the three weeks

preceding her death. The opioids can cause fluid retention, and if this is severe, it can lead to pulmonary edema. Weight loss and lack of peripheral edema are not consistent with fluid retention. Additionally, examination of the intestinal tract does not mention pill fragments that might be expected if the patient had overdosed on her medication. The coroner's report assumes that death was caused by methadone and alprazolam intoxication. The facts of the case do not clearly lead to this conclusion.

(Resp Ex. C at 13-14, 1154-1157; St. Ex. 22). Dr. Blatman testified that he disagrees with the "assumptions" made by the coroner. (Tr. 1352-1354; Resp. Ex. C at 13-14).

PATIENT 11

Allegations

175. In its February 13, 2002, Notice of Opportunity for Hearing, the Board alleged that, in her care and treatment of Patient 11, Dr. Dahlquist had prescribed medications in types, amounts and/or combinations that were inappropriate and/or for protracted periods of time that were not justified. As examples, the Board alleged that Dr. Dahlquist had prescribed concurrently multiple types of opioids without medical justification. In addition, Dr. Dahlquist prescribed escalating doses of opioids although Patient 11 had failed to demonstrate objective improvement and despite signs of possible drug abuse.

The Board further alleged that Dr. Dahlquist had failed to adequately recognize and/or address indications of drug abuse or the increased risk of drug abuse.

In addition, the Board alleged that Dr. Dahlquist had failed to obtain records of prior or concurrent medical treatment, including studies performed, and/or she had failed to refer Patient 11 for additional, necessary consultations, evaluations, studies, or treatment.

Finally, the Board alleged that Dr. Dahlquist had continued to use Matrix electroceutical therapy although this treatment modality had provided only temporary pain relief. (St. Ex. 17A).

Medical Records for Patient 11

176. Patient 11, a forty year old female, first presented to Dr. Dahlquist on March 8, 1997. Patient 11 had been referred by Mark Thomas, M.D., an addiction medicine specialist and family practitioner in the Dayton area. Patient 11 had had a history of chronic fibromyalgia and acute exacerbation of myofascial pain. Patient 11 complained of pain in her neck and shoulders, radiating to her low back. Dr. Dahlquist noted that Patient 11 was totally disabled from her employment as a certified chemical dependency counselor. Dr. Dahlquist noted that "because of her background with her work, she has also had a very difficult time

bringing herself to use narcotics when her pain becomes severe.” (St. Ex. 11 at I: 13; Tr. 234-235).

Dr. Dahlquist’s records include a report of an August 21, 1996, MRI of the lumbar spine which had revealed “a small focal central disc protrusion at L5-S1. Disc desiccation is noted of L3-4 and L5-S1.” Moreover, there was a report of a September 19, 1996, MRI of the cervical and dorsal spine that was “essentially negative.” (St. Ex. 11 at I: 9, 10).

At the time of her initial visit, the medications Patient 11 was taking were Flexeril, Ultram, Klonopin, Paxil, Baclofen, DayPro, and magnesium oxide. Patient 11 reported that these medications were as effective as placebos. Patient 11 stated, however, that medications that she had used in the past and which had provided relief included Vicodin, Soma, OxyContin, and trazodone. Moreover, Patient 11 had undergone intermittent psychological counseling over the previous three to four years, and had a history of anxiety disorder with panic attacks. (St. Ex. 11 at I: 13-14; St. Ex. 11 at II: 11).

Dr. Dahlquist prescribed Vicodin, methadone, and Soma. She also recommended that Patient 11 use a TheraCane and have massage therapy once weekly. In addition, Dr. Dahlquist scheduled Patient 11 for Matrix Electroceutical neuron blockage and interferential treatment. (St. Ex. 11 at I: 15).

On April 4, 1997, Dr. Dahlquist wrote to Dr. Thomas regarding her treatment plan for Patient 11. In the letter, Dr. Dahlquist noted that she had prescribed methadone for Patient 11. Nevertheless, Dr. Dahlquist did not advise Dr. Thomas that she was also prescribing Vicodin and Soma. Moreover, on April 16, 1997, Dr. Dahlquist added Percocet, but there is no indication that Dr. Dahlquist advised Dr. Thomas of this. (St. Ex. 11 at II: 16, 20).

On April 17, 1997, Patient 11 noted that Percocet was “working” and she requested another prescription. On April 29, 1997, Patient 11 noted that her daily medications included two methadone, four Soma, four Vicodin, and four to six Percocet. By May 1997, her methadone dosage had increased to four per day, and her Vicodin to four to eight. She had stopped using Percocet. (St. Ex. 11 at II: 20, 52a).

In 1997, Dr. Dahlquist administered Matrix Electroceutical neuron blockage and interferential treatment to Patient 11 on fifteen occasions between March 14 and June 13, 1997. Patient 11 reported varying degrees of pain relief with each treatment. (St. Ex. 11 at I: 19a, 23a, 28a, 36a, 40a, 49a, 52a, 55a, 58a, 61a, 73a, 76a, 79a, 86a). On June 23, 1997, Patient 11’s insurance company refused to pay for additional Matrix Electroceutical neuron blockage and interferential treatment. Dr. Dahlquist noted that she would continue pursuing authorization to continue the Matrix treatments. (St. Ex. 11 at I: 96).

On August 12, 1997, Patient 11 complained of pain in her neck, right arm, and wrists. She stated that her medication regimen of methadone, Vicodin, and Soma was not working.

Dr. Dahlquist noted that she would increase the Vicodin and Soma and administer myofascial trigger point injections. Patient 11 was also using a P.G.S. unit and receiving massage therapy. On August 28, 1998, Dr. Dahlquist added Reiki therapy. (St. Ex. 11 at II: 48, 60).

In September 1997, Dr. Dahlquist instructed Patient 11 to limit her Soma to four per day. (St. Ex. 11 at II: 65). On October 23, 1997, a pharmacist called Dr. Dahlquist's office to advise that Patient 11 had been taking more than her prescribed dosage of medication. (St. Ex. 11 at II: 35).

On December 4, 1997, Dr. Dahlquist noted that she needed "to discuss meds with pt." In the progress note, Dr. Dahlquist wrote as follows:

Since the patient is having such a rough episode right now with increased pain and increased stress, will continue with current oral medication regimen and not change anything. However, will bring her back in a couple weeks when she gets through this episode and discuss the option of adding adjuvant medication since she is on such high doses of methadone and Vicodin E.S., and I would prefer not to increase these doses any. Hopefully, we will be able to decrease the amount of Vicodin ES with addition of adjuvant meds.

(St. Ex. 11 at II: 103). Patient 11 reported taking five methadone, six Vicodin, and four Soma per day. On December 27, 1997, Dr. Dahlquist added Neurontin. (St. Ex. 11 at II: 104, 109).

On February 15, 1998, Patient 11 called Dr. Dahlquist's office to request additional medication for sleep. Dr. Dahlquist offered trazodone or, in the alternative, Elavil. Patient 11 chose Elavil. (St. Ex. 11 at II: 40).

On February 19, 1998, Patient 11 called Dr. Dahlquist's office to request additional pain medication. Dr. Dahlquist increased her medication to Vicodin six per day and Methadone six per day. (St. Ex. 11 at II: 38).

The following day, Patient 11 asked for ten to fifteen extra pain pills, and reported that she had gone to the emergency room twice in the past two weeks for severe pain. Dr. Dahlquist switched the methadone to Oramorph 30 mg. every six hours. She also prescribed Vicodin for breakthrough pain, in addition to Soma and Neurontin. (St. Ex. 11 at II: 115, 119).

On February 23, 1998, Patient 11 called Dr. Dahlquist's office stating that she had been taking four Oramorph per day, but was not receiving the same relief she had had with methadone. She further stated that she had taken five methadone per day, and wondered if she could take five Oramorph. Dr. Dahlquist agreed. (St. Ex. 11 at II: 39).

On March 5, 1998, Patient 11 called Dr. Dahlquist's office to advise that Elavil was not working. She asked to try something else. Dr. Dahlquist increased the dose of Elavil. (St. Ex. 11 at II: 41).

On March 20, 1998, Patient 11 reported that the Oramorph was ineffective, and asked to switch back to methadone. Dr. Dahlquist agreed. (St. Ex. 11 at II: 123).

On March 30, 1998, Patient 11 called Dr. Dahlquist's office and stated that she had gone to the emergency room in severe pain. She stated that she was out of Vicodin ES and asked for something to last until her refill was due. Dr. Dahlquist provided Duract samples. (St. Ex. 11 at II: 42).

On May 1, 1998, Patient 11 requested stronger pain medication. Dr. Dahlquist instructed her to alternate Percocet with Vicodin. Dr. Dahlquist also suggested that she increase her Neurontin. On May 11, 1998, Patient 11 called Dr. Dahlquist's office to request stronger medication. Dr. Dahlquist offered to exchange Percocet for Vicodin. (St. Ex. 11 at II: 43, 129).

In October 29, 1998, Dr. Dahlquist decreased Patient 11's Soma to two per day, but added Valium. (St. Ex. 11 at II: 150).

177. Dr. Dahlquist testified that she is still treating Patient 11. (Tr. 1869).

Dr. Shin's Testimony Regarding Patient 11

178. In his December 6, 2001 report concerning Patient 11, Dr. Shin stated that:

The concern for treatment of [Patient 11] as well as other patients I have reviewed is the fact that objectively the patients are not getting better despite escalating doses of opioids and polypharmacy therapy of opioids with other controlled substances. The doctor does not see the danger signs of abuse and furthermore she does not seek other specialists in pain management for a second opinion. Dr. Dahlquist, in treating [Patient 11], failed to provide the minimal standards of care.

(St. Ex. 25 at 13).

179. Dr. Shin testified that Dr. Dahlquist had not prescribed medications appropriately. Dr. Shin elaborated that Dr. Dahlquist had used combinations of controlled substances in addition to Matrix electroceutical therapy and other therapies. Dr. Shin testified that the goal of using the adjunctive therapies is to decrease the amount of controlled substances used. Dr. Shin testified that that had not happened with Patient 11. Moreover, he testified that there had been no objective improvement despite all of the treatment modalities employed by Dr. Dahlquist. Finally, Dr. Shin testified that Dr. Dahlquist had not determined a diagnosis

to justify the amounts of medications she had prescribed over a long period of time. Dr. Shin concluded that Dr. Dahlquist had failed to comply with the minimal standards of care. (Tr. 507-511, 516-517).

180. Dr. Shin noted that Patient 11 had made numerous requests for increases in medication or early refills, which had caused him concern. Dr. Shin noted that this conduct is a sign of potential drug abuse. (Tr. 512-516).
181. Dr. Shin testified that the Matrix electroceutical treatments provided by Dr. Dahlquist to Patient 11 had provided only temporary improvement in Patient 11's pain. Dr. Shin further testified that Patient 11's use of medications increased while she was receiving Matrix electroceutical therapy, and increased again after the Matrix Electroceutical therapy was stopped. Dr. Shin added that the treatment for pain provided by Dr. Dahlquist had neither improved her pain condition nor controlled her pain. (Tr. 507-508, 878-884).
182. Dr. Shin testified that Dr. Dahlquist should have referred Patient 11 for further evaluation and should have obtained records of prior treatment. Dr. Shin elaborated that, with all of the modalities of treatment Dr. Dahlquist provided to Patient 11, Patient 11 had not improved. Dr. Shin testified that Dr. Dahlquist should have investigated other causes of her pain. (Tr. 517).

Dr. Dahlquist's Testimony Regarding Patient 11

183. Dr. Dahlquist testified that she had provided appropriate care to Patient 11. (Tr. 1868-1869).
184. Dr. Dahlquist testified that she had appropriately prescribed pain medications to Patient 11. Dr. Dahlquist testified that Patient 11 had never demonstrated aberrant behavior. Dr. Dahlquist testified that she appreciated that Patient 11 had called the office when her pain was severe rather than increasing her medications on her own. (Tr. 1853-1854, 1868).

Dr. Dahlquist testified that she had acquiesced to Patient 11's request for an early refill when Patient 11 was leaving town for vacation because, based on Patient 11's behavior, Dr. Dahlquist had had no reason to believe that the request for an early refill was inappropriate. (Tr. 1850-1852).

Dr. Dahlquist testified that a pharmacist had telephoned her office concerned about the quantity of medication Patient 11 was taking. Dr. Dahlquist explained that, if Patient 11 had taken all the tablets that had been dispensed by the pharmacy, she would have taken only seven tablets per day. Dr. Dahlquist explained that that was only one more tablet than she had prescribed. Dr. Dahlquist added that the pharmacist had been concerned primarily with the amount of acetaminophen Patient 11 had been taking. (Tr. 1858-1859).

Dr. Dahlquist testified that she had recommended Percocet as an alternative to Vicodin during acute exacerbations of pain. She noted that some patients respond better to Percocet than Vicodin. (Tr. 240-241).

185. Dr. Dahlquist testified that if she had had reason to believe that Patient 11's pain was anything other than a continuation of her already diagnosed disease, Dr. Dahlquist would have done further evaluation. (Tr. 1860-1861).
186. Dr. Dahlquist testified that she had given Patient 11 three trials of Matrix therapy knowing that, in some cases, patients will obtain cumulative results and improve over time rather than with each individual treatment. Dr. Dahlquist added that, eventually, it became apparent that Patient 11 was only going to receive a few hours of relief following each therapy; therefore, Dr. Dahlquist had stopped the Matrix therapy. Dr. Dahlquist further testified that Patient 11's need for opioids increased subsequent to the termination of treatments. (Tr. 239-240, 1865-1868).
187. Dr. Dahlquist testified that she had not observed Patient 11 display "an instability in the psychiatric condition." Therefore she had not contacted Patient 11's psychologist. She further explained that she had prescribed Valium primarily for her muscle spasms. (Tr. 246-247).

Dr. Blatman's Testimony Regarding Patient 11

188. Dr. Blatman testified that Dr. Dahlquist met the standards of care and treatment of Patient 11. (Tr. 1160-1161, 1168).
189. Dr. Blatman testified that he could not find any evidence that Dr. Thomas ever expressed concern about possible opioid addiction or Dr. Dahlquist's choice of medications in treating Patient 11. (Tr. 1159-1161).
190. Dr. Blatman testified that he had not found anything in the medical record which indicated to him that Patient 11 had been using more medications than she should have been or giving or selling the medications to a third party. (Tr. 1163-1166).
191. Dr. Blatman testified that it would not have been unreasonable for Dr. Dahlquist to seek other specialists in pain management for a second opinion. However, he opined that it was certainly not below the standard of care for her not to do it. (Tr. 1167-1168).
192. Dr. Blatman testified that it would be ludicrous to say that a physician should not provide Matrix therapy to a patient because the therapy did not provide long term relief. Dr. Blatman commented that patients go to chiropractors three times a week for years because somebody listens to them, touches them, cares about them, and does something to help their body, despite the fact that they may get only a few hours or a few days of relief.

Dr. Blatman added that Matrix therapy is harmless and, for many people, it is effective. (Tr. 1166-1167).

PATIENT 12

Allegations

193. In its February 13, 2002, Notice of Opportunity for Hearing, the Board alleged that, in her care and treatment of Patient 12, Dr. Dahlquist had prescribed medications in types, amounts and/or combinations that were inappropriate and/or for protracted periods of time that were not justified. As an example, the Board alleged that Dr. Dahlquist had prescribed various opioids to Patient 12, on a protracted basis and frequently in high or escalating doses, although Patient 12's diagnosis and/or condition did not justify such prescribing.

The Board further alleged that Dr. Dahlquist had inappropriately administered injections or blocks.

Finally, the Board alleged that Patient 12's medical records contained results of toxicology screens indicating that Patient 12 had not been taking the prescribed medications as directed by Dr. Dahlquist. Nevertheless, Dr. Dahlquist failed to appropriately reflect these results in her office notes and/or to document in the patient's records consideration of these toxicology screens in formulating Patient 12's treatment plan. (St. Ex. 17A).

Medical Records for Patient 12

194. Patient 12, a thirty-six year old female, first presented to Dr. Dahlquist on November 30, 1993. Patient 12 had been referred by Dr. Moncrief. Patient 12 complained of lower back pain radiating to her neck and down her right leg. Dr. Dahlquist noted that an MRI in August 1993 had shown disk dehydration and mild posterior disk bulging at the L4-L5 and L5-S1 levels. Dr. Dahlquist noted that Dr. Moncrief had diagnosed myofascial strain of the thoracic and lumbar paraspinal muscles. (St. Ex. 12 at I: 11, 205-206).

Patient 12 reported that the medications she was taking included Prozac, Valium, and unidentified pain and sleep medications. Dr. Dahlquist prescribed Vicodin, one to two every six hours as needed for pain, with a maximum of six per day, and administered myofascial trigger point injections. (St. Ex. 12 at I: 11, 18; St. Ex. 12 at IV: 51).

On January 4, 1994, Dr. Dahlquist prescribed Darvocet N-100 and Valium. She also administered myofascial trigger point injections. Thereafter, Dr. Dahlquist continued myofascial trigger point injections and referred Patient 12 for physical therapy. In June 1994, Dr. Dahlquist added bilateral Occipital Nerve blocks with a local anesthetic. (St. Ex. 12 at I: 23-72).

On May 17, 1994, Patient 12 called Dr. Dahlquist's office requesting Valium. Dr. Dahlquist prescribed Valium, Vicodin, and Soma. (St. Ex. 12 at IV: 51, 72).

In August 1994, Dr. Dahlquist administered bilateral Lumbar Facet Joint Injections with local anesthetic and steroids. At that time, Patient 12 was taking Vicodin and Soma. Dr. Dahlquist continued to administer myofascial trigger point injections. (St. Ex. 12 at I: 78, 80-86).

On September 13, 1994, Patient 12 advised Dr. Dahlquist that she had gone to the dentist and had had an allergic reaction to penicillin. Patient 12 further advised that it had caused increased pain, so Patient 12 had "'doubled up' on her meds." (St. Ex. 12 at I: 87).

On November 15, 1994, Patient 12 advised that she had been taking her Vicodin "3 at a time." Patient 12 requested something stronger. Dr. Dahlquist advised Patient 12 that she could not take Vicodin at that rate on a chronic basis. (St. Ex. 12 at I: 92).

On February 6, 1995, Dr. Dahlquist added Percocet to Patient 12's medication regimen. On February 15, 1995, Patient 12 presented to an urgent care facility with complaints of back pain. The record states "denied Percocet refill from pain clinic." She was given twenty Vicodin. (St. Ex. 12 at I: 125; St. Ex. 12 at IV: 53).

On May 30, 1995, Patient 12 called Dr. Dahlquist's office stating that she had lost a bottle of Soma. Dr. Dahlquist refused to refill it. (St. Ex. 12 at IV: 73a). On June 28, 1995, Patient 12 reported that she had lost a two week supply of medications. (St. Ex. 12 at I: 156; St. Ex. 12 at V: 91).

In June 1995, Patient 12 stated that she had been taking Vicodin, two per day; Percocet, two per day; and Soma, two per day. In August, however, she reported that she had been taking Vicodin, four per day; and Soma, six to seven per day. (St. Ex. 12 at I: 156; St. Ex. 12 at V: 91).

On September 11, 1995, Patient 12 reported that her medications had been stolen. Dr. Dahlquist refilled her Vicodin and Soma. Dr. Dahlquist further noted that a pharmacist had contacted her office questioning the amount of medication Patient 12 was taking. (St. Ex. 12 at I: 165; St. Ex. 12 at IV: 53; St. Ex. 12 at V: 84).

On October 18, 1995, Patient 12 called Dr. Dahlquist's office stating that her medications had been stolen at a party. (St. Ex. 12 at IV: 74).

On October 23, 1995, Patient 12 presented to the emergency room for a psychiatric evaluation to assess her suicide potential after she took an overdose of her sleep medications. It was determined that she was not at risk for suicide. Dr. Dahlquist did not address the matter in her progress notes. She continued to prescribe Vicodin and Soma and to administer myofascial trigger point injections. (St. Ex. 12 at I: 194; St. Ex. 12 at V: 61-75).

On May 13, 1996, Dr. Dahlquist added Percocet for severe pain. (St. Ex. 12 at II: 18; St. Ex. 12 at V: 26).

On July 17, 1996, Patient 12 reported that she had been having migraine headaches, which were “sometimes relieved with [an] intramuscular shot of Demerol.” Patient 12 was also taking Vicodin, Percocet and Soma. Dr. Dahlquist noted that a Dr. Chamberlin had also been prescribing Lopressor and Depakote, and that she would consult him regarding calcium channel blockers to treat Patient 12’s headaches prophylactically. (St. Ex. 12 at II: 24; St. Ex. 12 at V: 24).

On October 10, 1996, Dr. Dahlquist prescribed Vicodin, four per day; Percocet, four per day; and Soma, four per day. She continued to administer myofascial trigger point injections. (St. Ex. 12 at II: 43). An MRI scan performed December 26, 1996, revealed “mild disc degeneration and disc bulging at L4-5 and L5-S1. There [were] no disc herniations.” (St. Ex. 12 at IV: 18).

On January 27, 1997, Patient 12 reported that she had been taking Vicodin, nine to ten per day; and Soma, three to four per day. Dr. Dahlquist did not mention medications in her progress note. (St. Ex. 12 at II: 68, 72).

On June 10, 1997, Patient 12 called Dr. Dahlquist’s office requesting additional Percocet. Dr. Dahlquist increased Vicodin to eight per day. (St. Ex. 12 at IV: 56, 77).

An MRI scan performed July 1, 1997, revealed the following:

- There is minimal anterolisthesis of L5 with respect to S1. Probable bilateral PARS defects are noted at the L5 level.
- Small disc bulges are present at L4-5 and L5-S1 with associated degenerative changes within the intervertebral disc, no focal disc herniations can be identified.
- Schmorl’s node at T11 is noted.

(St. Ex. 12 at IV: 19).

On July 3, 1997, Patient 12 reported that she had been taking Vicodin, eight per day. Dr. Dahlquist administered myofascial trigger point injections. On July 15, 1997, Dr. Dahlquist administered a Lumbar Epidural Steroid injection for numbness and pain in the right leg. On September 24, 1997, Dr. Dahlquist administered lumbar epidural steroid injections, trigger point injections and Matrix electroceutical neuron blockade and interferential treatments. (St. Ex. 12 at II: 97, 104, 127).

On October 14, 1997, Patient 12 called Dr. Dahlquist's office requesting an early refill of Vicodin. She stated that she had had a fight with her boyfriend, and that he had pushed her, injuring her back and breaking her finger. Dr. Dahlquist gave Patient 12 one week's worth of Percocet at a rate of eight per day. (St. Ex. 12 at IV: 80). On October 22, 1997, Patient 12 advised that she had "doubled up" on Percocet and Soma. (St. Ex. 12 at II: 143a).

An MRI scan performed October 30, 1997, revealed no significant change since the July 21, 1997, scan. (St. Ex. 12 at IV: 22).

On October 31, 1997, Patient 12 called Dr. Dahlquist's office requesting something other than trazodone for sleep. Dr. Dahlquist prescribed Elavil. (St. Ex. 12 at IV: 82).

On February 27, 1998, Patient 12 reported taking Vicodin, eight per day; Percocet, four per day; and Soma, four per day. Dr. Dahlquist continued to administer myofascial trigger point injections. (St. Ex. 12 at III: 13-14).

On April 10, 1998, Dr. Dahlquist noted that she would give Patient 12 samples of Phrenilin to treat muscle tension headaches. She instructed Patient 12 to call the office for a prescription if the Phrenilin was effective. Dr. Dahlquist did not record the provision of samples on the Medication Sheets. Moreover, there is no indication that Patient 12 requested a prescription after she took the sample. (St. Ex. 12 at III: 20).

On April 12, 1998, Patient 12 called Dr. Dahlquist's office stating that Percocet was not relieving her pain. Dr. Dahlquist told her that she could increase her Vicodin to eight tablets per day for the next three to five days. (St. Ex. 12 at IV: 80).

On May 20, 1998, Dr. Dahlquist administered Toradol and Norflex injections. Patient 12 reported "a significant worsening of her pain." (St. Ex. 12 at III: 28, 34).

On May 22, 1998, Dr. Dahlquist ordered a urine screen for toxicology. The urine screen revealed the presence of barbiturates and cannabinoids. It did not detect any opiates. The specific gravity was low. Dr. Dahlquist did not address the urine screen results in her progress notes. (St. Ex. 12 at IV: 26a-36).

On May 28, 1998, Patient 12 called Dr. Dahlquist's office requesting additional pain medications. Dr. Dahlquist increased her Percocet and Vicodin for one day. The following day, Dr. Dahlquist prescribed OxyContin. (St. Ex. 12 at IV: 58, 84).

An MRI scan of the lumbar spine performed June 2, 1998, revealed no significant change since the October 30, 1997, scan. An MRI scan of the pelvis revealed an injection granuloma of the left buttock. (St. Ex. 12 at IV: 40, 41).

On June 3, 1998, Patient 12 called Dr. Dahlquist's office to state that another physician had prescribed Restoril for sleep. She further stated that OxyContin was not helping her pain. Dr. Dahlquist prescribed MS Contin. (St. Ex. 12 at IV: 85).

On June 26, 1998, Patient 12 reported that MS Contin was relieving her pain. Nevertheless, Patient 12 asked for a short-acting opioid in addition to the MS Contin. Dr. Dahlquist prescribed Demerol and Arthrotec. Dr. Dahlquist continued to administer myofascial trigger point injections. (St. Ex. 12 at III: 41, 43).

On July 22, 1998, Patient 12 called Dr. Dahlquist's office requesting an increase in her MS Contin. Dr. Dahlquist allowed her to take two to three tablets every six hours, with a maximum of ten per day, for two days. (St. Ex. 12 at IV: 87).

On August 11, 1998, Patient 12 reported that she believed she was developing tolerance to MS Contin. She stated that she had been taking two tablets three times per day in addition to Soma. She further stated that she had been having trouble sleeping. Dr. Dahlquist prescribed Pamelor. Dr. Dahlquist noted diagnoses of spondylolisthesis, arthritis, and herniated disc. (St. Ex. 12 at III: 57, 59).

On October 20, 1998, Patient 12 called Dr. Dahlquist's office to state that her pain was intense, that she had difficulty getting out of bed, and that she sometimes felt as if she could "pass out" due to the pain. Dr. Dahlquist increased her MS Contin to two tablets every six hours. (St. Ex. 12 at IV: 88).

On October 29, 1998, Patient 12 called Dr. Dahlquist's office to state that her pain was intense. Dr. Dahlquist prescribed Dilaudid. (St. Ex. 12 at IV: 89).

On November 2, 1998, Patient 12 reported taking MS Contin, six per day; hydromorphone, two per day; and Soma, two per day. Dr. Dahlquist noted that she had increased Patient 12's medications temporarily after Patient 12 injured her back moving furniture. On November 17, 1998, Patient 12 was instructed to increase her MS Contin to eight per day. (St. Ex. 12 at III: 73, 75, 81).

An MRI scan performed November 7, 1998, revealed the following:

- Grade 1 spondylolisthesis with spondylolysis at L5-S1, stable when compared to June 1998.
- Small paracentral subligamentous disc protrusion at L4-L5 that is more conspicuous than on the prior exam.
- Suspect interval left lateral disc herniation at L5-S1 that is not seen on the prior study.

(St. Ex. 12 at IV: 43).

On November 17, 1998, Patient 12 called Dr. Dahlquist's office requesting an injection of Toradol and Norflex. Dr. Dahlquist increased her MS Contin. (St. Ex. 12 at IV: 90). On November 20, 1998, Dr. Dahlquist administered an injection of Toradol and Norflex. She also prescribed Dilaudid for breakthrough pain, to be used in addition to the other medications. (St. Ex. 12 at III: 84).

On November 23, 1998, Patient 12 called Dr. Dahlquist's office complaining of severe back pain. Dr. Dahlquist prescribed OxyContin. (St. Ex. 12 at IV: 91).

On November 25, 1998, Patient 12 called Dr. Dahlquist's office to state that the OxyContin was not as effective as MS Contin and Dilaudid. She requested refills of her Dilaudid. Dr. Dahlquist complied. (St. Ex. 12 at IV: 92).

On December 14, 1998, Patient 12 reported taking MS Contin, eight per day; hydromorphone, six per day; and Soma, 1 to 1½ per day. Dr. Dahlquist noted that an MRI scan had revealed spondylolisthesis. She stated that she would refer Patient 12 to a neurosurgeon to see if she would be a candidate for surgery. Dr. Dahlquist increased Patient 12's MS Contin and Elavil. (St. Ex. 12 at III: 89, 91a; St. Ex. 12 at IV: 14).

On December 18, 1998, Patient 12 reported that her pain was intense and that she was not sleeping. She further stated that, on her own initiative, she had increased her daily doses of MS Contin, Dilaudid, and Soma. She noted that she was telling Dr. Dahlquist because her refills would be due early. Dr. Dahlquist administered injections of Toradol and Demerol with Phenergan. (St. Ex. 12 at III: 97; St. Ex. 12 at IV: 93).

On January 25, 1999, Dr. Dahlquist noted that one of her employees had called Patient 12 the previous week, and that Patient 12's speech had been slurred. Patient 12 reported that she had accidentally taken too much Elavil. (St. Ex. 12 at IV: 106).

On March 8, 1999, Patient 12 was taking MS Contin, hydromorphone, amitriptyline, and Soma. Dr. Dahlquist continued to administer myofascial trigger point injections. She also administered bilateral sacroiliac joint injections. (St. Ex. 12 at IV: 122).

An MRI scan performed May 12, 1999, revealed the following:

- Degenerative change of the intervertebral disc at L4-5 with some minimal broad based protrusion and slight inferior lipping of the disc margin.
- Grade I spondylolisthesis at L5-S1 with degenerative change in the intervertebral disc and superior lipping of the disc margin. There is some extension into the

intervertebral foramen on the left similar to the previous study with no interval change.

(St. Ex. 12 at IV: 46-47).

On May 28, 1999, Patient 12 presented to a hospital because she had fallen, with a resulting L1 vertebral body compression fracture. A physician from the hospital called Dr. Dahlquist and stated that he did not feel comfortable increasing Patient 12's medications. Dr. Dahlquist increased the dose of Dilaudid and prescribed Morphine injectables. (St. Ex. 12 at IV: 10, 146, 148).

On September 9, 1999, Dr. Dahlquist added Phrenilin Forte for headaches. Patient 12 was also taking Oramorph, eight per day; hydromorphone, four per day; Soma, one per day, and Phenergan, two to three per day. Dr. Dahlquist continued to administer myofascial trigger point injections. She also administered bilateral sacroiliac joint injections and bilateral Greater Occipital nerve blocks. (St. Ex. 12 at IV: 164-169).

On October 15, 1999, Patient 12 reported that she had fallen four times since her last visit. (St. Ex. 12 at IV: 175).

On January 27, 2000, Patient 12 reported that she had been seen by an endocrinologist who had taken her off all opioid medication to see if it would improve her overall status. Nevertheless, Patient 12 reported that her pain was severe. Dr. Dahlquist prescribed OxyContin and Percocet. (St. Ex. 12 at IV: 60, 183).

Dr. Shin's Testimony Regarding Patient 12

195. Dr. Shin testified that Dr. Dahlquist had failed to conform to minimal standards of care in her care and treatment of Patient 12. In his December 6, 2001, report concerning Patient 12, Dr. Shin opined, in part, as follows:

The patient's medical diagnosis does not support the protracted course of nerve blocks and escalating doses of opioids. There is no justification for the use of self-injectable opioids for the diagnosis listed above. There are no pain emergencies, and if the patient had intractable pain that was not controlled by conventional dose of medications, an Emergency Room evaluation would be appropriate. The physician documents that the patient shows no signs of abuse. But the patient clearly demonstrates a significant pain behavior in pain levels that are not consistent with the diagnosis and ultimately not controlled by escalating doses of opioids as well as other controlled substances. In fact, the positive drug screen revealed that the patient was obtaining drugs for non-therapeutic use. Dr. Dahlquist did not change the course of treatment. The failure to review the study or simply ignoring the findings of the drug

screen is a violation. In treating [Patient 12], Dr. Dahlquist departed from the minimal standard of care.

(Tr. 528-530; St. Ex. 25 at 14) (See also Tr. 519-524).

196. Dr. Shin testified that he was concerned about the trigger point injections, greater occipital nerve blocks, sacroiliac joint injections, epidural joint injections and facet joint injections Patient 12 was receiving. He explained that the reason injections are done is ultimately to minimize the use of medication and restore patient function. The ultimate goal would be to require low-dose medication or no medication at all. Dr. Shin explained that he is even more concerned in the case of Patient 12 because of the use of injections combined with the increasing and protracted use of opioids. (Tr. 524).
197. Dr. Shin noted that at the time of the toxicology screen, Patient 12 had been prescribed Percocet, Vicodin, and Valium. Dr. Shin stated that he would have expected those medications to appear on the screen. Dr. Shin testified that Dr. Dahlquist should have confronted Patient 12 about why she was not taking the prescribed medication and what she was doing with that medication. Dr. Shin added that, when a violation such as this is established, the physician should either give the patient a probation period or refer the patient for evaluation. Dr. Shin asserted that he could not find any reference to the toxicology screens in Dr. Dahlquist's progress notes for Patient 12. Dr. Shin opined that these results should have been documented in the progress notes. (Tr. 524-528).

Dr. Dahlquist's Testimony Regarding Patient 12

198. Dr. Dahlquist testified that she had met the standards of care in her treatment of Patient 12. (Tr. 1893-1894, 1911-1912).
199. Dr. Dahlquist testified that she had never seen any signs that Patient 12 had abused her medications. Dr. Dahlquist elaborated that Patient 12 had never appeared sedated and family members confirmed that. Dr. Dahlquist further asserted that Patient 12 had not maximized her medications. Dr. Dahlquist stated that Patient 12 had tried to take her medications "as sparingly as possible." (Tr. 249, 1904-1908).

Dr. Dahlquist acknowledged that, in January 1999, Patient 12 had displayed slurred speech. Dr. Dahlquist explained that this had been an isolated incident and that Patient 12 had admitted that she had "taken two of her Elavil instead of her ten milligram tablets in the morning, which could have been a mistake on one incident." Dr. Dahlquist added that she did not recall Patient 12 slurring her speech on other occasions. Dr. Dahlquist commented that in evaluating a patient's use or potential misuse of medication it is necessary to "look at the whole picture." (Tr. 253-254, 1908-1910).

Dr. Dahlquist acknowledged that Patient 12 had fallen on a number of occasions. She testified that the falls had resulted from the severity of Patient 12's pain. Dr. Dahlquist

commented that it is not uncommon for pain patients to have sudden spasms or exacerbations of pain which cause them to fall. She added that this can occur with myofascial pain, particularly because the patients with myofascial pain are prone to intermittent muscle spasms. Dr. Dahlquist testified that she does not view the series of falls reported by Patient 12 as evidence of drug seeking behavior. Dr. Dahlquist asserted that Patient 12 had demonstrated enough responsibility to take her drugs as Dr. Dahlquist had prescribed them. (Tr. 254-256).

200. Dr. Dahlquist suggested that, at the time Patient 12 submitted her urine for screening, she may not have been taking any of the opiates Dr. Dahlquist prescribed. Dr. Dahlquist explained she had prescribed the opiates on an “as needed” basis. She added that, on one occasion in May 1998, Patient 12 had waited six days longer than necessary to get a refill of Vicodin. Dr. Dahlquist reasoned that, because she had not obtained the refill as early as possible, Patient 12 may not have been taking any opiates at the time she submitted the urine sample. Dr. Dahlquist added that Vicodin may be detected in the urine up to twenty-four hours. (Tr. 249-253, 1903-1904, 2204-2206).
201. Dr. Dahlquist testified that she had no indication, other than the single positive urine screen, that Patient 12 had been using marijuana. Dr. Dahlquist elaborated that Patient 12 had never smelled of marijuana. Dr. Dahlquist further testified that she had never received “anonymous phone calls suggesting that she was smoking pot on a regular basis.” (Tr. 1912).

Dr. Dahlquist testified that the presence of cannabinoids in Patient 12’s urine could have been a result of her taking ibuprofen, which Dr. Dahlquist stated can cause false positive results. Dr. Dahlquist admitted, however, that Patient 12 had not been taking ibuprofen. Dr. Dahlquist further testified that the appropriate management of a patient who is using marijuana in addition to prescribed medications would be to counsel the patient that they need to stop using marijuana. Dr. Dahlquist added that, if the patient refuses, the physician should wean the patient off the prescribed medications. Dr. Dahlquist noted that she would follow up with another random urine screen to ensure that the substance does not reappear. Nevertheless, there is no indication that Dr. Dahlquist did this in the case of Patient 12. (Tr. 1904, 2206-2209).

202. Dr. Dahlquist testified that, on April 10, 1998, she had given Patient 12 a sample of Phrenilin. Dr. Dahlquist testified that Phrenilin contains butalbital and caffeine, which would have accounted for the barbiturates in the urine screen. Dr. Dahlquist admitted, however, that if Patient 12 had obtained any barbiturate off the street, it could have produced this positive result. (Tr. 250-251, 1896-1897).
203. Dr. Dahlquist testified that she had continued to give myofascial trigger point injections to Patient 12 because Patient 12 had reported relief following the injections. Dr. Dahlquist added that, once a patient has myofascial pain syndrome for longer than eight to twelve weeks, it is highly unlikely to be reversible, particularly when they begin showing signs of fibromyalgia. Dr. Dahlquist testified that, if the treatment is helping the patient without

causing adverse side effects of muscle atrophy or steroid related problems, it is appropriate to continue the treatment. (Tr. 1881-1889, 1895, 2199).

Dr. Dahlquist testified that Patient 12 had obtained pain relief from trigger point injections. She further testified that Patient 12 had suffered no detrimental effects from the injections. (Tr. 1891).

304. Dr. Dahlquist testified that Patient 12's pain had been controlled by "what Dr. Shin described as escalating doses of opioids as well as other controlled substances." Dr. Dahlquist explained that Patient 12 had obtained relief due to the combination of trigger point injections and oral medications. Dr. Dahlquist added that the treatment she provided had not cured Patient 12's underlying condition; it had simply helped to manage her pain. (Tr. 1881-1883, 1898, 1900-1901, 2200-2204).

Dr. Blatman's Testimony Regarding Patient 12

205. Dr. Blatman testified that Dr. Dahlquist had met the standards of care in her treatment of Patient 12. Dr. Blatman further testified that there had been nothing inappropriate about Dr. Dahlquist providing escalating doses of opioids to Patient 12. (Tr. 1356, 1184-1186; Resp. Ex. B at 22).
206. Dr. Blatman testified that trigger point injections had been appropriate treatment for Patient 12 for her myofascial pain. Dr. Blatman asserted that there was no indication that Dr. Dahlquist's trigger point injections or nerve blocks had caused any harm such as muscle wasting to Patient 12. Moreover, Dr. Blatman noted that the medical record reflects the effectiveness of the injections administered by Dr. Dahlquist. (Tr. 1174-1175, 1184; Resp Ex. B at 21-22).
207. Dr. Blatman testified that a positive finding for barbiturates in the toxicology screen of the May 1998 urine sample would be consistent with Patient 12 taking Phrenilin. (Tr. 1179-1180).
208. Dr. Blatman testified that, when a patient tests positive for marijuana, the physician should confront the patient regarding the illegal and inappropriate behavior and warn the patient of the dangers of combining marijuana with the prescribed medications. Dr. Blatman acknowledged that he had not found any documentation in the medical records that Dr. Dahlquist had discussed the results of the urine toxicology screen with Patient 12. (Tr. 1179-1181, 1356-1357).
209. Dr. Blatman testified that it is possible for the hydrocodone level in a patient to be below the detectable level in a urine screen. Dr. Blatman further testified that he would not conclude that Patient 12 had engaged in inappropriate behavior "without speaking to the laboratory." Dr. Blatman added, however, that it is something that should be considered. Nevertheless,

Dr. Blatman opined that Dr. Dahlquist's management of the urine drug screen results had not been below the standard of care. (Tr. 1182-1184; St. Ex. 12 at IV: 58).

PATIENT 13

Allegations

210. In its February 13, 2002, Notice of Opportunity for Hearing, the Board alleged that, in her care and treatment of Patient 13, Dr. Dahlquist had prescribed medications in types, amounts and/or combinations that were inappropriate and/or for protracted periods of time that were not justified.

The Board further alleged that, although Patient 13's medical records contained results of toxicology screens indicating that Patient 13 had not been taking the prescribed medications as directed by Dr. Dahlquist, Dr. Dahlquist had failed to appropriately reflect these results in her office notes and/or to document in the patient's records consideration of these toxicology screens in formulating the patient's treatment. (St. Ex. 17A).

Medical Records for Patient 13

211. Patient 13, a forty year old male, first presented to Dr. Dahlquist on November 3, 1998. Patient 13 complained of left leg pain, resulting from falling off a roof. Patient 13 reported that he had been diagnosed with scoliosis and lumbar arthritis. Patient 13 further reported that he had had two bone fusion procedures and a spinal cord stimulator implanted. (St. Ex. 13 at 5-10, 58-61).

Patient 13 stated that he had used marijuana, cocaine, and alcohol nine years earlier. Although Patient 13 noted on an intake form that he had received inpatient treatment for alcohol detoxification, in her progress notes, Dr. Dahlquist noted only that he had "used alcohol in the past." (St. Ex. 13 at 12, 59).

Patient 13 stated that the only medication he was taking at the time of his initial visit was Soma. Dr. Dahlquist prescribed OxyContin and Soma. On November 17, 1998, Patient 13 called Dr. Dahlquist's office requesting additional Soma. On December 1, 1998, Patient 13 returned his OxyContin; Dr. Dahlquist prescribed Methadone, up to four per day. (St. Ex. 13 at 10, 37, 48).

A C.T. scan of the cervical spine performed on January 13, 1999, revealed a compressive disc herniation at C4-5. (St. Ex. 13 at 20). Subsequently, a post-myelogram C.T. scan of the cervical spine revealed the following:

- C5 through C7 fusion with no significant residual encroachment on the central canal. No cord compromise is seen.

- New right paracentral and lateral recess C4-5 soft disc herniation with moderate right cord compression.
- Foraminal stenosis with potential exiting left sided nerve root compromise at C4-5, C5-6, and right exiting nerve root compromise at C7-T1.

(St. Ex. 13 at 25).

On March 3, 1999, Patient 13 called Dr. Dahlquist's office complaining of increased pain. Dr. Dahlquist instructed Patient 13 to increase his methadone, up to eight tablets per day and his Soma, up to four tablets per day, for the next five to seven days. In April 1999, Dr. Dahlquist added Valium. (St. Ex. 13 at 37, 50, 79).

On July 7, 1999, Patient 13 complained of worsening pain. Dr. Dahlquist increased Patient 13's medications to methadone, a maximum of three per day; Soma, a maximum of four per day, and Valium, a maximum of four per day. Dr. Dahlquist noted that Patient 13 had had an unexplained weight loss of forty pounds, so she had ordered various tests to evaluate it. (St. Ex. 13 at 94).

On July 14, 1999, Patient 13 called Dr. Dahlquist's office stating that, since taking Valium, he had passed out, fallen asleep in a store, and had difficulty driving. Dr. Dahlquist's office instructed him to take Valium only at bedtime. (St. Ex. 13 at 51).

On July 27, 1999, Patient 13's family members called Dr. Dahlquist's office. The note provides, "The family wishes you to stop [prescribing] Valium. They are very concerned about him being doped up all the time. They said that you have been warned from family." Dr. Dahlquist stopped prescribing Valium for five or six weeks. (St. Ex. 13 at 37, 52).

In August 1999, Patient 13's family accompanied Patient 13 to Dr. Dahlquist's office and stated that Patient 13 had been doing better with his medications and had not been oversedated. (St. Ex. 13 at 100).

In September 1999, Dr. Dahlquist resumed prescribing Valium. On October 12, 1999, Patient 13 reported taking Methadone, twelve per day; Soma, four per day; and Valium, four per day. A urine screen for toxicology on urine submitted on October 12, 1999, revealed the presence of benzodiazepines, with metabolites of Valium. No other drugs were detected. (St. Ex. 13 at 31, 37, 108).

A post-myelogram C.T. scan of the cervical spine performed on January 5, 2000, revealed the following:

- Large broad-based central disc hernia at C4-5 with spinal stenosis (8-9 millimeters) spinal cord compression and evidence of bilateral foraminal stenosis.

- Small central subligamentous disc hernia at C3-4.
- Right paracentral-lateral disc hernia at C7-T1 without neural compression seen in the axial images.
- Previous fusion C5-6 and C6-7.

(St. Ex. 13 at 34-35).

In February 2000, Patient 13 underwent a microscopic anterior cervical discectomy with auto graft fusion at the C4-5 level. Patient 13 reported improvement in spasms and numbness. (St. Ex. 13 at 123).

On March 27, 2000, a pharmacist called to state that Patient 13 “comes in staggering as though drunk.” The pharmacist expressed concern regarding the amount of methadone Dr. Dahlquist prescribed to Patient 13. At that time, Dr. Dahlquist had been prescribing methadone at a rate of twenty-four tablets per day. Dr. Dahlquist initiated pill counts and ordered a urine toxicology screen. Dr. Dahlquist did not decrease the amount she prescribed. (St. Ex. 13 at 38, 54a-55).

On March 30, 2000, Dr. Dahlquist prescribed MSIR, with a maximum of eight per day, in addition to his other medications. On April 14, she prescribed methadone, with a maximum of twenty-four per day. (St. Ex. 13 at 120).

212. Dr. Dahlquist testified that she continues to see Patient 13. (Tr. 261).

Dr. Shin’s Testimony Regarding Patient 13

213. Dr. Shin testified that Dr. Dahlquist had failed to maintain minimal standards of care in rendering care to Patient 13. Dr. Shin commented that Dr. Dahlquist had inappropriately prescribed increasing amounts of opioids despite a lack of improvement in pain levels. Dr. Shin testified that the inappropriateness of the prescribing was intensified by a urine toxicology screen that did not reveal the drugs Dr. Dahlquist prescribed and complaints from family and a pharmacist that Patient 13’s mental status was impaired. Dr. Shin further testified that Dr. Dahlquist had not exhausted all of the available treatment modalities. (Tr. 532-538, 904-905, 897-898).

Dr. Dahlquist’s Testimony Regarding Patient 13

214. Dr. Dahlquist testified that, in her care and treatment of Patient 13, she had met applicable standards of care. (Tr. 1942).

215. Dr. Dahlquist testified Patient 13 had not shown signs of drug abuse. As an example, Dr. Dahlquist testified that Patient 13 had been prescribed Percocet during a hospitalization,

but had not wanted to continue taking Percocet after discharge. Dr. Dahlquist explained that Percocet is a faster acting drug than methadone. She opined that if someone was abusing drugs to obtain a high sensation from the drug, they would be more likely to abuse a short-acting medication because of its quick onset and because of the triggering effects that it has in the brain. Therefore, she had concluded that Patient 13 had wanted his medications relieve the pain rather than for purposes of abuse. (Tr. 1925).

216. Dr. Dahlquist testified that she had increased Patient 13's methadone because he had been complaining of severe pain and frequent flare-ups of pain. Dr. Dahlquist testified that when she increases a medication such as methadone, she cautions the patient and the patient's family regarding oversedation and side effects of the medication. Dr. Dahlquist commented that the reason for involving the family members is that family members may observe signs of oversedation before the patient becomes aware of it. Dr. Dahlquist testified that there had been no complaints subsequent to August 11, 1999, from Patient 13's family concerning oversedation. (Tr. 259-261, 1195, 1230, 1920-1922, 1926-1927, 1931).

217. Dr. Dahlquist acknowledged that the urine toxicology report indicated that no methadone had been detected. She opined that the result would be negative for methadone until at least a level of 300 nanograms per milliliter was present in the blood. Therefore, Dr. Dahlquist concluded the results of Patient 13's urine screen did not necessarily indicate that Patient 13 had not been taking his methadone. (Tr. 264, 1933-1934).

Dr. Dahlquist testified that Patient 13 had been attempting to reduce his use of methadone. Dr. Dahlquist further testified that on October 12, 1999, she had not been aware of how much he had cut down on the methadone, and she had given him a prescription for the medication at the same number of tablets she had been prescribing. Dr. Dahlquist acknowledged, however, that, if Patient 13 had not been taking all of the pills she prescribed, it was an indication that she had been overprescribing. (Tr. 264- 265).

218. Dr. Dahlquist acknowledged that a pharmacist had called her office expressing concern that Patient 13 had been staggering in the pharmacy. Dr. Dahlquist stated that she had seen Patient 13 three days later, and he had not seemed sedated. She further testified that Patient 13 walks with a limp. Moreover, she had not received calls from Patient 13's family complaining of oversedation. Therefore, Dr. Dahlquist had presumed that "what the pharmacist had observed was [Patient 13's] characteristic limp as opposed to oversedation." (Tr. 261-262, 1936-1940, 2211-2115, 2245-224, 2258-2259).

Dr. Dahlquist admitted that she had not returned the pharmacist's call to discuss the matter. She explained that she had investigated the matter and had found no reason to conclude that Patient 13 was abusing his medications. Dr. Dahlquist testified that Patient 13 had never had an odor of alcohol on his breath and had never showed signs of taking illegal street drugs. Dr. Dahlquist further testified that Patient 13's family had never provided any information to suggest that he had relapsed in the use of alcohol or cocaine. (Tr. 262-263, 1919, 1941-1943).

219. Dr. Dahlquist testified that she had not caused any harm to Patient 13. Moreover, Dr. Dahlquist testified that her pattern of escalating opioids with Patient 13 had not been contraindicated. Dr. Dahlquist noted that Patient 13 had reported obtaining relief from his medications. Moreover, she testified that, if she had discontinued his medications, the pain would have been severe, which is a trigger for a relapse. (Tr. 1941-1942, 2215-2217).

Dr. Blatman's Testimony Regarding Patient 13

220. Dr. Blatman opined that Dr. Dahlquist had met the standards of care in her treatment of Patient 13. Dr. Blatman testified that, in light of Patient 13's surgical history, it is not a fair criticism of Dr. Dahlquist to say that she had been overprescribing opioids while not reducing his pain sufficiently. Dr. Blatman added that one could argue that the medication dose should have been higher. Dr. Blatman further testified that both the use of opioids and the increasing dosages seemed appropriate. (Tr. 1187-1189; 1195).
221. Dr. Blatman asserted that a negative finding for methadone in a urine toxicology report is not in and of itself an indication that the patient was misusing his pain medications. Nevertheless, Dr. Blatman admitted that it might be a reasonable inference that Patient 13 had not been taking methadone. On the other hand, Dr. Blatman testified that methadone metabolizes to hydromorphone, and that hydromorphone had not been tested on this drug screen. (Tr. 1189-1194).
222. Dr. Blatman testified that Dr. Dahlquist's handling of the March 27, 2000, pharmacist's phone call expressing concern about Patient 13's level of medication had been appropriate. Dr. Blatman admitted, however, that it is possible that Patient 13 had been showing evidence of oversedation. (Tr. 1190-1192).

PATIENT 14

Allegations

223. In its February 13, 2002, Notice of Opportunity for Hearing, the Board alleged that, in her care and treatment of Patient 14, Dr. Dahlquist had prescribed medications in types, amounts and/or combinations that were inappropriate and/or for protracted periods of time that were not justified.

The Board further alleged that Dr. Dahlquist had inappropriately administered injections or blocks. As an example, the Board alleged that Dr. Dahlquist had administered epidural injections to Patient 14 although the injections were contraindicated because Patient 14 had been taking Coumadin, an anticoagulant.

Furthermore, the Board alleged that Dr. Dahlquist had failed to obtain records of prior or concurrent medical treatment, including studies performed, and/or Dr. Dahlquist had

failed to refer Patient 14 for additional, necessary consultations, evaluations, studies, or treatment. (St. Ex. 17A).

Medical Records for Patient 14

224. Patient 14, a sixty-three year old female, first presented to Dr. Dahlquist on May 4, 1998. Patient 14 complained of pain in her neck, both shoulders, spine, lower back, both hips, and both legs. Patient 14 had had a lumbar laminectomy in 1986. Patient 14 reported that a friend had recommended Dr. Dahlquist. (St. Ex. 14 at 6, 9, 19, 46-49).

Patient 14 reported that, at the time of her initial visit, she had been taking Coumadin, Vicodin ES, Soma, Klonopin, and other non-controlled drugs. Dr. Dahlquist prescribed Vicodin ES, Neurontin, and Soma. She stated that she would also consider physical therapy, and lumbar epidural steroid injections, and a psychological evaluation depending on Patient 14's response to medications. (St. Ex. 14 at 11, 24, 48-49).

On May 14, 1998, David McFadden, M.D., wrote Dr. Dahlquist and advised that he had been prescribing Vicodin for Patient 14. He stated that Patient 14 had returned to his office after seeing Dr. Dahlquist and receiving Vicodin from Dr. Dahlquist. Dr. McFadden stated that Patient 14 had not told him that she had seen Dr. Dahlquist and she had accepted a prescription for Vicodin from him. Dr. McFadden further stated that, after receiving a letter from Dr. Dahlquist, he had confronted Patient 14 for the fact that she had not told him that she had received medications from Dr. Dahlquist. He added that Patient 14 told him that she had destroyed the prescription he had given her. Finally, Dr. McFadden advised that he would no longer prescribe pain medications for Patient 14. (St. Ex. 14 at 164).

On June 2, 1998, Patient 14 reported that her pain had "improved dramatically" with the addition of Neurontin. She requested epidural steroid injections, which Dr. Dahlquist administered. Dr. Dahlquist also administered myofascial trigger point injections. She also prescribed Xanax to decrease spasms at night. Patient 14's intake form does not list Coumadin as one of the medications she was taking, and Dr. Dahlquist did not address Patient 14's use of Coumadin in the progress note. (St. Ex. 14 at 53, 54-60).

On July 2, 1998, Dr. Dahlquist administered an epidural steroid injection. Patient 14's intake form does not list Coumadin as one of the medications she was taking, and Dr. Dahlquist did not address Patient 14's use of Coumadin in the progress note. (St. Ex. 14 at 33, 62-70).

On July 13, 1998, Patient 14 called Dr. Dahlquist's office requesting additional pain medication. Dr. Dahlquist increased her Vicodin and Soma for two days. (St. Ex. 14 at 33).

In August 1998, Patient 14 complained of having experienced side effects after the epidural steroid injections and myofascial trigger point injections. She requested to forego additional treatment. Patient 14 had also stopped taking Neurontin. In addition, Patient 14

reported significantly increased pain and asked for stronger medications. Dr. Dahlquist prescribed methadone and Arthrotec. (St. Ex. 14 at 73).

On September 14, 1998, Patient 14 called Dr. Dahlquist's office complaining of a back injury. Dr. Dahlquist prescribed Valium. (St. Ex. 14 at 34).

On September 22, 1998, Patient 14 reported that she had increased her medication on her own. She also asked for Klonopin to treat her restless leg syndrome. Dr. Dahlquist agreed, and stated that she would discontinue Soma and give samples of Norflex and Skelaxin. Nevertheless, the medication sheet indicates that Dr. Dahlquist prescribed OxyContin, Vicodin ES, Soma and Klonopin. Dr. Dahlquist also administered lumbar epidural steroid injections with Benadryl to control the side effects. Patient 14's intake form does not list Coumadin as one of the medications she was taking, and Dr. Dahlquist did not address Patient 14's use of Coumadin in the progress note. (St. Ex. 14 at 24, 78-85).

On September 25, 1998, Patient 14 called Dr. Dahlquist's office and stated that Skelaxin and Norflex had not helped. She requested Soma. Dr. Dahlquist prescribed Soma and instructed Patient 14 to decrease her Vicodin by one. Dr. Dahlquist also prescribed Robaxin, and continued myofascial trigger point injections. (St. Ex. 14 at 35, 91b, 96-118).

On June 30, 1999, Patient 14 called Dr. Dahlquist's office stating that she had increased her medications on her own and requesting additional pain medication. Dr. Dahlquist prescribed Dilaudid, and noted that it was for one time only. Nevertheless, Dr. Dahlquist continued to prescribe Dilaudid, one to two tablets every four hours as needed for pain. (St. Ex. 14 at 25, 39, 118).

On October 4, 1999, Patient 14 called Dr. Dahlquist's office for additional Dilaudid. On October 15, 1999, Dr. Dahlquist started prescribing Baclofen instead of Soma. Dr. Dahlquist continued to administer myofascial trigger point injections. (St. Ex. 14 at 25, 40, 133).

On December 1, 1999, Patient 14 called Dr. Dahlquist's office stating that she had had a flare up of pain. She requested an increase in her medications. Dr. Dahlquist increased her Vicodin to eight tablets per day for five days. (St. Ex. 14 at 41, 141).

On December 3, 1999, Dr. Dahlquist increased her Klonopin to four tablets per day. She also administered myofascial trigger point injections and bilateral sacroiliac joint injections. On that date, Patient 14 had listed Coumadin as one of the medications she was taking. (St. Ex. 14 at 41, 140-146).

On January 5, 1999, Dr. Dahlquist gave Patient 14 samples of Vicoprofen, Sonata, and Phrenilin. Patient 14 continued to take Dilaudid, Baclofen and Klonopin. (St. Ex. 14 at 150, 159).

On January 14, 2000, Dr. Dahlquist administered myofascial trigger point injections. On that date, Patient 14 had listed Coumadin as one of the medications she was taking, although Dr. Dahlquist did not address Coumadin in her progress note. (St. Ex. 14 at 148-154).

On January 31, 2000, Patient 14 called Dr. Dahlquist's office stating that Klonopin was not helping and requesting something for sleep. Dr. Dahlquist prescribed Xanax, Dilaudid, and Klonopin, and increased Patient 14's Topamax. (St. Ex. 14 at 25, 42).

On February 25, 2000, Patient 14 complained that Dilaudid was making her too sleepy. Dr. Dahlquist switched to Vicodin ES. Dr. Dahlquist administered myofascial trigger point injections and a right sacroiliac joint injection. On that date, Patient 14 had listed warfarin, an anticoagulant, as one of the medications she was taking. Dr. Dahlquist did not address the warfarin in her progress note. (St. Ex. 14 at 156-162).

On March 24, 2000, Patient 14 called Dr. Dahlquist's office stating she had increased her Vicodin. She added that she had taken ten tablets the day before, but that it had not relieved the pain. She asked for Percodan. Dr. Dahlquist prescribed Percodan. (St. Ex. 14 at 25, 43).

Dr. Shin's Testimony Regarding Patient 14

225. Dr. Shin testified that Dr. Dahlquist had deviated from the standards of care in her treatment of Patient 14. Dr. Shin testified that Dr. Dahlquist had prescribed a combination of controlled substances over a long period of time without effectively improving Patient 14's pain. He added that Dr. Dahlquist should have realized that Patient 14's pain was not being controlled effectively, and she should have taken further action. He suggested that steps Dr. Dahlquist could have taken included further evaluations, specific tests or outside consultations. (Tr. 541, 547-549, 551-552; St. Ex. 25 at 16).
226. Dr. Shin testified that Dr. Dahlquist had also administered numerous injections to Patient 14. Dr. Shin further testified that the purpose of these injections was to control pain and to reduce the need for oral medications. Dr. Shin further testified that Dr. Dahlquist had not reduced Patient 14's need for oral medications by the use of epidural injections. (Tr. 549-550).
227. Dr. Shin further testified that Dr. Dahlquist's treatment of Patient 14 had been below the minimal standards of care because Dr. Dahlquist had administered epidural steroid injections while Patient 14 was actively taking Coumadin. He stated that epidural injections are absolutely contraindicated in a patient who is anticoagulated. Dr. Shin testified that the danger of giving an epidural injection while a patient is on Coumadin is that uncontrolled bleeding in the epidural space can have serious consequences, including paralysis. He added that Coumadin must be stopped at least five days in order for coagulation time to be normalized. (Tr. 542-547, 551-552).

Moreover, Dr. Shin testified that there is no evidence in the medical records of any discussion with Patient 14 concerning Coumadin. He added that there is no documentation of Dr. Dahlquist consulting with the physician who was prescribing Coumadin for Patient 14. (Tr. 542-547, 912-916, 960-961).

Dr. Shin testified that, if a patient is taking Coumadin and the plan is to give an epidural steroid injection, the physician should document that the patient has stopped taking Coumadin. The physician should also obtain objective lab studies to indicate that the coagulation level has returned to normal prior to proceeding with the injection. Dr. Shin testified that there is no evidence that Dr. Dahlquist did this. In fact, Dr. Shin noted that, on December 3, 1999, Patient 14 reported that she was taking Coumadin. Dr. Dahlquist performed myofascial trigger point injections and bilateral sacroiliac joint injections that day. (Tr. 542-543, 918-919).

228. Dr. Shin testified that, with the exception of Dr. McFadden's May 14, 1998, letter to Dr. Dahlquist, there are no prior medical records in Dr. Dahlquist's medical records for Patient 14. (Tr. 550 and 959-960).

Dr. Dahlquist's Testimony Regarding Patient 14

229. Dr. Dahlquist denied that she had prescribed increasing doses of opioids and/or a combination of opioids in increasing doses. Dr. Dahlquist explained the dosages had not increased over time. She further testified that, in most cases, one drug was stopped before another was added. (Tr. 1960-1967).
230. Dr. Dahlquist stated that Patient 14 had listed Coumadin on her intake form. Dr. Dahlquist further testified that she discusses each patient's intake form with the patient. Dr. Dahlquist explained that she would have explained to Patient 14 the dangers of receiving injections while taking Coumadin. Dr. Dahlquist further testified that she had instructed Patient 14 to discuss the matter with Dr. McFadden. Therefore, Dr. Dahlquist had assumed that Patient 14 would be concerned about it enough that she would have told Dr. Dahlquist that she was still taking Coumadin before Dr. Dahlquist administered an epidural injection. Dr. Dahlquist further noted that Patient 14 had not always listed Coumadin on her intake form. Dr. Dahlquist testified that, for all of these reasons, she is sure that Patient 14 had discontinued the Coumadin prior to receiving epidural injections. (Tr. 268-273, 1948-1958, 2218-2219).

When asked to point out where she had documented her conversation with Patient 14 concerning the dangers of Coumadin, Dr. Dahlquist acknowledged that she had not documented it. Dr. Dahlquist further acknowledged that she had not done any studies to confirm that Patient 14's coagulation time had returned to normal before giving lumbar injections. Dr. Dahlquist opined that, since Dr. McFadden had prescribed the Coumadin, he would have been the physician to order studies if he deemed them necessary. (Tr. 1948-1958, 2218-2219, 1957).

231. Dr. Dahlquist asserted that she does not believe that there had been any reason to order additional testing over and above that which Dr. McFadden had obtained in order to establish a diagnosis. Dr. Dahlquist explained that when she had initially evaluated Patient 14, her pain had not changed substantially. She had not complained of any new symptoms or anything which would indicate that further testing was necessary. (Tr. 1954).
232. Dr. Dahlquist testified that Patient 14's pain was improved with therapy. She further testified that her underlying physical condition was not improved, but that Dr. Dahlquist had not expected the underlying physical condition to improve. (Tr. 1968-1969)

Dr. Blatman's Testimony Regarding Patient 14

233. Dr. Blatman testified that Dr. Dahlquist had met the standards of care in her treatment of Patient 14. Dr. Blatman stated that Dr. Dahlquist had prescribed medication types, amounts, and combinations there were appropriate, and for periods of time that were justified for Patient 14. Dr. Blatman asserted that Patient 14's diagnoses and condition justified the prescriptions and injections. (Tr. 1202; Resp Ex. B at 24-25; Resp. Ex. C at 18).
234. Dr. Blatman opined that Coumadin is not an absolute contraindication to epidural injections, and the risks and benefits should be weighed by the physician and the patient. He added that informed consent is a requirement. Dr. Blatman testified that his review of the medical records revealed that Dr. Dahlquist had been aware that Patient 14 was taking Coumadin. Dr. Blatman further testified his review of the records indicated to him that Patient 14 had stopped taking Coumadin before the epidural injections. He added, however, that he would have been more comfortable if the issue of Coumadin had specifically been addressed in the consent forms signed by Patient 14. Nevertheless, Dr. Blatman testified that Dr. Dahlquist had met the standard of care regarding the issue of Coumadin. Dr. Blatman further testified that it appears that Patient 14 did not have any complications from the administration of the epidural injections. (Tr. 1200-1202, 1358-1359, 1374-1375; Resp Ex. B at 24-25; Resp. Ex. C at 18).
235. Dr. Blatman opined that Dr. Dahlquist's records for Patient 14 contain repeated notes that trigger point injections resulted in noticeable improvement in the patient's pain level for several weeks. (Resp. Ex. B at 24-25).
236. Finally, Dr. Blatman testified that there had been no need for Dr. Dahlquist to obtain Patient 14's prior treatment records. Dr. Blatman testified that records are fairly voluminous and oftentimes not helpful. Dr. Blatman asserted that he does not believe that Dr. Dahlquist was "missing anything of any significance." (Tr. 1198-1200; Resp. Ex. B at 24-25).

PATIENT 15

Allegations Concerning Patient 15

237. In its February 13, 2002, Notice of Opportunity for Hearing, the Board alleged that, in her care and treatment of Patient 15, Dr. Dahlquist had prescribed medications in types, amounts and/or combinations that were inappropriate and/or for protracted periods of time that were not justified. As an example, the Board alleged that Dr. Dahlquist had prescribed various opioids to Patient 15, on a protracted basis and frequently in high or escalating doses, although Patient 15's diagnosis and/or condition did not justify such prescribing.

The Board further alleged that Dr. Dahlquist had failed to adequately recognize and/or address indications of drug abuse or the increased risk of drug abuse. The Board provided the following examples: Dr. Dahlquist continued to prescribe escalating doses of medications, including opioids and psychoactive drugs, despite the fact that Patient 15 had requested early refills of medications on several occasions; her records indicate that she was a possible drug seeker who had had rehabilitation in the past; her toxicology screens indicated that she had not been taking her prescribed medications; and she had gone through detoxification at a hospital.

Finally, the Board alleged that, although Patient 15's medical records contained results of toxicology screens indicating that she had not been taking her prescribed medications as directed by Dr. Dahlquist, Dr. Dahlquist failed to appropriately reflect these results in her office notes and/or to document in the patient's records consideration of the toxicology screens in formulating Patient 15's treatment plan. (St. Ex. 17A).

Medical Records for Patient 15

238. Patient 15, a forty-four year old female, first presented to Dr. Dahlquist on January 23, 1995. Patient 15 complained of low back and shoulder pain. She stated that she had been taking various narcotics on and off over the past eight years, and that Percocet had been discontinued two months earlier. Patient 15 stated that her pain had been worsening since then. Dr. Dahlquist noted that Patient 15 presented with a flat affect, "almost in a catatonic stupor." Dr. Dahlquist diagnosed diffused severe myofascial syndrome and bilateral inflammation of the sacroiliac joint. (St. Ex. 15 at I: 5-6; St. Ex. 15 at III: 168-169).

Previous records contain studies performed in 1994, including a normal C.T. of the abdomen, performed for a diagnosis of chronic active hepatitis; a normal C.T. scan of the right knee; a normal C.T. scan of the cervical spine; and a normal scan of the liver and spleen. (St. Ex. 15 at II: 23-26).

Dr. Dahlquist administered myofascial trigger point injections and bilateral sacroiliac joint steroid injections. She also prescribed Percocet and Soma. (St. Ex. 15 at I: 6-8, 21). The

medication sheet states in big letters, “Possible drug seeker, has [been] in St. E’s drug rehab.” (St. Ex. 12 at III: 35).

In a January 23, 1995, letter, Dr. Dahlquist thanked Morris Brown, M.D., for the referral. Dr. Dahlquist advised that she had administered myofascial trigger point injections and bilateral sacroiliac joint steroid injections. She did not tell Dr. Brown, however, that she had prescribed Percocet and Soma. (St. Ex. 15 at II: 7-8).

On April 27, 1995, Dr. Dahlquist noted that Patient 15 had been through a drug rehabilitation treatment program and that there was “a request that she be given a minimal amount of narcotics to help with her injections.” Dr. Dahlquist noted that Patient 15 was taking Percocet, four per day; and Soma, two to three per day. (St. Ex. 15 at I: 25).

In an April 27, 1995, letter to Dr. Brown, Dr. Dahlquist wrote as follows:

I have been giving her Percocet 30 tablets to use in the immediate post block period for pain caused due to the block. However, I understand that she has attended St. Elizabeth’s Drug Rehabilitation Program and I have not been giving her any other pain medication in the interim between appointments. I wanted you to know exactly how much narcotics she was being given. Again, I reiterate that this is only to help her with the pain caused from the blocks themselves for the 1st few days following each block.

(St. Ex. 15 at II: 9).

Dr. Dahlquist continued to administer myofascial trigger point injections and bilateral sacroiliac joint steroid injections. On September 5, 1995, Dr. Dahlquist referred Patient 15 to physical therapy for “myofascial release massage.” (St. Ex. 15 at I: 25-54).

On September 29, 1995, Dr. Dahlquist prescribed Fiorinal in addition to Percocet and Soma, although the progress note does not indicate the reason she added Fiorinal to the medication regimen. (St. Ex. 15 at I: 63; St. Ex. 15 at III: 35).

On November 9, 1995, Patient 15 reported that she had been to the emergency room for severe pain. She further stated that she had been taking eight tablets of Fiorinal daily. Dr. Dahlquist added Norflex to the medication regimen. (St. Ex. 15 at I: 72; St. Ex. 15 at III: 35).

On January 2, 1996, Patient 15 was transported to the emergency room by ambulance after ingesting “an unknown quantity of Fiorinal tabs – (up to 50).” Patient 15 underwent a psychological evaluation. The report of the psychological evaluation stated that Patient 15 denied that she had been attempting suicide. Patient 15 claimed that she had only been trying to relieve her pain, and had “lost track of how many pills she had taken.” The report noted that Patient 15 had been hospitalized three times during the previous two years for

depression. After the overdose, however, Patient 15 refused inpatient treatment, but agreed to follow-up with counseling. (St. Ex. 15 at III: 122-123).

Dr. Dahlquist did not see Patient 15 for several months after the overdose. Nevertheless, Dr. Dahlquist continued to prescribe controlled substances for Patient 15. On May 16, 1996, Dr. Dahlquist prescribed sixty tablets of Fiorinal. (St. Ex. 15 at III: 35).

On May 28, 1996, Patient 15 returned to Dr. Dahlquist's office for the first time since the overdose. Dr. Dahlquist noted that it had been recommended that Patient 15 receive only non-addicting types of medications, but that Patient 15 had requested Fiorinal refills. Furthermore, Dr. Dahlquist noted that,

I did have a discussion [with] the pt. regarding her oral pain meds, in that it would be [un]wise for me to give her a significant amount of addictive medications since she had been [treated at] St. E's drug rehab previously and she was taken in again with an overdosage in Jan. 1996. What I will do is give her a Rx for Ultram and suggest that she take as many as 1-2 q 4 [hours with] a max of 8/day prn pain. If she needs to supplement [with] Fiorinal I will give her no more than 20 tabs/month of Fiorinal. That should get her through the first few days of [increased] pain from the [myofascial trigger point injections] alone without giving her so many that she will be tempted to take an overdosage. The pt. understands & reluctantly agrees to this therapeutic regimen.

(St. Ex. 15 at III: 91-92). Nevertheless, in July, Dr. Dahlquist prescribed sixty tablets of Vicodin, and four days later she prescribed sixty tablets of Percocet. In August, Dr. Dahlquist prescribed OxyContin in addition to Percocet, in an attempt to "wean" Patient 15 off Percocet. (St. Ex. 15 at III: 35, 102, 112).

Patient 15 was also evaluated by "Turning Point" for her use and abuse of pain medications. It was recommended that Patient 15 change to non-addictive pain medications. She was also advised regarding the disease concept and the addictive potential of long term use of opiates, barbiturates and benzodiazepines. The recommendations were discussed also with Dr. Brown. (St. Ex. 15 at II: 124).

Dr. Dahlquist referred Patient 15 to physical therapy. On February 12, 1997, Patient 15 was discharged from physical therapy for failure to keep appointments. Dr. Dahlquist continued to prescribe Percocet and administer myofascial trigger point injections. (St. Ex. 15 at II: 43, 48; St. Ex. 15 at III: 170-171).

On February 27, 1997, the medication sheet provides the following,

Pt. reported that car was broken into & Rx stolen along with \$1,200 in cash. No police report taken! (She says she was illegally parked & didn't want to

be given a ticket.) I told her I would refill this one time. She must guard all future Rx's well, because I won't do this again.

(St. Ex. 15 at III: 36).

On April 25, 1997, Dr. Dahlquist noted that she had increased Patient 15's Percocet to six to eight per day for two months. Dr. Dahlquist further noted that after two months, Patient 15 must return to taking only four Percocet per day. Dr. Dahlquist wrote that Patient 15 had recently been released from a one week hospitalization. She did not document the reason for the hospitalization. (St. Ex. 15 at II: 59, 60).

On May 5, 1997, Dr. Dahlquist prescribed 100 tablets of Percocet. On May 14, only nine days later, Dr. Dahlquist prescribed another 100 tablets of Percocet. (St. Ex. 15 at III: 36-37).

On May 19, 1997, Patient 15 reported that she had lost her Percocet "when she was in an accident with her car and her car blew up." Patient 15 asked for a refill of Percocet. She also asked for something stronger in the morning for jaw pain. Dr. Dahlquist prescribed 180 tablets of Percocet and sixty tablets of Demerol. (St. Ex. 15 at II: 77; St. Ex. 15 at III: 36-37).

On June 2, 1997, Patient 15 called Dr. Dahlquist's office and stated that Demerol had not helped her pain, and she had been taking eight to ten Percocet per day. Dr. Dahlquist prescribed 100 tablets of Percocet and thirty tablets of Demerol. Dr. Dahlquist noted that she would give Demerol only once per month. Nevertheless, Dr. Dahlquist prescribed additional Demerol only nine days later. (St. Ex. 15 at II: 74, 84; St. Ex. 15 at III: 36-37).

On June 11, 1997, Patient 15 reported that she had been seen in the emergency room for pain. She asked "to be put back on higher doses of Demerol." (St. Ex. 15 at II: 74, 84).

On June 24, 1997, Patient 15 called Dr. Dahlquist's office and asked for an additional fifty Percocet. She stated that she had been taking two Percocet every two to three hours due to pain, and that she would be out of Percocet by the end of the day. Dr. Dahlquist prescribed OxyIR one to two every three hours, a maximum of twelve per day, for one week. (St. Ex. 15 at III: 75).

On June 30, 1997, Patient 15 called Dr. Dahlquist's office and stated that she was unable to come to the office due to jaw pain. She asked for Medrol Dose Pak and Xanax. Dr. Dahlquist prescribed Xanax and Percocet. (St. Ex. 15 at III: 37, 72).

On August 14, 1997, Dr. Dahlquist advised that Patient 15 had become totally permanently disabled due to her pain. (St. Ex. 15 at II: 19).

On August 20, 1997, Dr. Dahlquist noted that Patient 15 had been taking thirty Percocet per day for the past four to five days. Dr. Dahlquist prescribed OxyContin. (St. Ex. 15

at II: 94). On August 29, 1997, Dr. Dahlquist prescribed methadone and Xanax. (St. Ex. 15 at III: 37).

On September 2, 1997, Patient 15 called Dr. Dahlquist's office and stated that she had had an adverse reaction to methadone, and that she had "black[ed] out." She further stated that OxyContin was effective but that it was not covered by her insurance. Dr. Dahlquist prescribed MS Contin 30 mg, one to two every eight hours. (St. Ex. 15 at III: 77).

On September 5, 1997, "Assured Care" called to say that "they had" Patient 15 and that a family member would pick her up to take her to Dr. Dahlquist's office. They further reported that Patient 15 had taken "three MS Contin at one time, in addition to Vivarin." (St. Ex. 15 at III: 79).

On September 5, 1997, Patient 15 reported that she had been taking approximately ten Percocet and ten MS Contin daily. Patient 15 reported that she received poor pain relief from MS Contin, and that it made her too sleepy. She reported, however, that she did not want to take OxyContin since it was not covered by her insurance. Dr. Dahlquist wrote a letter to her insurer. She also prescribed Baclofen. (St. Ex. 15 at II: 99).

On September 15, 1997, a liver panel indicated abnormal enzyme levels, including a GGT of 164, with a normal range of 8-78. A hand written note states as follows: "Liver injury 2° to Percocet (Tylenol)." Dr. Dahlquist stopped prescribing Percocet, and noted that she would not resume prescription of Percocet until Patient 15's liver enzymes had normalized. (St. Ex. 15 at II: 28, 110).

On September 23, 1997, Patient 15 called Dr. Dahlquist's office and stated that she had been taking six MS Contin per day and had run out of medication. She stated that she had not filled her OxyContin prescription, but wanted Percocet instead. Dr. Dahlquist refilled the MS Contin prescription. (St. Ex. 15 at III: 37, 81).

On September 30, 1997, a hand surgeon wrote Dr. Dahlquist thanking her for the referral. He noted that Patient 15 had "rather severe carpal tunnel syndrome bilaterally." He recommended an "external neurolysis median nerve of the wrist be performed under outpatient Bier block anesthesia." He noted that Patient 15 would contact him if she chose to have the procedure performed. (St. Ex. 15 at II: 125-126).

On October 13, 1997, Patient 15 called Dr. Dahlquist's office and stated that she had accidentally disposed of her medications. Dr. Dahlquist advised that she would refill the medications if Patient 15 filed a police report. Patient 15 responded that she would rather get a prescription for OxyContin than file a police report. Dr. Dahlquist agreed, but cautioned that she would not replace lost or stolen medications in the future. (St. Ex. 15 at III: 84).

The medication sheet for November 7, 1997, states, "Pt. was placed on a 3 day plan. She will receive #2 Fentanyl patches and 12 Percodans [every] 3 days until further notice." (St. Ex. 15 at III: 38).

On November 10, 1997, Patient 15 called Dr. Dahlquist's office and stated that she had had a reaction to MS Contin, including dizziness and visual hallucinations. When asked if she was taking other medications, Patient 15 reported that she was taking Valium, Soma, an antidepressant, and an anti-seizure medication. Dr. Dahlquist did not ask where Patient 15 had obtained the additional medications. Dr. Dahlquist stated that she would prescribe Percodan if Patient 15 returned her unused MS Contin. (St. Ex. 15 at III: 37, 85).

The medication sheet for November 17, 1997, states that Patient 15 was on a four day plan for her medication refills. (St. Ex. 15 at III: 38).

On December 29, 1997, Dr. Dahlquist noted that she had prescribed Duragesic patches to be changed once every other day, but that Patient 15 had been changing them daily. Dr. Dahlquist wrote that, since Patient 15 had not received relief from the Duragesic [Fentanyl], Percodan, and Xanax, she would prescribe Neurontin "in hopes of being able to decrease the total amount of narcotics." Dr. Dahlquist also noted that she would attempt to "speed up the process of getting approved for [a] surgical procedure" related to the TMJ disorder. (St. Ex. 15 at II: 116).

On March 25, 1998, Patient 15 reported that she was concerned that she had become tolerant to Duragesic patches. She also stated that she was interested in undergoing drug rehabilitation treatment. Dr. Dahlquist noted,

I respect the patient's wishes to be placed through drug rehabilitation. Her biggest fear is going through D-tox and then not having the pain adequately controlled. I explained to her that she may find that going through rehab, she will require at least some baseline level of pain medication (be it narcotic or otherwise). However, if she is able to get through the rehabilitation program and go without narcotic medication for a few weeks, she may be able to be started back on the medication at a much lower dose and have it be much more effective for her.

(St. Ex. 15 at III: 119).

On April 6, 1998, Patient 15 called Dr. Dahlquist's office and stated that she had been hospitalized for detoxification. She asked Dr. Dahlquist to visit her and to prescribe non-narcotic pain medications upon her release. She also asked for Xanax. (St. Ex. 15 at III: 97).

On April 9, 1998, Patient 15 called Dr. Dahlquist's office and stated that she would be having surgery for nasal polyps, that she was concerned about cancer, and that her blood pressure had been 244/144 during a procedure. Patient 15 asked to go back on medications

to keep her blood pressure down prior to surgery. Dr. Dahlquist contacted the physician responsible for Patient 15's detoxification. That physician stated that Patient 15 should not have any medications. (St. Ex. 15 at III: 98).

On April 10, 1998, Patient 15 called Dr. Dahlquist's office and stated that she had taken a friend's Ultram. She asked to use Duragesic patches that she had obtained prior to her detoxification. (St. Ex. 15 at III: 99).

On April 13, 1998, Patient 15 called Dr. Dahlquist's office and stated that she was in severe pain and complained of right sided weakness. Dr. Dahlquist instructed Patient 15 to go either to her family physician or the emergency room. Dr. Dahlquist noted that she later spoke to Patient 15, who stated that she had gone to the emergency room and that her blood pressure had been 250/145. Dr. Dahlquist further noted that she had contacted the emergency room physician, who advised her that Patient 15's blood pressure had been 185/114. (St. Ex. 15 at III: 99).

On April 15, 1998, Patient 15 reported that she had been having severe pain. She requested pain medication. Dr. Dahlquist prescribed Duragesic patches and Xanax. She also ordered a "posture back brace" and an MRI of the cervical spine to rule out root compression or facet disease. The MRI was normal. (St. Ex. 15 at III: 6, 12-13, 40).

The medication sheet for April 24, 1998, states,

Will allow pt. to take Percocet up to 20 per week when it rains. (She understands that 20 per/week is the limit.)

(St. Ex. 15 at III: 40) (Emphasis in original).

Dr. Dahlquist referred Patient 15 for a psychological evaluation. The report noted severe depression and anxiety, and stated that her emotional stability was fragile and a required close monitoring. The recommendations included the following:

- If opiate therapy is initiated, written prescriptions and tox screenings should be weekly.
- Weekly psychological counseling is strongly recommended.

(St. Ex. 15 at III: 50) (Emphasis in original).

On May 4, 1998, Dr. Dahlquist noted that she had spoken to Patient 15's psychologist who had advised that it would be "okay" to give Patient 15 an oral narcotic so long as Patient 15 was followed closely. Dr. Dahlquist prescribed Percodan. (St. Ex. 15 at III: 126).

A urine toxicology screen was performed on a urine sample submitted by Patient 15 on May 4, 1998. The sample tested positive for Darvon, but negative for any other drugs.

Dr. Dahlquist was prescribing Percocet, Duragesic, and Xanax at that time. (St. Ex. 15 at II: 15a; St. Ex. 15 at III: 40). The medication sheet for May 7, 1998, states, "Pt. stated she received Darvon from a friend. We need a urine on next visit or Rx pick up." (St. Ex. 15 at III: 40).

A urine toxicology screen was performed on a urine sample submitted by Patient 15 on May 11, 1998. The sample tested negative for all drugs, including benzodiazepines. The report contains a hand written note that states, "Does this screen for Xanax? Yes." (St. Ex. 15 at II: 15a). Dr. Dahlquist did not comment in her progress notes on the drug screen results, and continued to prescribe Percocet, Duragesic and Xanax. (St. Ex. 15 at III: 40).

On July 10, 1998, Dr. Dahlquist wrote that Patient 15 had continued in psychological counseling since undergoing drug rehabilitation. She further noted that,

it was decided that she needed something for pain, and she did not appear to be psychologically addicted to the medication. Since that time, she had been very careful about not overusing her medications, regardless of the amount of pain she is having.

Dr. Dahlquist added that she would schedule Patient 15 for an epidural catheter to see if she would be a candidate for an implantable pump. (St. Ex. 15 at II: 143).

Dr. Dahlquist referred Patient 15 to physical therapy and a Physical Capacity Evaluation. In July 1998, Patient 15 was discharged from physical therapy for failure to keep appointments. (St. Ex. 15 at III: 51-64, 65).

On August 20, 1998, Dr. Dahlquist inserted an epidural catheter for a one week trial. The trial was successful, and Patient 15 requested an implantable pump. (St. Ex. 15 at III: 150).

239. Dr. Dahlquist testified that she continues to treat Patient 15. (Tr. 1996).

Dr. Shin's Testimony Regarding Patient 15

240. Dr. Shin opined that Dr. Dahlquist had fallen below the minimal standards of care in her treatment of Patient 15, in part, because Dr. Dahlquist had prescribed high and escalating doses of opioids. For example, Dr. Shin noted that, on her August 20, 1997, progress note for Patient 15, Dr. Dahlquist documented that Patient 15 had been taking thirty Percocet a day for the four or five days prior to this office visit. (Tr. 555-557, 920-922; St. Ex. 25 at 17).

Dr. Shin further testified that Dr. Dahlquist had provided refills to Patient 15 despite reports of lost and stolen medications. In particular, Dr. Shin questioned Dr. Dahlquist's judgment refilling a prescription for 120 Percocet tablets after Patient 15 reported that her

medications and \$1,200 in cash had been stolen from her car, and asserted that she had not made a police report because she had been illegally parked and did not want to be given a ticket. Dr. Shin also questioned Dr. Dahlquist's judgment refilling a prescription after Patient 15 asserted that she had "misplaced her medication" and thought she had thrown it away while clearing out old bottles. (Tr. 555-5605, 1205-1206; St. Ex. 25 at 17).

Dr. Shin noted that Dr. Dahlquist had continued to prescribe combinations of controlled substances to Patient 15 despite the fact that Patient 15 had taken doses of medications much higher than that which Dr. Dahlquist prescribed which still did not give her adequate relief of pain. (Tr. 563-564; St. Ex. 15 at II: 110).

Dr. Shin opined that the negative findings on Patient 15's urine screen had been an indication that Patient 15 was not taking her prescribed medications. Dr. Shin testified that Dr. Dahlquist should have questioned what Patient 15 was doing with her medications. Dr. Shin further testified that Dr. Dahlquist should have been even more concerned and very suspicious when she learned that Patient 15 had been taking Darvon, another controlled substance, that she had received "from a friend." (Tr. 556-566; 922-923).

Dr. Shin noted that, in her May 4, 1998, progress note, Dr. Dahlquist wrote that Patient 15's psychologist had advised that, as long as Patient 15 "is followed very closely, it would be okay to give her an oral narcotic." Dr. Shin testified that Patient 15 had office visits with Dr. Dahlquist on April 15, 1998, and July 10, 1998. He further testified that there was no office visit between those dates. He noted that the July 10, 1998, progress note does not contain discussion of the May 4, 1998, urine screen. (Tr. 529-561, 923-926).

Dr. Shin testified that Dr. Dahlquist had continued to prescribe controlled substances to Patient 15 despite the advice of other treatment providers that Patient 15 should receive only non-addicting medications. (Tr. 555, 561-563).

Finally, Dr. Shin concluded that Dr. Dahlquist had not adequately addressed Patient 15's signs of drug abuse which was a deviation from the minimal standards of care. (Tr. 556-566; 922-923).

Dr. Dahlquist's Testimony Regarding Patient 15

241. Dr. Dahlquist testified that she had met the standards of care in her treatment of Patient 15. Dr. Dahlquist further testified that Patient 15 had reported receiving relief from the treatment Dr. Dahlquist provided. Dr. Dahlquist concluded that she had done no harm to Patient 15. (Tr. 1991-1992, 1995-1996).
242. Dr. Dahlquist testified that Patient 15's intractable pain had required opioids or a combination of opioids. Dr. Dahlquist commented that myofascial pain is not treatable by surgery. She further commented that the main treatments for myofascial pain are oral

medications, trigger point injections, and exercise, which the patient was already doing. Dr. Dahlquist added Patient 15's pain had not been well controlled by exercise; therefore, she had needed trigger point injections and oral medications. (Tr. 1995-1996).

Dr. Dahlquist testified that concrete objective findings had supported her treatment of Patient 15 with opioids. These findings included physical examinations showing palpable muscle spasm in the areas of trigger point tenderness. Dr. Dahlquist stated that, on physical examination, that type of muscle spasm is not reproducible voluntarily. (Tr. 1992).

243. Dr. Dahlquist testified that she had continued to prescribe for Patient 15 when Patient 15 reported lost and stolen medications because stopping opioid therapy abruptly can lead to a withdrawal syndrome. (Tr. 1986-1987).

Dr. Dahlquist admitted that there have been occasions when she has been fooled by a drug-abusing patient. Dr. Dahlquist commented that, when a patient reports lost or stolen medications, she makes an honest attempt to evaluate the veracity of the patient's story. Dr. Dahlquist added:

I'm always open to the possibility that something may be true or it may not be true. So I try to look at the whole picture so as not to falsely accuse somebody of lying when they're actually telling me the truth. I would rather look at a pattern of occurrences rather than one single incident.

(Tr. 2260-2261).

244. Dr. Dahlquist testified that she had not discontinued Patient 15's medications after her January 1996 overdose of Fiorinal. Dr. Dahlquist explained that Patient 15 had had a tendency to misuse her medications when she was in a significant amount of pain. Dr. Dahlquist added that, when Patient 15's pain was under control, she had been less likely to misuse her medications. Dr. Dahlquist added that she had been concerned that, if Patient 15's pain was not adequately controlled, she would have "end[ed] up out on the street, possibly abusing street drugs or harming herself in some way." Therefore, Dr. Dahlquist asserted that she had continued to prescribe pain medications to Patient 15 after the overdose, but had adjusted her management of Patient 15 by giving her fewer tablets at a time. (Tr. 1991).
245. Dr. Dahlquist testified that she had continued to prescribe for Patient 15 despite the fact that, after the overdose, the emergency department physician had recommended that she be given non-addictive types of pain medications. Dr. Dahlquist asserted that she believes that the emergency department physician's statement is misleading, because medications in and of themselves are not inherently addictive. Moreover, Dr. Dahlquist asserted that people who become addicted to one type of medication may not become addicted to another type of medication. (Tr. 281-282).

246. Dr. Dahlquist testified that she had continued to prescribe for Patient 15 despite the fact that the May 5, 1998, urine specimen had tested positive for Darvon. Dr. Dahlquist justified her continued prescribing by stating that she had explained to Patient 15 that she should not take other people's medications. Moreover, Dr. Dahlquist ordered a second urine screen to make sure that Patient 15 did not continue to take other people's drugs. Dr. Dahlquist added that another urine screen had been done, and Darvon had not been detected. (Tr. 282-283).

Dr. Dahlquist further acknowledged that the urine specimen had tested negative for opiates and benzodiazepines. Dr. Dahlquist testified that this result indicated that Patient 15 had not had enough morphine or benzodiazepines in her system to trigger a positive result. Dr. Dahlquist asserted that this does not necessarily indicate that Patient 15 had not been taking any of her drugs. Dr. Dahlquist added that Percodan is oxycodone, so Percodan would not trigger a positive opiate screen for morphine or codeine. (Tr. 1979-1980, 1992-1994).

247. Dr. Dahlquist testified that she had continued to prescribe for Patient 15 despite the fact that Patient 15 had gone through two drug detoxification programs. Dr. Dahlquist added that the fact that a patient completes a drug detoxification program does not mean that the patient should not be prescribed opioids or a combination of opioids for her pain. Dr. Dahlquist commented that Patient 15's willingness to go through drug detoxification was a very responsible act. Dr. Dahlquist explained that Patient 15 realized that she had overused the medications, and wanted to make sure that she was not misusing them because of an addiction. Dr. Dahlquist continued that, after Patient 15 completed the drug detoxification program, she learned that she was not very functional without the medication. (Tr. 1982-1986)

Therefore, Dr. Dahlquist reasoned, following detoxification, Patient 15 had been willing to be evaluated by psychologist. The psychologist felt that it was appropriate to treat Patient 15 with opioids as long as she was monitored. Dr. Dahlquist testified that she had complied with the advice of the psychologist. (Tr. 1982-1986). Dr. Dahlquist acknowledged, however, that psychologists do not have the legal authority to prescribe drugs in Ohio. Dr. Dahlquist explained that she had relied on the psychologist's expertise only as pertaining to Patient 15's psychological status relating to the continued use of opioids. (Tr. 2222).

Dr. Dahlquist further justified her prescribing of opioids to Patient 15 after Patient 15 completed the drug detoxification program as follows:

Well, as -- again, as long as the patient is monitored -- you know, if a patient, for example, has a history of addiction and the addiction has gone into remission, like I mentioned before, stress which can be caused by pain can trigger re- -- relapse of the addiction. So it's actually better to treat a patient

who has misused substances in the past or has had -- has shown an addiction to the substances.

(Tr. 1996-1997).

Dr. Dahlquist concluded that she had followed Patient 15 closely, and had seen no evidence of aberrant or drug-seeking behavior. (Tr. 1976, 1980-1982).

248. Dr. Dahlquist testified that she had continued to prescribe for Patient 15 despite the fact that Patient 15 had had normal MRIs. Dr. Dahlquist testified that a patient can have a normal MRI and still be in pain. Dr. Dahlquist explained “myofascial pain does not show up on an MRI scan. This was only done to rule out any abnormalities in the spine itself to see if there was something else triggering her pain. Dr. Dahlquist concluded that the MRI had demonstrated that there was nothing besides the myofascial pain. (Tr. 1994-1995).

Dr. Blatman’s Testimony Regarding Patient 15

249. Dr. Blatman testified that addiction is a disease and does not preclude appropriate treatment for pain. Dr. Blatman acknowledged that a history of addiction requires that the physician pay closer attention, and perhaps practice a little bit differently as far as making sure that the patient is complying. (Tr. 1203-1205).

250. Dr. Blatman testified that Dr. Dahlquist had responded appropriately to Patient 15’s reports of lost and stolen medications. Dr. Blatman noted that Dr. Dahlquist had limited Patient 15’s refills and had told Patient 15 to guard all future medications well. (Tr. 1205-1206).

Dr. Blatman testified that it is sometimes difficult to determine whether to continue treating a patient who reports the loss of medications. He added that a physician has to decide whether he or she believes the patient. He explained that the decision must be made based on the doctor-patient relationship; the doctor’s intuition, training and experience; and the reliability of the patient (Tr. 1208-1209).

251. Dr. Blatman testified that periodic urine screens are especially appropriate in the case of a patient what has been documented as a possible drug seeker and “previous drug rehab and possible previous addiction.” He continued that urine drug screens on a random basis is a way to pull the reins a little bit tighter and assure compliance. (Tr. 1207).

Dr. Blatman testified that he did not see evidence that Patient 15’s behavior was “really aberrant.” He added that her behavior was consistent with a person who was conscious of her potential problem, and who was concerned enough that she was willing to risk the pain to withdraw from her pain medications. Dr. Blatman continued that the “patient [was] obviously dealing with this conflict on her own and doing it in a conscientious fashion, and [was] participating with Dr. Dahlquist as a team together, which is the way a doctor-patient relationship is supposed to work.” (Tr. 1209).

PATIENT 16

Allegations

252. In its February 13, 2002, Notice of Opportunity for Hearing, the Board alleged that, in her care and treatment of Patient 16, Dr. Dahlquist had prescribed medications in types, amounts and/or combinations that were inappropriate and/or for protracted periods of time that were not justified.

The Board further alleged that, in her treatment of Patient 16, Dr. Dahlquist had failed to adequately recognize and/or address indications of drug abuse or the increased risk of drug abuse. As examples, the Board alleged that, although Patient 16 had a history of alcohol abuse and continued to use marijuana and alcohol, Dr. Dahlquist prescribed various medications, including opioids, benzodiazepines, and muscle relaxants, and she failed to document consideration of a detoxification program as part of Patient 16's treatment.

The Board further alleged that, in her treatment of Patient 16, Dr. Dahlquist had failed to obtain records of prior or concurrent medical treatment, including studies performed, and/or failed to refer the Patient 16 for additional, necessary consultations, evaluations, studies, or treatment. (St. Ex. 17A).

Medical Records for Patient 16

253. Patient 16, a thirty-four year old male, first presented to Dr. Dahlquist's office on July 21, 1998. Patient 16 complained of back pain, bilateral leg pain, and numbness in the right leg. Patient 16 stated that his pain was caused by an injury at work in May 1986. Patient 16 had undergone an L5-S1 disectomy in 1986. In 1987, he had a repeat lumbar laminectomy with disectomies at L5-S1 and repair of a cerebral spinal fluid leak. (St. Ex. 16 at 44).

Patient 16 was seeing a psychiatrist, and stated that he had heard of Dr. Dahlquist from a member of his counseling group. (St. Ex. 16 at 44).

Patient 16 reported that he had been taking Xanax, Elavil, hydrocodone, and Soma. He stated that he had taken morphine in the past with good relief of his pain. Moreover, Patient 16 advised Dr. Dahlquist that he drank six to eight beers per week and used marijuana. Patient 16 admitted that he had attended Alcoholics Anonymous meetings in the past. (St. Ex. 16 at 12, 45-46).

Dr. Dahlquist diagnosed low back pain with probable lumbar facet joint arthritis and chronic muscle strain. Dr. Dahlquist ordered an MRI scan to rule out facet disease, disc herniation, and nerve root compression. She prescribed Lorcet and noted that she would see him in one month for reevaluation. (St. Ex. 16 at 28, 47).

Patient 16 did not return to Dr. Dahlquist's office until October 16, 1998. Nevertheless, Dr. Dahlquist had continued to prescribe Lorcet in the interim. (St. Ex. 16 at 29, 50).

On October 16, 1998, Patient 16 reported that he had been taking Lorcet, four tablets per day, which decreased his pain. (St. Ex. 16 at 50).

On January 28, 1999, Dr. Dahlquist noted that Patient 16 had failed to obtain the MRI she had ordered. Dr. Dahlquist increased his Lorcet to one tablet every four to six hours. Dr. Dahlquist ordered a psychological evaluation for depression and anxiety related to chronic pain. She also ordered an MRI of the lumbar spine to rule out nerve root compression and facet disease. She noted that she would see him in one month for reevaluation. (St. Ex. 16 at 25, 26, 29, 53).

Patient 16 did not return to Dr. Dahlquist's office until April 14, 1999. Nevertheless, Dr. Dahlquist had continued to prescribe Lorcet in the interim. (St. Ex. 16 at 29, 59).

On April 14, 1999, Dr. Dahlquist noted that Patient 16 had failed to obtain the MRI she had ordered, but stated that he now had insurance and would comply. Patient 16 further advised that the Lorcet had not been working, and that he had taken a friend's Dilaudid which had been effective. Patient 16 was also taking Soma prescribed by another physician. Patient 16 asked Dr. Dahlquist to prescribe Dilaudid. Dr. Dahlquist instead prescribed ten tablets of methadone and 180 tablets of Lorcet. She reordered the MRI scan and psychological evaluation. (St. Ex. 16 at 29, 59, 61)

On April 16, 1999, two days later, Dr. Dahlquist prescribed 180 tablets of methadone and three tablets of Valium. An MRI performed April 20, 1999, revealed,

- Postoperative changes after right hemilaminectomy.
- No criteria for disc herniation.
- Slight bulging of the annulus at L5-S1.

(St. Ex. 16 at 22).

On June 17, 1999, Dr. Dahlquist administered myofascial trigger point injections. She prescribed 180 tablets of methadone, 150 tablets of Lorcet, and 60 tablets of Soma. (St. Ex. 16 at 29, 65).

On August 17, 1999, Patient 16 contacted Dr. Dahlquist's office requesting a refill of methadone. Dr. Dahlquist prescribed 180 tablets of methadone, and 150 tablets of Lorcet. (St. Ex. 16 at 29, 39).

On October 15, 1999, Patient 16 contacted Dr. Dahlquist's office requesting a refill of methadone. Dr. Dahlquist wrote the following note:

[Patient 16] received an Rx. two months ago, and he had been able to stretch it out for the past 2 months rather than using at the maximum that it was prescribed. When questioned why the patient had not come in for his visit in September, the patient stated he had been sick with the flu, and he had forgotten to call the office. I explained to him that he would need to be seen every 3 months for reevaluation if he were to continue receiving medications. Because I was concerned that the patient may go into withdrawal if he were to stop his medications abruptly, I told him that I would go ahead and renew his medications for another month, but we would need to get him in and be seen ASAP. The patient stated that he has continued to receive good relief from his oral medications. In reviewing the chart, the patient has not called in early for any medications. He has not shown any signs of abuse of the medications. He has always had reasonably good function when he has come in to see me. Office staff has been notified to schedule the patient for follow up visit as soon as possible.

(St. Ex. 16 at 40). Dr. Dahlquist prescribed 168 tablets of methadone. (St. Ex. 16 at 29).

254. Patient 16 died on October 18, 1999. On November 3, 1999, Dr. Dahlquist's office was notified that the Green county Coroner's Office was investigating his death. The Coroner's office requested his medical records. (St. Ex. 16 at 29, 41).

A postmortem report of Patient 16's death listed the primary cause of death as "Multiple drug intoxication (methadone, hydrocodone, [Soma], meprobamate and [Placidyl]." The report also documented a "[h]istory of drug and alcohol abuse" and noted alcohol in Patient 16's blood at the time of his death. (St. Ex. 21).

Dr. Shin's Testimony Regarding Patient 16

255. Dr. Shin opined that that, in her care and treatment of Patient 16, Dr. Dahlquist had departed from the minimal standards of care. (Tr. 573-574). Dr. Shin stated:

With the patient's history of alcohol abuse and the active use of marijuana and alcohol, Dr. Dahlquist should have obtained prior treatment records before proceeding with any opioid therapy. In the list of plan of treatment, a detoxification program should have been considered. The concurrent use of the opioids, benzodiazepine, anti-depressants, and meprobamate, which is a muscle relaxant, in addition to alcohol and marijuana is a dangerous mixture of drugs. A careful professional judgment should have been exercised in weighing the potential risks including an overdose and fatality before proceeding with her treatment plan. Instead of discouraging the use of opioids with other sedatives and recreational drugs, the patient was provided with an additional opioid. Although Dr. Dahlquist had carefully documented her medication dispenses as well as educating the patient with the dangers of chronic use of the opioids, she did not attempt decreasing the dose of opioids or refer the patient to detoxification

program. In treating [Patient 16], Dr. Dahlquist failed to use reasonable care discrimination in administration of medications to a patient with a history of substance abuse and she departed from the minimal standards of care.

(St. Ex. 25 at 8).

256. Dr. Shin noted that Dr. Dahlquist had prescribed Lorcet on the first visit, and had regularly increased the amount she prescribed. He further noted that on May 14, 1999, Dr. Dahlquist had written a prescription for 180 tablets of Lorcet. Dr. Shin opined that these medications were prescribed in amounts or combinations that were inappropriate. (Tr. 568-570).
257. Dr. Shin opined that the combination of opioids, benzodiazepines, and muscle relaxants that Dr. Dahlquist had prescribed to Patient 16, in light of his abuse of marijuana and alcohol, was inappropriate. Dr. Shin explained that these combinations of medications are considered central nervous system depressants and can lead to an increased state of sedation, mental status changes, respiratory depression, respiratory failure, and death. (Tr. 571-572).
258. Dr. Shin noted that Patient 16 had reported taking Dilaudid from a friend. He explained that, when a patient is receiving controlled substances from a physician, it is inappropriate for that patient to be exchanging drugs with others. Dr. Shin testified that it had been a “red flag” for drug abuse. Moreover, Dr. Shin testified that it is the physician’s responsibility to respond appropriately to the patient’s inappropriate behavior. (Tr. 570-571).

Dr. Shin opined that Dr. Dahlquist should have considered, and documented her consideration of, a detoxification program as part of the patient’s treatment. (Tr. 571-572).

259. Dr. Shin testified that Dr. Dahlquist’s records for Patient 16 do not indicate that she requested or obtained records of prior treatment. (Tr. 572).

Dr. Dahlquist’s Testimony Regarding Patient 16

260. Dr. Dahlquist testified that she had met the standards of care and treatment in her care of Patient 16. (Tr. 2032).
261. Dr. Dahlquist testified that Patient 16’s use of alcohol and marijuana had not hindered his functioning. Dr. Dahlquist asserted that Patient 16 never smelled of marijuana. Dr. Dahlquist further testified that she never received any telephone calls suggesting that Patient 16 engaged in aberrant behavior. Dr. Dahlquist added that, during the entire time that she treated Patient 16, he had never exhibited any signs of oversedation or toxic side effects. Dr. Dahlquist concluded that Patient 16 had not been actively drinking alcohol while being treated by her. (Tr. 288-289, 2007-2009, 2017-2018, 2038-2039).

262. Dr. Dahlquist explained that Patient 16's psychiatrist had never indicated to her that he disagreed with her prescribing to Patient 16. Dr. Dahlquist acknowledged, however, that she did not have any records from Patient 16's psychiatrist in her records for Patient 16. (Tr. 288-289).
263. Regarding Patient 16's admission that he had received Dilaudid from a friend, Dr. Dahlquist testified it had been an isolated incident, and that she had not seen any other signs of inappropriate drug use. (Tr. 289-291, 2018). Dr. Dahlquist added that,

any time a patient takes medication from a friend and reports that, I respect their honesty for at least telling me what happened. I do have a discussion with the patient that this is not only illegal, but is dangerous, particularly if they don't know what the friend is giving them.

(Tr. 2010-2011).

264. Dr. Dahlquist testified that, because Patient 16 had remained stable on methadone for six months, it was an indication that he had been using his medication for pain relief. She added, "If he had been just seeking it for a high, he would have become disgruntled with methadone quite quickly and wanted something else." (Tr. 2012-2014).
265. Dr. Dahlquist asserted that Patient 16 had not required a detoxification program while she was treating him. She explained,

[i]f he was going to be detoxified from something, I don't know what we would be detoxifying him from. But he did report having taken Lorcet, and he -- he did obviously have a physical condition which can cause severe intractable pain which would reasonably warrant using Lorcet. So given that the patient reported good relief with the Lorcet and the fact that it improved the quality of his life and gave him pain relief, I can't think of any reason why a patient would be sent to a detox program for that.

(Tr. 2032-2033).

266. Dr. Dahlquist conceded that the postmortem toxicology report for Patient 16 indicated a positive finding for alcohol. Dr. Dahlquist asserted that, other than alcohol, she could find nothing in the postmortem toxicology report for Patient 16 that would be unexpected considering what was being prescribed to him. (Tr. 2029-2031; St. Ex. 21).

Dr. Blatman's Testimony Regarding Patient 16

267. Dr. Blatman opined that,

The patient reported 40-50 percent improvement with medication. With this level of response, and the absence of adverse side effects or aberrant behavior, proper management would be to increase the medication, rather than wean off the medication. The patient however, was reasonably satisfied with this degree of relief, and the medication dosages remained stable throughout his treatment.

(Resp Ex. C at 20).

268. Dr. Blatman noted that Patient 16 had reported that he consumed six to eight cans of beer per week. Dr. Blatman opined that one drink of alcohol per day is not going to be a significant factor in Patient 16's care. Nevertheless, Dr. Blatman testified that it would be appropriate to counsel Patient 16 about his alcohol use. (Tr. 1213-1215).

Dr. Blatman further opined that,

While the use of marijuana is controversial, and as a street drug it is illegal, there is considerable medical literature that discusses its use in the treatment of chronic pain. Medically, it has not been shown to be dangerous, and it is not an absolute contraindication to the doctor prescribing opioid medication. Additionally, detoxification is entirely unrealistic. The physician needs the patient to be honest, and needs to establish a relationship based upon trust. When a patient privately uses marijuana synergistically with pain medication, it is not seen as harmful by the patient, and a detoxification program will fail. Medically, denying this patient appropriate medication for pain in this circumstance, is very much like denying insulin to a diabetic because the patient will not stop eating sugar, despite dietary counseling.

(Resp Ex. B at 27-29).

269. Dr. Blatman opined that Dr. Dahlquist's response to Patient 16's telephone calls indicated that Dr. Dahlquist was "on top of her game." (Tr. 1215-1216; St. Ex. 16 at 39-40).
270. Dr. Blatman concluded that it is not possible to make a reasonable inference from the postmortem report for Patient 16 that medications prescribed by Dr. Dahlquist caused or contributed to his death. (Tr. 1216-1219; St. Ex. 21).

PATIENT TESTIMONY ON BEHALF OF DR. DAHLQUIST

Susan L. Getz, R.N.

271. Susan L. Getz, R.N., testified at hearing on behalf of Dr. Dahlquist. Ms. Getz testified that she has been a patient of Dr. Dahlquist since July or August 1996. (Tr. 1396-1403).

Ms. Getz testified that she had been injured while on active duty on the USNS Mercy in the Persian Gulf where she served from January through April 1991. Ms. Getz explained that she had suffered with a dislocated shoulder, a broken fibula, and bone chips her ankle. The injuries required repeated surgical repair, and the nerve in her ankle was permanently damaged. Ms. Getz testified that she had been in constant pain. She stated that she was later diagnosed with RSD. Ms. Getz guessed that she has had between thirty and forty surgeries. Ms. Getz testified that she had had at various times epidurals with morphine and Demerol and Fentanyl. She has also taken Robaxin and Orudis, and increasing doses of Vicodin. She added that she had taken Phrenilin as well as other medications for pain. Ms. Getz testified that she finally found Dr. Dahlquist. (Tr. 1399-1406, 1411, 1421-1422, 1425-1429, 1444-1445).

Ms. Getz testified that at the time of hearing she was taking MS Contin, Oruvail, Robaxin, Skelaxin on a regular schedule. She added that "when things get really, really bad," she also takes Baclofen. Ms. Getz continued that she is on morphine injections at night as well as Demerol. (Tr. 1411, 1421-1422).

272. Ms. Getz testified that when you go into Dr. Dahlquist's office, you fill out a form that asks you how often you're taking your medications and what you're taking. Ms. Getz added that Dr. Dahlquist reviews that with you and goes over any current problems. Ms. Getz testified that Dr. Dahlquist has never simply given her a new prescription and sent her out the door. She elaborated that Dr. Dahlquist always talks with her during a visit. (Tr. 1412-1413, 1421-1425).

Ms. Getz testified that she sees Dr. Dahlquist two or three times per week. Ms. Getz testified that in addition to the blocks Dr. Dahlquist has provided her with epidurals, trigger point injections, a spinal cord stimulator. Patient Getz noted that the spinal cord stimulator had to be removed due to an allergy but that the trigger point injections had made her headaches bearable for periods of three to five weeks and sometimes longer. (Tr. 1417-1420).

273. Dr. Dahlquist testified that she had become aware that Ms. Getz had been refused pain medication by the VA because she had been labeled a drug seeker. She explained that Ms. Getz had mentioned this to her. Dr. Dahlquist commented that, as far as she knows, the VA physician is the only physician who had ever labeled Ms. Getz a drug seeker. (Tr. 2127-2128).

Dr. Dahlquist testified that Ms. Getz' testimony that she would lay in bed at a hospital and just scream until they gave her meds concerned her because Ms. Getz' pain was not being managed adequately. Dr. Dahlquist observed that Ms. Getz never demonstrated that kind of behavior to her. She added that Ms. Getz has "never appeared histrionic in any way to me since I've cared for her." Dr. Dahlquist testified that Ms. Getz is not currently receiving mental health care. (Tr. 2128-2129).

Sajona M. Weaver

274. Sajona M. Weaver, testified at hearing on behalf of Dr. Dahlquist. Ms. Weaver testified that she is a patient of Dr. Dahlquist. She further testified that she had been treated by Dr. Dahlquist for about two years. Ms. Weaver testified that she works two days per week as an instructor at Sinclair Community College. (Tr. 1445-1452).

Ms. Weaver testified that she had first gone to see Dr. Dahlquist because of pain in her back which had rendered her nonfunctional. She added that she had been diagnosed with fibromyalgia and osteoporosis. (Tr. 1449-1452).

Regarding the treatment she had received from Dr. Dahlquist and the effect of that treatment on her everyday life, Ms. Weaver commented:

She actually introduced me to target point injections, which no one else had ever offered. And I was really kind of afraid to have it done. But with her guidance and explaining how this worked and giving me the freedom to make a choice, I felt good about it and tried it. And, by golly, it worked.

It was the first time in years that I had truly been able to walk straight, to have some relief, to not walk around the house crying. If it hadn't been for her at the time I went to see her, I don't know what I'd be like today, I really don't. That's how much I -- I appreciate what she's done for me.

(Tr. 1454-1456).

Ms. Weaver testified that when she visits Dr. Dahlquist's office she spends time talking with Dr. Dahlquist. Ms. Weaver testified that she currently takes Dilaudid and Vicodin every day. Ms. Weaver opined that Dr. Dahlquist has a very good monitoring program which has included random urine screens and pill counts. (Tr. 1456-1459).

275. When asked what would happen to her without Dr. Dahlquist's treatment, Ms. Weaver asserted:

I probably would go back to a -- to the way I used to be and probably worse. I don't believe that I can find another pain management physician. I mean, I spent a long time looking for one. The other one that I went to didn't help me. I need someone to help me regulate my intake of -- of the pain medication and I trust her with that.

(Tr. 1459-1460).

Patient C, D.O.

276. Patient C, D.O., testified at hearing on behalf of Dr. Dahlquist. Patient C testified that he had graduated from the West Virginia School of Osteopathic Medicine. He stated that he had moved to Dayton to enter a neurosurgery residency, but that he had not completed his residency. Thereafter, he practiced family and rehabilitation medicine in the Dayton area until 1996, when he was forced to retire for health reasons. (1469-1473, 1493-1494).

277. Patient C testified that he has congenital spinal stenosis and had had emergency surgery in 1992 after herniating three discs and occluding the spinal cord. The surgery consisted of “a total decompression laminectomy, three levels, from T12 through L3.” (Tr. 1474).

Patient C testified that after his initial surgery he had returned to work and had done fairly well until he “herniated out three more discs.” Patient C explained that he has severe degenerative disc disease. Consequent to a second surgery in 1994, he had severe problems including a staph infection in his spinal cord. A third surgery ensued and he returned to work until herniating another disc in 1995. Patient C elaborated that he had undergone four major spine surgeries and that “the cover of the cord” had been cut during an operation in 1995. As a result of spinal regression and spasms which could not be corrected surgically, he had retired. (Tr. 1469-1474).

278. Patient C testified that he had first seen Dr. Dahlquist after he had been seen at the Mayo Clinic and the Cleveland Clinic Foundation. Patient C testified that his condition had continued to worsen and the only thing he was being offered was large quantities of oral pain medication to control pain. Patient C testified that he had been prescribed opioids including morphine, Vicodin, and OxyContin for pain prior to seeing Dr. Dahlquist. Patient C testified that the quantity of these drugs necessary to control his pain had turned him into a “zombie.” Patient C asserted that he had concluded that he “just couldn’t live that way” so he sought other options. Patient C testified that he had had a spinal stimulator placed and that, subsequently, he had developed RSD. Shortly thereafter, Patient C had been referred to Dr. Dahlquist. (1475-1478).

Patient C further testified that at the time he had first seen Dr. Dahlquist he still had the spinal stimulator in place. However, it was not providing any relief for his RSD. Patient C testified that, subsequent to her evaluation, Dr. Dahlquist had implanted a pump and that it had been “a godsend” to him. Patient C added that he takes Baclofen to control spasms, and bupivacaine and Dilaudid for pain. Patient C testified that he also takes MSIR and MS Contin for breakthrough pain. Patient C explained that he has pain every waking moment which becomes much worse at night. (1478-1483).

279. Patient C testified that he does not consider himself a drug seeker. Patient C opined that many physicians do not handle pain, do not treat pain, and are not qualified to treat pain. He asserted that he had been many places seeking relief, not drugs. (Tr. 1482-1483).

IMPROVEMENTS TO DR. DAHLQUIST'S PRACTICE.

280. Dr. Dahlquist testified that, in response to this hearing, she has hired another person in her office to work on "compliance." She explained that this means "making sure that we do have pertinent medical records on every single patient and that nothing slips through the cracks. And that person also works with us on compliance regarding urine screens and any signs of aberrant behavior." Dr. Dahlquist further testified that her patient charts now have a new section for patient compliance that makes it more convenient to look down a single list and see what signs of aberrant behavior, if any, the patient has demonstrated throughout the course of treatment. (Tr. 1591-1592, 2064).

FINDINGS OF FACT

1. In the course of her treatment of Patients 1 through 16, Glenda M. Dahlquist, M.D., prescribed medications in types, amounts and/or combinations that were inappropriate and/or for protracted periods of time that were not justified. Examples of Dr. Dahlquist's inappropriate prescribing include, but are not limited to, the following:
 - a. Dr. Dahlquist prescribed various opioids to Patients 1, 3, 4, 10, 12, and 15, on a protracted basis and frequently in high or escalating doses, although the patient's diagnosis and/or condition did not justify such prescribing.
 - b. Dr. Dahlquist prescribed high doses of opioids and benzodiazepines to Patient 2, who was a chronic smoker and had a history of emphysema, despite the unacceptable risk of cardiopulmonary failure.
 - c. Dr. Dahlquist prescribed a combination of medications including opioids, anti-depressants, anxiolytics, and benzodiazepines to Patient 10, without attempting to identify Patient 10's declining function and increased sedation, and despite the risk of respiratory depression.
 - d. Dr. Dahlquist concurrently prescribed multiple types of opioids to Patient 11 without medical justification for such prescribing. In addition, Dr. Dahlquist prescribed escalating doses of opioids although Patient 11 failed to demonstrate objective improvement and despite signs of possible drug abuse.
2. In her treatment of Patients 2, 3, 4, 6, 10, 12 and 14, Dr. Dahlquist inappropriately administered injections or blocks including, but not limited to, the following:
 - a. On approximately sixteen occasions, Dr. Dahlquist administered Depo-Medrol trigger point injections to Patient 2, who had compromised respiratory functions due to

- emphysema and a history of congestive heart failure, despite the increased risk of congestive heart failure and pulmonary edema. In addition, on approximately twenty-five occasions, Dr. Dahlquist administered Toradol injections to Patient 2 rather than an oral anti-inflammatory, despite the risk of gastrointestinal bleeding.
- b. Dr. Dahlquist administered Toradol injections to Patient 3 on approximately thirty-five occasions although the injections were contraindicated due to Patient 3's history of peptic ulcer disease and duodenitis. Dr. Dahlquist also administered corticosteroid injections to Patient 3 on approximately thirty-five occasions despite the risks of steroid dependency, adrenal suppression, hyperglycemia, and fluid retention.
 - c. Dr. Dahlquist continued to administer lumbar epidural blocks to Patient 6 on a regular basis over a period of more than three years although the blocks were not clearly providing Patient 6 with adequate long-term pain relief.
 - d. Dr. Dahlquist administered multiple trigger point injections using a corticosteroid to Patient 10 on approximately fifty-six occasions over a period of almost five years although Patient 10 was not responding significantly to the injections and although frequently injecting corticosteroids into the same area can cause skin irritation, muscle wasting and sloughing, and can increase pain.
 - e. There is insufficient evidence in the record to find specifically that Dr. Dahlquist administered epidural injections to Patient 14 although the injections were contraindicated since Patient 14 was on an anticoagulant, Coumadin, at the time the injections were given. However, there is sufficient evidence for the general finding that in her treatment of Patient 14, Dr. Dahlquist inappropriately administered injections or blocks.
3. In her treatment of Patients 3, 4, 11, 15 and 16, Dr. Dahlquist failed to adequately recognize and/or address indications of drug abuse or the increased risk of drug abuse. Examples of such failure include, but are not limited to, the following:
- a. Although Patient 4 had a history of alcohol abuse and detoxification, Dr. Dahlquist prescribed increasing doses of opioids. Moreover, Dr. Dahlquist failed to order a toxicology screen or to document consideration of a detoxification program as part of Patient 4's treatment plan.
 - b. Dr. Dahlquist continued to prescribe to Patient 15 escalating doses of medications, including opioids and psychoactive drugs, despite the facts that Patient 15 requested early refills of medications on several occasions; her records indicate that Patient 15 was a possible drug seeker who had had rehabilitation in the past; Patient 15's toxicology screen indicated that the patient was not taking her prescribed medications; and the patient went through detoxification in a hospital.

- c. Although Patient 16 had a history of alcohol abuse and continued to use marijuana and alcohol, Dr. Dahlquist continued to prescribe various medications, including opioids, benzodiazepines, and muscle relaxants, to Patient 16. In addition, Dr. Dahlquist failed to document consideration of a detoxification program as part of the patient's treatment.
4. In her treatment of Patients 1, 3, 4, 6, 8 and 10, Dr. Dahlquist failed to identify a reasonable pain diagnosis or differential pain diagnosis and/or to clarify or confirm the diagnosis and/or identify the organic cause, mechanism, or source of the patients' pain.
5. In her treatment of Patients 5, 6, 7, 9, 11, 14, and 16, Dr. Dahlquist failed to obtain records of prior or concurrent medical treatment, including studies performed, and/or failed to refer the patient for additional, necessary consultations, evaluations, studies or treatment. Examples of such failures include, but are not limited to, the following:
 - a. Although Patient 5's pain had not been relieved by high doses of opioids and other procedures offered by Dr. Dahlquist, and despite the possibility of psychological factors in this case, Dr. Dahlquist failed to refer Patient 5 to a tertiary pain center with an inpatient pain rehabilitation and detoxification program for treatment.
 - b. Dr. Dahlquist failed to obtain appropriate neurological studies, such as a Magnetic Resonance Imaging, an electromyographic study, and/or a nerve conduction study, for Patient 6.
 - c. Dr. Dahlquist failed to obtain a neurological consult, or records of a prior neurological consult, for Patient 7.
 - d. Although Patient 9 reported being hospitalized for three weeks and on life support for four days due to a severe sickle cell crisis, Dr. Dahlquist failed to obtain any medical records regarding the hospitalization.
 - e. Dr. Dahlquist failed to obtain copies of appropriate prior medical records for Patients 14 and 16.
6. In her treatment of Patients 12, 13, and 15, although the patients' medical records contained results of toxicology screens indicating that the patients were not taking their prescribed medications as directed by her, Dr. Dahlquist failed to appropriately reflect these results in her office notes and/or to document in the patients' records consideration of these toxicology screens in formulating the patients' treatment plan.
7. In her treatment of Patients 5 and 6, Dr. Dahlquist failed to appropriately consider and/or address whether psychological factors were affecting the patients' pain.

8. Although she prescribed medications containing acetaminophen on a protracted basis to Patient 3 who had prior elevated liver function enzymes and a history of alcohol abuse and to Patient 2, Dr. Dahlquist failed to obtain and/or document appropriate liver function studies.
9. In her care of Patient 1, Dr. Dahlquist failed to include the findings of outside specialists, including normal upper GI studies and normal sigmoidoscopy findings, in her office notes.
10. In her treatment of Patient 2, Dr. Dahlquist failed to inform the patient and/or to document having informed the patient, of her increased risk of cardiopulmonary failure due to the high doses of opioids, benzodiazepines, and corticosteroids Dr. Dahlquist provided. Dr. Dahlquist also failed to prescribe anti-depressants to Patient 2 or to refer Patient 2 to a specialist, despite indications of depression.
11. In her treatment of Patient 11, Dr. Dahlquist continued to use Matrix electroceutical therapy although this treatment modality provided only temporary pain relief.

CONCLUSIONS OF LAW

1. The conduct of Glenda M. Dahlquist, M.D., as described in the Findings of Fact, constitutes “[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established,” as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.
2. The conduct of Dr. Dahlquist, occurring on or after March 9, 1999, as alleged in Findings of Fact 1 and 2, constitutes “[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease,” as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code, as in effect on and after March 9, 1999.
3. The conduct of Dr. Dahlquist, occurring prior to March 9, 1999, as alleged in Findings of Fact 1 and 2, constitutes “[f]ailure to use reasonable care discrimination in the administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease,” as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code, as in effect prior to March 9, 1999.

* * * * *

At hearing, Dr. Dahlquist argued that the heart of this matter is the controversy regarding the use of controlled substances to treat chronic pain. Nevertheless, the provision of safe and effective care for chronic pain should be the true objective. In this matter, Dr. Dahlquist demonstrated reckless and unjustifiable disregard of patients’ obvious drug seeking behavior, alcohol and drug abuse, depression, and suicidal tendencies. She further disregarded the advice and concerns of

consultants and family members. In addition, Dr. Dahlquist prescribed depressant medications in amounts that could have had, and may have had, disastrous effects.

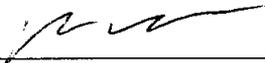
It is difficult to imagine that any physician could fail to recognize the inherent dangers in Dr. Dahlquist's treatment of Patients 1 through 16. Nevertheless, even at hearing, Dr. Dahlquist argued that her care of these patients had been appropriate. Dr. Dahlquist's failure to comprehend the egregiousness of her conduct suggests that Dr. Dahlquist is not amenable to reeducation.

PROPOSED ORDER

It is hereby ORDERED that:

The certificate of Glenda M. Dahlquist, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

This Order shall become effective immediately upon the mailing of notification of approval by the Board.



Daniel J. Roberts
Hearing Examiner



State Medical Board of Ohio

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EXCERPT FROM THE DRAFT MINUTES OF JANUARY 14, 2004

REPORTS AND RECOMMENDATIONS

Ms. Sloan announced that the Board would now consider the findings and orders appearing on the Board's agenda. She asked whether each member of the Board had received, read, and considered the hearing record, the proposed findings, conclusions, and order, and any objections filed in the matters of: Mark L. Allen, M.D.; Glenda M. Dahlquist, M.D.; Joseph W. Fischkelta, P.A.; Timothy A. Gooden, M.D.; Richard W. Liss, M.D.; Larry John Little, M.D.; and Geoffrey D. Snyder, M.D. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye
	Ms. Sloan	- aye

Ms. Sloan asked whether each member of the Board understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye

Dr. Robbins	- aye
Dr. Garg	- aye
Dr. Steinbergh	- aye
Ms. Sloan	- aye

Ms. Sloan noted that, in accordance with the provision in Section 4731.22(F)(2), Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of these matters.

Ms. Sloan stated that if there were no objections, the Chair would dispense with the reading of the proposed findings of fact, conclusions and orders in the above matters. No objections were voiced by Board members present.

The original Reports and Recommendations shall be maintained in the exhibits section of this Journal.

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GLEND A M. DAHLQUIST, M.D.

Ms. Sloan directed the Board's attention to the matter of Glenda M. Dahlquist, M.D. She advised that objections were filed to Hearing Examiner Roberts' Report and Recommendation and were previously distributed to Board members. She noted that Dr. Kumar will abstain from discussion and voting on this case.

Ms. Sloan continued that a request to address the Board has been timely filed on behalf of Dr. Dahlquist. Five minutes would be allowed for that address.

Dr. Dahlquist was accompanied by her attorney, Neil F. Freund.

Dr. Dahlquist at this time reviewed her education, training and practice history, as outlined in paragraph 1 of the Hearing Examiner's Report and Recommendation, with the Board, adding that she has done 100 percent chronic pain management since 1994. Dr. Dahlquist noted that this is the first time she's appeared before the Board for any complaint, at least of which she is aware. She has had three malpractice cases in the past thirteen years. Two were voluntarily dropped by the patients, without any money for settlement. The third one is still pending. She doesn't have a criminal record.

Dr. Dahlquist stated that during the past thirteen years she has always tried to practice the best medicine she could. She's tried to be a good doctor to her patients. Her patients have always been foremost in her attempts to at least try to provide effective pain management to improve the quality and function of the patients' lives while at the same time monitoring the patients at regular intervals for problems that might occur from side effects from the medications that she has prescribed, or problems that might occur from the

patients misusing their medications in any way.

Dr. Dahlquist stated that, probably, the most challenging thing that pain management physicians face is trying to sort out which patients are legitimate patients who are not going to abuse their medications and which patients are prone to abusing their medications. Dr. Dahlquist stated that she believes that she's done her best to sort that out at all times. She does continue to attend medical education seminars. She attended a seminar in New York that was dedicated just to challenges with pain management and chemical dependency. Each year she modifies her practice based on things she learns at medical education seminars. Dr. Dahlquist stated that she feels that she has been responsive to patients when issues come up in their individual lives. Each patient is treated as an individual.

Dr. Dahlquist stated that the thing she found most disturbing about the Hearing Examiner's Report and Recommendation was that he felt that she wouldn't be open to education. Dr. Dahlquist believes there is ample evidence in the testimony that she does continue to go to educational seminars and modify her practice based on that.

Dr. Dahlquist continued that, regarding the issue of increasing dosages of medications, she treats each patient on an individual basis. If a patient develops tolerance to a medication, it may be appropriate to increase the dose. She stated that, without going into details, she feels that her record substantially shows that there was a reason she increased medications for patients each time that she did so. Apparently, the Hearing Examiner felt that her records weren't necessarily complete, in every case, regarding referral physician information that was actually on the chart, but she has done her best to communicate with referring physicians and with consultants. She admitted that her records aren't always perfect, but she has always tried to provide the best patient care she could, and even the State's expert, Dr. Shin, brought out the fact that he thought her records overall were quite good, as far as the documentation.

Ms. Sloan advised that Dr. Dahlquist has one more minute to conclude her statement.

Dr. Dahlquist stated that she hopes that the Board, in looking over the information submitted to this point, will see that there is documentation in the charts, that she has provided medical care within the standard of care and that she is open to education. If the Board feels that she needs reeducation, she's open to that. Dr. Dahlquist asked that the Board reconsider the permanent revocation of her license because she doesn't feel that she's provided care that would require permanent revocation of her license. She asked that, if the Board does decide to sanction her by suspending or revoking her license, in the interest of her patients, the Board allow her 30 to 60 days to find referral sources for the patients so that she can provide continuity of care for them.

Ms. Sloan asked whether the Assistant Attorney General wished to respond.

Ms. Albers stated that, in the case before the Board, the Hearing Examiner set forth very detailed information from the patient records, as well as detailed explanations of Dr. Dahlquist's testimony, her expert witness' testimony and the state's expert witness, Dr. Shin. Ms. Albers stated that she believes that

the record in this case clearly shows excessive and long periods of prescribing multiple medications for patients. She referred to Patient 1, who had, at one time, been prescribed Prevacid, Duragesic patches, Roxanol, Soma, Darvocet, Vicodin, Xanax, MS Contin and Phenergan. The last record for this patient showed that the patient was on Roxanol 20 mg per cc, two four-ounce bottles every five days. This kind of prescribing is repeated on and on and on throughout the records.

Ms. Albers stated that another disturbing matter in this case is the multiple injections and lumbar blocks that were administered. She stated that it is her understanding from the expert testimony that these blocks are administered so that the doses of opioid medications can be reduced. When you review the records in this case, that didn't happen. These patients received increasing doses of medications while also receiving these multiple trigger point injections and lumbar blocks.

Ms. Albers continued that the records are also full of what Dr. Shin called "red flags" of instances of drug-seeking behavior. There were patients calling for early refills on scripts, and patients reporting medications lost or stolen. Ms. Albers stated that the most egregious case involved one patient who said that her car had been broken into, \$1,200 in cash stolen along with her medication, but that she had not called the police because she had been parked illegally and didn't want to get a ticket. Dr. Dahlquist refilled her scripts. There are multiple occasions of such cases. Clearly Dr. Dahlquist is either not able to recognize drug-seeking behavior, or she so believes that these people are in pain that she continues to refill medications when the patients are showing these types of behavior.

Ms. Albers stated that she strongly agrees with the Report and Recommendation. She added that she believes that Dr. Dahlquist's inability to recognize the problems in her practice shows that she is not amenable to re-education. The fact that she goes to pain symposiums and takes continuing education does not argue against that fact. There are definite deficiencies in Dr. Dahlquist's practice that the Hearing Examiner did not believe could be fixed by re-education. Ms. Albers spoke in support of the permanent revocation of Dr. Dahlquist's license.

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MR. ROBERTS' PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF GLENDA M. DAHLQUIST, M.D. DR. ROBBINS SECONDED THE MOTION.

Ms. Sloan stated that she would now entertain discussion in the above matter.

Dr. Steinbergh stated that this was a very large case and was very detail oriented. The treatment of chronic, intractable benign pain is very difficult, and she takes her hat off to those in the medical profession who focus on this field. Dr. Steinbergh commented that, no matter what field of medicine one chooses, a physician is obligated to be as knowledgeable as possible about the ability to diagnose, treatment choices, medications being prescribed, interactions of pharmaceuticals in the human body, and understanding the patient's total needs in the quest for pain control and improved health.

Dr. Steinbergh stated that, in reviewing Dr. Dahlquist's case extensively, she finds fault in every case,

some worse than others. Dr. Dahlquist's ability to properly diagnose was compromised by her lack of review of previous medical records on many of these patients. She often continued to prescribe without proper assessment. Her treatment choices were sometimes appropriate, but the inappropriate treatments were dangerous to patients' health. The medications, although very often necessary for pain management, were used in combinations that would cause patients to be potentially addicted, and, in fact, were addicted.

Dr. Steinbergh continued that, without realizing the dangerous combinations and escalating use in many of these patients, Dr. Dahlquist failed to meet the needs of patients regarding their general health. Dr. Dahlquist often caused potential harm, and did, in fact, cause serious harm to patients. She failed to recognize the seriousness of abuse, and she failed to refer for addiction therapy. She failed to properly manage these cases.

Dr. Steinbergh stated that, in her mind, Dr. Dahlquist used the moniker of "pain management specialist" to recklessly prescribe narcotics to the patients the Board reviewed, and Dr. Dahlquist fails to recognize her errors. Prescribing for chronic benign pain is a science and an art to be sure. Dr. Dahlquist has not met appropriate standards of care. Dr. Steinbergh stated that she concurs with the Proposed Order.

Dr. Steinbergh stated that she believes it is important that the Board encourage the appropriate management of chronic pain and make physicians aware that all modalities and pharmaceuticals may be used by law. She added, however, that physicians must be guided by the very basic medical standards of appropriate history taking, thorough examination as it pertains to each case, the wise choice of pharmaceuticals, alternative treatment options and consulting with other specialists, if needed, and to be thorough in the approach to each patient in order to maintain good health as the physician relieves their pain.

Dr. Egner stated that Dr. Steinbergh gave an excellent presentation, and she agrees with everything that Dr. Steinbergh said. She noted that there were multiple episodes in this case of Dr. Dahlquist not looking for an organic cause for the pain. Dr. Dahlquist's rationale seemed to be that that had been done by other people and therefore she didn't need to do that. By the time the patients came to her, those avenues were exhausted. Dr. Egner stated that she doesn't think that such tests and evaluations are ever exhausted. Some patients developed new symptoms and new complaints of pain, and yet there was not any testing done to look for the cause of that pain. They were just given more and more pain medication.

Dr. Egner stated that, in the case of Patient 5, there was obvious drug seeking behavior. This patient even sold drugs to an undercover police officer. Dr. Dahlquist was aware of that episode, yet she did not take any future measures to monitor that patient's pain medications with drug screens or to limit the number of prescriptions that that patient was given.

Dr. Egner remarked that there is no evidence in the record that Dr. Dahlquist's style of practice changed at all over a long period of time. That is what she looked for in this case. It was a long, arduous case with so many egregious errors, and yet she looks at Dr. Dahlquist and sees a young physician, practicing a very difficult specialty. She has to ask herself whether permanent revocation is the only answer the Board can

come up with in view of the fact that it is such a serious outcome for Dr. Dahlquist. Dr. Egner stated that, unfortunately, she doesn't see an alternative. Even in her objections, Dr. Dahlquist claims that she did not deviate from the minimal standards of care, but she did deviate from those standards. She reiterates her expertise in pain management and totally disqualifies what the State's expert says. Dr. Dahlquist says that Dr. Shin is unfamiliar with the medical records and with current research and techniques. Dr. Egner stated that that is just the opposite of what she has come away with. Dr. Egner stated that, unfortunately, she doesn't see that there is remediation or change in Dr. Dahlquist's future. She added that she feels very bad about saying that because she believes that Dr. Dahlquist does care about her patients, but she does not feel that Dr. Dahlquist takes care of them as a responsible physician would.

Mr. Browning agreed with Dr. Egner. He stated that he doesn't think that there was intent to harm patients, but it's amazing after going through all of this that Dr. Dahlquist doesn't understand that instead of helping, she was hurting the patients. That is so fundamental in what the Board does in protecting the public, it's hard to ignore when looking for an alternative to permanent revocation. He stated that he wishes that that were not the only choice the Board has because the State needs physicians working in this area; and, yet, it's awfully tough to look in a different direction for an alternative in this case.

Dr. Buchan concurred. The issues for him are that Dr. Dahlquist failed to accurately diagnose the etiology of the patient's pain time and time again. He stated that he couldn't find that there was any differential pain diagnoses being discussed in this process.

Dr. Buchan stated that the second thought he was taken by was that Dr. Dahlquist failed to provide pain control despite the escalating amounts of medicine that she was prescribing, not only with opioid treatment but with polypharmacy treatments. She failed miserably on both counts. Dr. Buchan stated that, in reviewing each case, he had concerns about every one, between the numbers of injections to Patient 3, who, on March 22, received 90 tablets of Soma in addition to Darvocet. The patient called thirteen days later and had already refilled the Soma prescription, but there were only 50 left. At that point, Dr. Dahlquist refilled the prescriptions again.

Dr. Buchan noted that Patient 15 had been admitted for overdosing and had three different hospitalizations. Dr. Buchan stated that he was impressed with Dr. Dahlquist's conversation about this overdosing situation and the contract to which the patient agreed, and he thought that there was good discussion. However, two months later, Dr. Dahlquist prescribed 60 Vicodin. Four days later she prescribed 60 Percocet. In August she started prescribing Oxycontin in addition to the Percocet.

Dr. Buchan stated that, although he believes Dr. Dahlquist had good training, he could not find a way to salvage this physician. He does agree with the Proposed Order, as written.

Dr. Davidson stated that this is probably the hardest case she has seen in her tenure on the Board. A lot of work went into this case. It's obviously been a long, drawn-out proceeding. Dr. Davidson stated that she was interested in several things in the objections submitted by Dr. Dahlquist. She took issue with their maligning of Dr. Shin for not being certified by the American Board of Pain Medicine. Dr. Davidson

stated that the American Board of Pain Medicine is not an ABMS certified body. People eligible for that are certified by other Boards that are ABMS certified bodies, such as their expert, Dr. Blatman, who came in by another route, not the more traditional pain medicine certifying route.

Dr. Davidson stated that she did find some solace in the objections about changes that Dr. Dahlquist has made. They outline things like patient contracts, urine specimens, and it seems that there were changes made. Can the Board take that as acknowledgement on Dr. Dahlquist's part that she was wrong before and there is room for improvement and that she can take steps? Dr. Davidson stated that she would like to think so.

Dr. Davidson continued that, over and over, she was left with the question of motive. That was not addressed in the record. Was this just sloppy care? Was this a physician overwhelmed by pain patients that the Board knows are out there looking for care? Or was she greedy, working 24 hours a day, 7 days a week, seeing these patients and making lots and lots of money? Dr. Davidson stated that she doesn't know the answers to any of those questions.

Dr. Davidson commented that Board members have said that the treatment of intractable pain is very, very difficult. Physicians have come to find that a multi-disciplinary team approach is clearly the best way to go, if, for no other reason, than you have multiple sets of eyes, multiple sets of opinions, multiple different backgrounds and expertise coming around each pain patient. Dr. Davidson stated that she believes that that is the standard of care right now, and certainly that's not where Dr. Dahlquist was. She was out there, a solo practitioner on her own, over and over not referring, not even, as far as recordkeeping, acknowledging the consultation and the referrals of others or the input she was getting from other physicians about these patients. Instead of being part of the solution of pain treatment for patients with intractable pain, Dr. Davidson ended up feeling that Dr. Dahlquist was part of the problem.

Dr. Davidson stated that in the cases of permanent revocation that the Board has taken before, she has always felt that the physician was almost never on course. If you looked back at their record you could see multiple cases of criminal intent, bad decision-making, and any number of excuses. But those physicians were never on course. However, she believes that Dr. Dahlquist was on course for many years throughout her training and the early years of her practice. Clearly, Dr. Dahlquist has veered off course. Dr. Davidson stated that she would like to argue that permanent revocation is not the only option. She would like to see Dr. Dahlquist get the opportunity to remediate. This would be with a lot of supervision and with some suspension time out, possibly quite a long suspension period. Dr. Dahlquist really has to get away from the practice that she had that was clearly a failure. Five of the 16 patients reviewed died. Does that go to say that these are patients who are on a lethal track no matter what you do? The Board isn't saying that Dr. Dahlquist was the cause of their deaths, but this was a failing practice. Dr. Dahlquist needs to get away from it, needs to take stock, and is, perhaps, remediable in Dr. Davidson's eyes.

Dr. Steinbergh stated that she has concerns about that argument. Dr. Dahlquist has clearly done substantial harm. In some cases where the Board does consider remediation, the Board feels that it's strictly an educational piece for physicians who have been out of practice for a long time, or have been isolated and

perhaps didn't understand ramifications. In this particular case, the amount of narcotics prescribed, the combinations, and the danger that Dr. Dahlquist presented to her patients was so overwhelming.

Dr. Steinbergh added that she does agree that Dr. Dahlquist does need some time to wind down her practice. In considering whether 30 days or 60 days would be appropriate, Dr. Steinbergh stated that she does not want Dr. Dahlquist out there very long because she doesn't want Dr. Dahlquist to continue to prescribe the way she's been prescribing. Dr. Steinbergh indicated that she believes that 30 days is an appropriate period for Dr. Dahlquist to wind down her practice and arrange for patient care. She doesn't see remediation for Dr. Dahlquist. She understands that Dr. Dahlquist is a young physician and it's a shame, but the amount of patient harm done overwhelmingly convinces her that this needs to be a permanent revocation.

DR. STEINBERGH MOVED TO AMEND THE PROPOSED ORDER TO GO INTO EFFECT 30 DAYS FROM THE DATE OF MAILING THE ORDER IN ORDER TO ALLOW DR. DAHLQUIST TIME TO WIND DOWN HER PRACTICE AND TO REFER HER PATIENTS TO OTHER PHYSICIANS. DR. EGNER SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- abstain
	Mr. Browning	- aye
	Dr. Davidson	- abstain
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye

The motion carried.

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MR. ROBERTS' PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER, AS AMENDED, IN THE MATTER OF GLENDA M. DAHLQUIST, M.D. DR. ROBBINS SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- abstain
	Mr. Browning	- aye

EXCERPT FROM THE DRAFT MINUTES OF JANUARY 14, 2004
IN THE MATTER OF GLENDA M. DAHLQUIST, M.D

Page 9

Dr. Davidson	- nay
Dr. Robbins	- aye
Dr. Garg	- abstain
Dr. Steinbergh	- aye

The motion carried.



State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.state.oh.us/med/

February 13, 2002

Glenda M. Dahlquist, M.D.
845 London Ct
Springboro, OH 45066

Dear Doctor Dahlquist:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery, or to reprimand or place you on probation for one or more of the following reasons:

- (1) In the routine course of your practice, you undertook the treatment of Patients 1-16 (as identified on the attached Patient Key--Key confidential to be withheld from public disclosure).
- (2) In your treatment of Patients 1 through 16, you prescribed medications in types, amounts and/or combinations that were inappropriate and/or for protracted periods of time that were not justified. Examples of such prescribing include, but are not limited to, the following:
 - (A) You prescribed various opioids to Patients 1, 3, 4, 10, 12 and 15, on a protracted basis and frequently in high or escalating doses, although the patient's diagnosis and/or condition did not justify such prescribing;
 - (B) You prescribed high doses of opioids and benzodiazepines to Patient 2, who was a chronic smoker and had a history of emphysema, despite the unacceptable risk of cardiopulmonary failure;
 - (C) You prescribed to Patient 10 a combination of medications including opioids, anti-depressants, anxiolytics and benzodiazepines, without attempting to identify the reason for this patient's declining function and increased sedation, and despite the risk of respiratory depression; and
 - (D) In your treatment of Patient 11, you concurrently prescribed multiple types of opioids without medical justification for such prescribing. In addition, you prescribed escalating doses of opioids although Patient 11 failed to demonstrate objective improvement and despite signs of possible drug abuse.

Mailed 2-14-02

- (3) In your treatment of Patients 2, 3, 4, 6, 10, 12 and 14, you inappropriately administered injections or blocks. Examples of such inappropriate injections or blocks include, but are not limited to, the following:
 - (A) On approximately 16 occasions, you administered Depo-Medrol trigger point injections to Patient 2, who had compromised respiratory functions due to emphysema and a history of congestive heart failure, despite the increased risk of congestive heart failure and pulmonary edema. In addition, on approximately 25 occasions, you administered Toradol injections to Patient 2, rather than an oral anti-inflammatory, and despite the risk of GI bleeding;
 - (B) You administered Toradol injections to Patient 3 on approximately 35 occasions although the injections were contraindicated due to Patient 3's history of peptic ulcer disease and duodenitis. You also administered corticosteroid injections to Patient 3 on approximately 35 occasions despite the risks of steroid dependency, adrenal suppression, hyperglycemia, and fluid retention;
 - (C) You continued to administer lumbar epidural blocks to Patient 6 on a regular basis over a period of more than three years although the blocks were not clearly providing Patient 6 with adequate long-term pain relief;
 - (D) You administered multiple trigger point injections using a corticosteroid to Patient 10 on approximately 56 occasions over a period of almost five years although Patient 10 was not responding significantly to the injections and although frequently injecting corticosteroids into the same area can cause skin irritation, muscle wasting and sloughing, and can increase pain; and
 - (E) You administered epidural injections to Patient 14 although the injections were contraindicated since Patient 14 was on an anticoagulant, Coumadin.

- (4) In your treatment of Patients 3, 4, 11, 15 and 16, you failed to adequately recognize and/or address indications of drug abuse or the increased risk of drug abuse. Examples of such failures include, but are not limited to, the following:
 - (A) Although Patient 4 had a history of alcohol abuse and detoxification, you prescribed increasing doses of opioids to the patient and you failed to order a toxicology screen or to document consideration of a detoxification program as part of the patient's treatment;
 - (B) You continued to prescribe to Patient 15 escalating doses of medications, including opioids and psychoactive drugs, despite the fact that Patient 15 requested early refills of medications on several occasions; your records indicate that Patient 15 was a possible drug seeker who had rehabilitation in the past; Patient 15's toxicology screen indicated that the patient was not taking her

prescribed medications; and the patient went through detoxification at a hospital; and

- (C) Although Patient 16 had a history of alcohol abuse and continued to use marijuana and alcohol, you continued to prescribe various medications, including opioids, benzodiazepines, and muscle relaxants, to Patient 16, and you failed to document consideration of a detoxification program as part of the patient's treatment.
- (5) In your treatment of Patients 1, 3, 4, 6, 8, and 10, you failed to identify a reasonable pain diagnosis or differential pain diagnosis, and/or to clarify or confirm the diagnosis, and/or to identify the organic cause, mechanism, or source of the patients' pain.
- (6) In your treatment of Patients 5, 6, 7, 9, 11, 14 and 16, you failed to obtain records of prior or concurrent medical treatment, including studies performed, and/or you failed to refer the patient for additional, necessary consultations, evaluations, studies, or treatment. Examples of such failures include, but are not limited to, the following:
 - (A) Although Patient 5's pain had not been relieved by high doses of opioids and other procedures offered by you, and despite the possibility of psychological factors in this case, you failed to refer Patient 5 to a tertiary pain center with an inpatient pain rehabilitation and detoxification program for treatment;
 - (B) You failed to obtain appropriate neurological studies such as a Magnetic Resonance Imaging, an electromyographic study, and/or a nerve conduction study, for Patient 6;
 - (C) You failed to obtain a neurological consult, or records of a prior neurological consult, for Patient 7;
 - (D) Although Patient 9 reported being hospitalized for three weeks and on life support for four days due to a severe sickle cell crisis, you failed to obtain any medical records regarding his hospitalization; and
 - (E) You failed to obtain copies of appropriate prior medical records for Patients 14 and 16.
- (7) In your treatment of Patients 12, 13 and 15, although the patient's medical records contained results of toxicology screens indicating that the patient was not taking their prescribed medications as directed by you, you failed to appropriately reflect these results in your office notes and/or to document in the patient's records, consideration of these toxicology screens in formulating the patient's treatment.
- (8) In your treatment of Patients 5 and 6, you failed to appropriately consider and/or address whether psychological factors were affecting the patients' pain.

- (9) Although you prescribed medications containing acetaminophen, on a protracted basis, to Patient 3, who had prior elevated liver function enzymes and a history of alcohol abuse, and to Patient 2, you failed to obtain and/or document appropriate liver function studies.
- (10) In your treatment of Patient 1, you failed to include the findings of outside specialists, including normal upper GI studies and normal sigmoidoscopy findings, in your office notes.
- (11) In your treatment of Patient 2, you failed to inform the patient and/or to document having informed the patient, of her increased risk of cardiopulmonary failure due to the high doses of opioids, benzodiazepines and corticosteroids you provided her. You also failed to prescribe anti-depressants to Patient 2 or to refer Patient 2 to a specialist, despite her indications of depression.
- (12) In your treatment of Patient 11, you continued to use Matrix electroceutical therapy although this treatment modality only provided temporary pain relief.

Your acts, conduct, and/or omissions as alleged in paragraphs (2) through (12) above, individually and/or collectively, constitute “[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established,” as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions occurring on or after March 9, 1999, as alleged in paragraphs (2) and (3) above, individually and/or collectively, constitute “[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease,” as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code, as in effect March 9, 1999.

Further, your acts, conduct, and/or omissions occurring prior to March 9, 1999, as alleged in paragraphs (2) and (3) above, individually and/or collectively, constitute “[f]ailure to use reasonable care discrimination in the administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease,” as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code, as in effect prior to March 9, 1999.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty (30) days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice

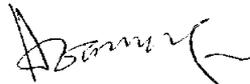
before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty (30) days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, effective March 9, 1999, provides that "[w]hen the board refuses to grant a certificate to an applicant, revokes an individual's certificate to practice, refuses to register an applicant, or refuses to reinstate an individual's certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Anand G. Garg, M.D.
Secretary

AGG/bjs
Enclosures

CERTIFIED MAIL # 7000 0600 0024 5141 7706
RETURN RECEIPT REQUESTED

Duplicate Mailing to:
Vicki Myckowiak, Esq.
Myckowiak Associates
1724 Ford Building
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CERTIFIED MAIL # 7000 0600 0024 5141 7713
RETURN RECEIPT REQUESTED