1 BEFORE THE BOARD OF MEDICAL EXAMINERS

2 STATE OF MONTANA

3 In the matter of Case No. 2013-MED-LIC-372
Regarding:

4

In the Matter of the Proposed) Case No.
5 Discipline of) 190-2014
)
6 MARK IBSEN, M.D.)
)
7 Medical Doctor, License)
No. 7378.)

8

9

TRANSCRIPT OF CONTESTED CASE HEARING
10 VOLUME V

11

12 On the 4th day of December, 2014,

13 beginning at 8:30 a.m., a contested case hearing was

14 heard at the Department of Labor and Industry,

15 1315 Lockey, Helena, Montana, before David Scrimm,

16 Hearing Examiner, and Lisa R. Lesofski, Registered

17 Professional Reporter, Notary Public.

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1 The following testimony was taken:
2 * * * * * * * * * *
3
4 **HEARING EXAMINER SCRIMM:** Good morning,
5 everyone. We'll go on the record at this time.
6 I won't get any lengthy details like we did
7 last time.
8 This is day four of the hearing involving
9 Dr. Ibsen in Case Number 2013-MED-LIC 372
10 regarding the proposed disciplinary treatment
11 of the license of Dr. Mark Ibsen, M.D.
12 We are going backwards a little bit to
13 have Mr. Fanning call one of his witnesses.
14 Before we do that, I will note for the record
15 that Ms. Blank is your witness there is someone
16 that I have seen in a group of people from time
17 to time at the Montana City Grill. I don't
18 know that we've had ever any discussion of any
19 kind and certainly not about pharmacy or this
20 case or anything. So I just want to disclose
21 that for the record.
22 And then, Ms. Blank, I'll have you take a
23 seat up here. And before you sit down, I'll
24 swear you in.
25 **MR. FANNING:** I know you weren't going to

1 go through your introductory remarks, but does
2 the Hearing Examiner's admonition about no
3 recording and photographs still apply except to
4 the press?
5 **HEARING EXAMINER SCRIMM:** Indeed. Indeed.
6 If you have a cell phone on, please turn it off
7 at this time, or any other recording devices
8 for that matter.
9 (Witness sworn.)
10
11 DIRECT EXAMINATION OF STARLA BLANK, PHARM.D.
12 **BY MR. FANNING:**
13 Q. Good morning. Would you state your name
14 for the record, please?
15 **A. Starla Blank.**
16 Q. What do you do for a living, Ms. Blank?
17 **A. I'm a pharmacist.**
18 Q. Who is your employer?
19 **A. St. Peter's Hospital.**
20 Q. Let's go through a little bit of your
21 professional background and training. Do you have
22 any professional degrees?
23 **A. I do. I have a bachelor of science in**
24 **pharmacy from the University of Montana, and I have**
25 **a doctor of pharmacy degree from Idaho State**

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1 **University.**
2 Q. Do you hold any licenses?
3 **A. I do. I hold a Montana pharmacist**
4 **license.**
5 Q. How long have you been licensed?
6 **A. Twenty-six years. Twenty-eight. Oops.**
7 Q. Are you a member of any professional
8 societies?
9 **A. I am. I'm a member of the Montana**
10 **Pharmacy Association and a member of the American**
11 **Society of Health-System Pharmacists.**
12 Q. Have you ever had any association with
13 regulatory offices?
14 **A. I have. I was the executive director of**
15 **the Board of Pharmacy starting in July in 2006, and**
16 **I held that position until May of 2007.**
17 Q. Have you ever served on the Board of
18 Pharmacy for the State of Montana?
19 **A. I have. I was recently appointed to the**
20 **Board of Pharmacy by Governor Bullock in July.**
21 Q. Have you ever taught pharmacy?
22 **A. I have. I'm an adjunct faculty at the**
23 **University of Montana; we have pharmacy students.**
24 **I've also taught in a classroom setting at Rocky**
25 **Mountain College to their physician assistant**

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1 **program.**
2 Q. What did you teach at the University of
3 Montana Pharmacy School?
4 **A. We host pharmacy students for on-the-job**
5 **training.**
6 Q. Have you taken any leadership roles in
7 topics of narcotics abuse or diversion?
8 **A. I have. In my role as the executive**
9 **director of the Board of Pharmacy I helped to**
10 **champion the Prescription Drug Registry legislation.**
11 Q. When was that?
12 **A. That was in 2000 -- that was the 2007**
13 **session, I believe.**
14 Q. Did that pass then?
15 **A. It did not.**
16 Q. So...
17 **A. And then I was also the president at the**
18 **time of the Montana Pharmacy Association, and that**
19 **group led the charge for the Prescription Drug**
20 **Registry legislation in 2009. That was also an**
21 **unsuccessful attempt at passing that legislation.**
22 Q. Ultimately that did pass?
23 **A. Ultimately it did pass in 2011. The**
24 **Attorney General's Office, then Steve Bullock, had**
25 **to champion that. The Pharmacy Association had also**

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1 **sponsored a bill that I helped craft that**
2 **strengthened the fraudulently obtaining dangerous**
3 **drug statute, and that is 45-9-104, I believe, and**
4 **that did pass in the 2000 session as well.**
5 Q. After the MPDR passed, did you have a role
6 in its implementation?
7 **A. I did. I was selected, I was appointed by**
8 **then Attorney General Bullock to a council that was**
9 **mandated by the legislation to advise the Board of**
10 **Pharmacy on the Prescription Drug Registry, on**
11 **implementation, rule writing, functionality, that**
12 **sort of thing, and I ultimately was elected chair of**
13 **that committee, and I still hold that position.**
14 Q. Do you have any particular experience in
15 pain management and treatment of chronic pain
16 patients?
17 **A. I have education in pain management. In**
18 **the late '90s I attended a seminar at the University**
19 **of Wisconsin, which is well known for being thought**
20 **leaders in pain management, and I obtained a pain**
21 **resource professional certification through the**
22 **University of Wisconsin. And then, you know,**
23 **through that -- my employer at the time had sent me**
24 **to that and because of that I helped to implement**
25 **pain protocols in the hospital, more in an acute**

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1 **care setting, not chronic pain protocols.**
2 **In my current role at St. Peter's, I sit**
3 **with the multidisciplinary group at St. Peter's**
4 **Medical Group and we review cases of chronic pain**
5 **patients, and I am part of that group and make**
6 **recommendations for pain management or tapering**
7 **medications or changing medications.**
8 Q. Can you describe the role of a pharmacist
9 in the medication management team?
10 **A. Sure. The pharmacists are part of the**
11 **medication management team, especially in the**
12 **setting where I work in in the hospital and clinic**
13 **setting. Pharmacists are involved in the management**
14 **of anticoagulation therapy, so that would be blood**
15 **thinner, Coumadin or Warfarin therapy. Pharmacists**
16 **are involved in other disease, take management**
17 **roles, such as hypertension, lipid management,**
18 **osteoporosis, asthma and COPD, congestive heart**
19 **failure. There are pharmacists in the state who are**
20 **pain management providers.**
21 Q. Can you describe your pharmacological
22 training versus a medical doctor's, if you know?
23 **A. I don't know how much pharmacology or**
24 **pharmacy training, drug training that a physician**
25 **has. For pharmacists, that's pretty much what we**

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1 **do. The professional curriculum for a pharmacist**
2 **is, there is two years of prepharmacy, that's**
3 **general. The professional curriculum is four years,**
4 **three of that is didactic, and that is all around**
5 **medications, pathophysiology and drug therapy**
6 **management. And then that last year is practical**
7 **experience in different pharmacy practice settings.**
8 Q. Have you ever previously been qualified as
9 an expert?
10 A. **I have not.**
11 Q. Did we overlook anything on your CV?
12 A. **Yes. I am a board certified**
13 **pharmacotherapy specialist. That is a certification**
14 **that is -- in post-graduate you have to apply to be**
15 **considered to take a national exam. There are exams**
16 **in different specialties of pharmacy, for example,**
17 **there is a nutrition, you can be certified in**
18 **nutrition, you can be certified in oncology, you can**
19 **be certified in ambulatory care. Mine is**
20 **pharmacotherapy, more of a general. And that is**
21 **somewhat of a status. There are in Montana 64 BCPS**
22 **certified pharmacists.**
23 Q. Out of how many pharmacists, do you have
24 any idea?
25 A. **In the state of Montana licensed about,**

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1 **oh, 1,500, but that's a guess.**
2 Q. Now, there is sometimes an image of
3 pharmacists as a person with a white coat who just
4 counts pill. Is that the condition of the pharmacy
5 practice nowadays?
6 A. **I hope not. And that kind of**
7 **pill-counting role, that's what people see in the**
8 **drugstores sometimes. Hopefully those pharmacists**
9 **are coming out and speaking with patients and**
10 **talking with patients. I have in the past worked as**
11 **a community pharmacist.**
12 **My current role that I've had for most of**
13 **my professional career is in acute care and**
14 **ambulatory care, and very much the pharmacists are**
15 **involved in patient care, patient education, drug**
16 **therapy management.**
17 **MR. FANNING:** I would move to qualify
18 Ms. Blank as an expert in drug therapy
19 management, including pain management and drug
20 therapy for chronic diseases.
21 **HEARING EXAMINER SCRIMM:** Any objection?
22 **MR. DOUBEK:** It's your call.
23 **HEARING EXAMINER SCRIMM:** All right. Can
24 you read that back?
25 (Read back: "I would move to

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1 qualify Ms. Blank as an expert
2 in drug therapy management,
3 including pain management and
4 drug therapy for chronic
5 diseases.")
6 **HEARING EXAMINER SCRIMM:** Just to be
7 clear, we're not -- well, let me ask. You
8 don't write prescriptions or diagnose people
9 and we're not going into that sort of...
10 **MR. FANNING:** There would be, Mr. Scrimm,
11 a little bit of testimony on her review of
12 charts and when a particular symptom or
13 complaint is announced, in her professional
14 judgment certain medications would be called
15 for. And the question is whether or not they
16 were applied.
17 **MR. DOUBEK:** May I ask one question then
18 just to clarify that?
19 **HEARING EXAMINER SCRIMM:** Yes.
20
21 VOIR DIRE EXAMINATION OF STARLA BLANK, PHARM.D.
22 **BY MR. DOUBEK:**
23 Q. Ms. Blank, you're not qualified to discuss
24 the standard of care for a medical practice, are
25 you?

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1 A. **I am not.**
2 **MR. DOUBEK:** Thank you.
3 **HEARING EXAMINER SCRIMM:** She is qualified
4 as an expert.
5 **MR. FANNING:** Thank you.
6
7 DIRECT EXAMINATION OF STARLA BLANK, PHARM.D.
8 (Continued)
9 Q. (By Mr. Fanning) Now, lest I forget from
10 time to time. Can we assume that all of your
11 opinions that you offer are based on a reasonable
12 degree of pharmaceutical or scientific certainty?
13 A. **Yes.**
14 Q. What material did you review in
15 preparation for your testimony? You're wincing.
16 A. **Yeah. I reviewed the original material**
17 **that was provided that I believe was provided to the**
18 **Board of Medical Examiners on nine patients of**
19 **Dr. Ibsen's. And I reviewed the records from the**
20 **Montana Prescription Drug Registry for those nine**
21 **patients. I also reviewed the records of patients**
22 **that were transferred from the care of one provider**
23 **to Dr. Ibsen.**
24 Q. And let's go ahead and be clear. That was
25 Dr. Christensen?

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1 A. **Yes. And then I reviewed the, rereviewed**
2 **the original nine patient records with all the extra**
3 **content.**
4 Q. With respect to Dr. Christensen's
5 patients, how much time did you spend on that
6 relative to the others?
7 A. **Very little.**
8 Q. All right. Now, when a pharmacist
9 receives a prescription from a lawful provider, are
10 certain laws applicable to your conduct?
11 A. **Sure. There is -- yes, there are laws**
12 **around the practice of pharmacy. There are laws**
13 **regulating what a valid prescription is. There are**
14 **laws regulating how long the records must be kept.**
15 **There are many laws around, rules and laws around**
16 **drug storage and accountability, inventories.**
17 Q. Sure. But that comes from both federal
18 and state agencies?
19 A. **Correct.**
20 Q. Is it part of your training and your
21 credentialing to be familiar with pharmaceutical
22 jurisprudence?
23 A. **Yes, it is.**
24 Q. What is that?
25 A. **We have to -- in order to be licensed as a**

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1 **pharmacist in the state that you're practicing, you**
2 **have to take a jurisprudence exam, which includes**
3 **components of both federal law and the law of the**
4 **state that you're practicing in.**
5 Q. Okay. When considering a prescription
6 order, what does a pharmacist have to review? What
7 thought goes into dispensing that?
8 A. **So, again, if it's a valid prescription,**
9 **it needs to have all of the components of a valid**
10 **prescription. Then drug, the dosage, the**
11 **instructions, the quantity, that the prescription**
12 **is, again, lawfully signed and dated by the**
13 **prescriber.**
14 Q. Do you consider drug interactions?
15 A. **Absolutely.**
16 Q. What would that be?
17 A. **If you have information about other**
18 **medications that the patient is currently taking,**
19 **that is a very important component of filling a**
20 **prescription is to review for drug interactions.**
21 Q. What is the harm for failing to do that?
22 A. **Well, potential harm with interacting, two**
23 **drugs interacting with each other.**
24 Q. But physical harm to the patient?
25 A. **Absolutely.**

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1 Q. And you mentioned dosage. What would you
2 consider in the dosage analysis?
3 A. **It varies by drug. And that it may be the**
4 **actual total milligram dosage of the drug that's**
5 **prescribed, especially for children, you would be**
6 **looking at dose versus their, the dose of the drug**
7 **versus their weight, and then it's all the frequency**
8 **of how often the medication is prescribed to be**
9 **taken, so that maybe that is excessive.**
10 Q. Now, specifically with pain medications,
11 is that what you're talking about?
12 A. **Any medication.**
13 Q. Is it your obligation to determine whether
14 or not that prescription is consistent with
15 legitimate medical care?
16 A. **It is, and --**
17 Q. What does that mean to you?
18 A. **And the DEA specifically says that around**
19 **controlled substances that pharmacists have a**
20 **corresponding duty to make sure that a prescription**
21 **for a controlled substance is written for a**
22 **legitimate medical purpose.**
23 Q. Can a pharmacist overrule a doctor or
24 other prescriber?
25 A. **A pharmacist can exercise their own**

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1 **judgment and not fill a prescription and --**
2 Q. In fact, they're obligated to do that if
3 they think it's warranted, aren't they?
4 A. **Yes, they are.**
5 Q. But if they don't overrule, what are their
6 options?
7 A. **Contacting the physician or the prescriber**
8 **and having a conversation about whatever they have**
9 **concerns with that specific prescription or**
10 **interactions, whatever the issue is.**
11 Q. Is that commonly done?
12 A. **Yes, it is.**
13 Q. Okay. Another topic of law. The
14 prescription controlled substance in the United
15 States are in what's called a closed system; is that
16 correct?
17 A. **That is correct.**
18 Q. And what does that mean?
19 A. **That means it's a closed distribution**
20 **system, where it's from the manufacturer to the**
21 **pharmacy to the patient is all regulated and it is a**
22 **closed system.**
23 Q. So it goes from point one to two to three?
24 A. **Uh-huh.**
25 Q. Where does it end?

1 **A. It ends with the user, with the patient,**
2 **whoever is going to consume the medications.**
3 Q. Is it ever lawful for that patient to
4 transfer the drug to another person?
5 **MR. DOUBEK:** Objection, beyond the scope
6 of the witness's disclosures in this case.
7 There has been no disclosure about this.
8 **HEARING EXAMINER SCRIMM:** Mr. Fanning, I
9 see you looking for your disclosures.
10 **MR. FANNING:** Indeed. Forget it. I'll
11 withdraw the question and move on.
12 **MR. DOUBEK:** Thank you.
13 Q. (By Mr. Fanning) Do pharmacists risk any
14 sort of sanction if they violate any of the laws
15 that you described?
16 **A. Yes, they do.**
17 Q. Have you heard of that occurring?
18 **A. Yes. There was just the case in the paper**
19 **recently where a pharmacist was actually sent, was**
20 **going to be imprisoned for inappropriate dispensing**
21 **of controlled substances.**
22 Q. So that's not just an academic issue but
23 it's something that pharmacists recognize?
24 **A. Sure.**
25 Q. Let's talk about the present history of

1 pain management and chronic pain management in the
2 United States. Let's say 25 years ago or so, what
3 were the common applications of chronic pain
4 treatment, what diseases?
5 **A. The pain management really has changed.**
6 **In the like late '80s, in the '80s, chronic pain was**
7 **considered cancer pain and that was -- you treated**
8 **cancer pain, but we didn't have a lot of this**
9 **chronic pain like we do now.**
10 **There really became a shift in medical**
11 **practice and thinking where pain -- there was a much**
12 **more heightened awareness of pain, treating pain.**
13 **Pain became the vital sign. Regulatory and**
14 **accreditation agencies were, you know, advocating**
15 **for patients and surveying health systems for**
16 **appropriate pain management and recognizing pain.**
17 **Pain is what the patient says it is. So really,**
18 **there really was this big shift of the pendulum**
19 **from, you know, pain and pain medicines being**
20 **reserved for either acute instances or in a chronic**
21 **case just for like cancer pain, and that really has**
22 **shifted.**
23 Q. What did that do to the number of
24 prescriptions for opioids?
25 **A. It increased it tremendously.**

1 Q. You mentioned the pendulum swinging. Has
2 that reversed?
3 **A. It is. The pendulum is moving the other**
4 **way in that thought leaders in chronic pain**
5 **management, and there is evidence in the literature**
6 **to show that chronic opioids are really not that**
7 **effective for pain.**
8 Q. Were there other worries besides the
9 efficacy that drove that shift?
10 **A. Sure. There have been studies done as**
11 **recently as 2011 showing that people who are on**
12 **chronic pain management have higher rates of**
13 **depression, less activity, they're less productive,**
14 **they're not working when matched with controls. So**
15 **it really begs the question about the efficacy of**
16 **opioids for chronic pain in many cases.**
17 Q. Were there also societal repercussions?
18 **A. Sure. There are societal repercussions**
19 **with overdoses and lost productivity, increase in**
20 **costs of health care for recovery and**
21 **rehabilitation. It is a very big price tag.**
22 Q. Are you familiar with statistics on
23 American's use of opioids versus the rest of the
24 world?
25 **A. I am. Well, I think that in the United**

1 **States we have 18 percent of the world's population,**
2 **but we use 95 percent of the Hydrocone manufactured**
3 **in the world and we in the United States use 75**
4 **percent of all opioids used in the world.**
5 Q. Apart from the human misery of drugs, are
6 there legal issues that are worrisome?
7 **A. Well, sure. I mean, I referenced that law**
8 **that the pharmacy association helped champion where**
9 **fraudulently obtaining medications puts people at**
10 **risk for being in trouble with the law. You know,**
11 **if people are addicted or dependent to opioids, they**
12 **may become and get in trouble with the law to try**
13 **and obtain those.**
14 Q. There is a label for that transfer, isn't
15 there, applying the drug improperly? I'll just say
16 it, diversion.
17 **A. Sure, diversion.**
18 Q. So let's talk about diversion. What drugs
19 are commonly diverted?
20 **A. The most common drugs diverted in Montana**
21 **anyway as of a 2008 statistic was Hydrocone,**
22 **oxycodone, Fentanyl and Methadone.**
23 Q. And why are those desirable on the street?
24 **A. Well, those are the most, some of the most**
25 **commonly used opioids and they are, they bring, they**

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1 **have a high street value.**
2 Q. Do you know from your experience how
3 diversion is accomplished? Where do the drugs come
4 from? What are the sources?
5 **A. There is national data from SAMHSA that**
6 **shows the --**
7 Q. Excuse me. You used an acronym.
8 **A. SAMHSA, Substance Abuse and Mental Health**
9 **Service Administration, it's a federal agency. And**
10 **they have information on where people obtain the**
11 **prescription drugs that they abuse. They've done**
12 **surveys. And overwhelmingly -- it's a big pie**
13 **chart -- and, overwhelmingly, the drugs come from**
14 **friends and family, physicians, directly from a**
15 **physician, or they were bought or sold from a**
16 **friend. Drug dealers and the Internet, very, very**
17 **small pieces of that pie, very small percentage.**
18 **And ultimately the drugs that we get from friends**
19 **and family come from physicians prescribing and**
20 **pharmacies filling those prescriptions.**
21 Q. So what are the risks of unregulated usage
22 of these drugs?
23 **A. Well, I mean, ultimately death. I mean,**
24 **if people can take opioids, especially combine them**
25 **with other substances like alcohol or**

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1 **benzodiazepines, which is another class of**
2 **controlled substances, like Valium or Ativan, the**
3 **risk of death is a possibility. And then there is**
4 **impairment with driving. It is a risk to have**
5 **unregulated opioid medication use.**
6 Q. Let's take that example you just offered,
7 driving. Suppose somebody was on a course of 30
8 milligram oxycodone. Is that a high dosage?
9 **A. That is a high dosage for a single tablet,**
10 **yes.**
11 Q. Would it be safe for such a person to
12 operate a motor vehicle?
13 **A. Well, that's hard to say. Certainly there**
14 **is warnings put on every prescription that says**
15 **caution, this drug causes drowsiness and may impair**
16 **your ability to drive. So, yes, that is a risk.**
17 **Those drugs will affect everyone differently.**
18 Q. Given all of this, has there been a
19 response by government leaders or law enforcement
20 leaders?
21 **A. I'm sorry. I don't understand.**
22 Q. Given the societal and individual dangers,
23 has there been a societal response?
24 **A. Well, there definitely has, yes.**
25 **Nationally, and specifically in Montana, the**

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1 **American General's Office under Bullock's**
2 **administration did a lot of work on enhancing**
3 **enforcement of prescription drug laws. He created a**
4 **task force with a dedicated prosecutor to**
5 **prescription drug crimes and hired several**
6 **investigators, and had implemented drug take-back**
7 **days, where the public could bring back their unused**
8 **medications to get them out of the home. That's**
9 **certainly a risk for diversion to have medications**
10 **sitting in the home. People may be at risk for**
11 **theft of those medications, controlled or not.**
12 **So we implemented drug take-back days and**
13 **ultimately permanent drug drop-off locations. So**
14 **those are located in generally in law enforcement**
15 **offices because law enforcement -- previously law**
16 **enforcement was the only, were the only people who**
17 **could accept controlled substances back from the end**
18 **user, part of that closed system. Just recently the**
19 **DEA changed those rules and with some work and some**
20 **regulation, pharmacies and hospitals can take back,**
21 **will be able to take controlled substances back as**
22 **well lawfully.**
23 Q. Just as a way to get that off the street?
24 **A. Exactly.**
25 Q. What about change in thinking in the

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1 medical community or education?
2 **A. Yes. Lots of educational programs just**
3 **about this kind of changing, swinging the pendulum**
4 **back the other way about the lack of effectiveness**
5 **of chronic opioids for treating pain, educating**
6 **patients about the dangers of opioids, educating**
7 **patients about alternatives to managing their pain**
8 **other than medications. So there is a lot of**
9 **education going on but we still need a lot, lot**
10 **more. We have a long way to go.**
11 Q. In fact, that's occurring right here in
12 Helena, isn't it?
13 **A. Yes, it is.**
14 Q. Did you happen to see the IR on Tuesday
15 about the high rate of prescription drug use by
16 local middle schoolers?
17 **A. I did see that.**
18 Q. That's nationwide and locally as well?
19 **A. Locally, for sure.**
20 Q. Was the MPDR one of the other outcomes of
21 this?
22 **A. Yes, it was. How could I forget that?**
23 **Yes, it was. So the implementation of the PDR, the**
24 **legislation passed in 2011, January of 2011. Went**
25 **into effect in July of 2011 and then, maybe October.**

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1 **And then the Prescription Drug Registry went live at**
2 **the end of 2012.**
3 Q. Maybe that's clear, but by live, it was
4 accessible to health care providers --
5 **A. Yes. I'm sorry. It was accessible to**
6 **health care providers.**
7 Q. What data is collected?
8 **A. The information in the PDR contains all**
9 **controlled substance prescription information, so it**
10 **has the patient's name, their date of birth, their**
11 **address, it has the prescriber, the drug that was**
12 **prescribed, the quantity, the day's supply, it has**
13 **the pharmacy that filled the prescription and it**
14 **also notes how the prescription was paid for,**
15 **whether that was cash or insurance, Medicaid or**
16 **workman's comp.**
17 Q. What can a doctor learn from that data
18 that you just described?
19 **A. That is very powerful data. That data can**
20 **help a physician or a pharmacist determine, you**
21 **know, what that, if that patient has been compliant**
22 **with the current regimen that the physician**
23 **prescribed, if they're getting prescriptions from**
24 **multiple providers, if they haven't disclosed to one**
25 **provider other controlled medications that they are**

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1 **taking. It's all very helpful. Again, it will show**
2 **quantities. How the medications are paid for is**
3 **telling.**
4 Q. What does that tell us?
5 **A. If someone has insurance and then all of a**
6 **sudden they're paying cash, that would kind of be a**
7 **red flag that why are you paying cash if you have**
8 **insurance. And a lot of times that means the**
9 **insurance won't pay for it because you already got a**
10 **supply that they covered and they keep an eye on the**
11 **day supply. So if you get 30 days and you try to**
12 **get some more in 15 days, they likely will not fill**
13 **it and if you want it, you're going to have to pay**
14 **cash for that transaction.**
15 **It's also a great tool for prescribers**
16 **because they can look up their own information and**
17 **see all of the prescriptions that they have written**
18 **by a patient. And so they can keep an eye on the,**
19 **like the integrity of their DEA number, their**
20 **prescription pads if they are ever worried that**
21 **somebody is misusing that information to obtain**
22 **controlled substances.**
23 Q. Is it mandatory to supply the information
24 from the pharmacies?
25 **A. The pharmacies by law are mandated that**

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1 **they must supply the information at least weekly.**
2 **Even pharmacies that are out of state and mail in to**
3 **patients of Montana, they must be licensed in the**
4 **state, thus, they are held to those same laws. So**
5 **out-of-state pharmacies would also be required to,**
6 **if they are licensed in the state of Montana, would**
7 **be required to submit that information.**
8 Q. While it's mandatory for the pharmacy to
9 submit it, is it mandatory for the doctor or other
10 provider to inspect it?
11 **A. It is not.**
12 Q. Now, I'd like to turn our attention to
13 opioid prescribing in general and sometimes I use
14 the word narcotic and sometimes opioid and that may
15 be haphazard. Can you describe the difference?
16 **A. Sure. Narcotic is more of a layman's term**
17 **and kind of a big basket of things that we tend to**
18 **throw a lot of things in there. Opioids are in that**
19 **narcotic basket. But opioids specifically are**
20 **derived from opium, and that would include the**
21 **opioid pain relievers like Morphine, Hydromorphone,**
22 **oxycodone, Hydrocone. Other things that we throw in**
23 **the narcotic basket might include the**
24 **benzodiazepines that I talked about before, those**
25 **are sedative types of medications, Ativan, Valium.**

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1 **So in the pure sense it's best to say opioid when**
2 **you're talking about the prescription pain**
3 **medicines.**
4 Q. In your review of Dr. Ibsen's charts and
5 the MPDRs, what did you typically prescribe?
6 **A. For the treatment of pain he typically**
7 **prescribed opioids.**
8 Q. Now, are those among the ones that can be
9 diverted or desirable on the street?
10 **A. Sure. Yes.**
11 Q. Can you describe what is meant by chronic
12 pain versus acute pain?
13 **A. Sure. And there are different**
14 **definitions. But acute pain is just that, something**
15 **that occurs right now. You cut yourself with a**
16 **knife, you have pain. If you get treatment for**
17 **that, you'll likely get a small supply and within a**
18 **couple of days you're better.**
19 Q. Small supply of what?
20 **A. Of pain medication. I'm sorry. Of an**
21 **opioid or even a nonopioid pain medication. So when**
22 **acute pain continues longer than we expect,**
23 **sometimes people call that the definition of chronic**
24 **pain and that might be for some people three months**
25 **or six months. But basically chronic pain is acute**

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1 **pain that lasts longer than we expect.**
2 Q. Is it incumbent on a physician to take
3 precautions about misuse of an acute pain
4 prescription?
5 **A. Yes. Responsible, I mean, responsible**
6 **prescribing, and there are lots of guidelines for**
7 **responsible opioid prescribing. It specifically**
8 **says that you do an evaluation, you look for**
9 **alternatives to opioids either in lieu of opioids or**
10 **along with opioids, so that might be whatever, heat,**
11 **ice, elevation, other medications.**
12 Q. What I'm talking about specifically, and I
13 don't know if I was clear. Are there different
14 differences between an acute prescription versus one
15 is that going to be a chronic prescription?
16 **A. Sure. Sorry.**
17 Q. Presumably there are minimums for acute
18 pain, right?
19 **A. Sure. And that's what I was describing,**
20 **just doing a proper assessment no matter what. But**
21 **when somebody is taking opioids long term and there**
22 **is a relationship between that prescriber and that**
23 **patient, generally the prescriber has a duty to**
24 **protect him or herself and also the patient by**
25 **explaining the risks and benefits of opioids, by**

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1 **cautioning the patient to store them correctly.**
2 **Many prescribers will enter into a pain**
3 **agreement or a pain contract and set out rules that**
4 **both the provider and the patient will abide by.**
5 **For example, the provider says I agree to treat your**
6 **pain, I agree to accept your reports of pain and as**
7 **the patient you must only use me as your provider**
8 **for pain medication, or if you go elsewhere, you**
9 **must let me know. You must -- if I want to count**
10 **your pills, I have the right to do that as the**
11 **provider. It I want to do a urine drug test to make**
12 **sure that you're taking the medications, I have the**
13 **right to do that. Those sorts of things would be**
14 **part of a pain agreement, again, along with a lot of**
15 **education about the risks and benefits of long-term**
16 **opioids.**
17 Q. We've heard testimony about oral pain
18 agreements. In your experience is there such a
19 thing in proper medicine?
20 **MR. DOUBEK:** Objection, asking for a
21 conclusion about the practice of medicine.
22 Q. (By Mr. Fanning) From the pharmacist's
23 point of view, is that --
24 **HEARING EXAMINER SCRIMM:** Overruled.
25 **A. No. Whether it's a medical practice or**

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1 **pharmacy practice, any type of agreements need to be**
2 **written down and signed by both the provider and the**
3 **patient to acknowledge understanding.**
4 Q. (By Mr. Fanning) Now, from your point of
5 view, is a chronic pain relationship improper in an
6 urgent care setting?
7 **MR. DOUBEK:** Objection, beyond the scope
8 of this witness' ability to address that.
9 **HEARING EXAMINER SCRIMM:** Sustained.
10 **MR. FANNING:** Okay.
11 Q. (By Mr. Fanning) Do you feel as though
12 from your experience with local providers that there
13 are, is there an exodus of doctors from the chronic
14 pain arena?
15 **A. Not from my perspective. I work with the**
16 **physicians at the St. Peter's Medical Group and they**
17 **all have chronic pain patients. I realize**
18 **physicians come and go from the community, but, to**
19 **my knowledge, the primary care providers have most**
20 **of the chronic pain patients in the Helena**
21 **community.**
22 Q. Has the topic of chronic pain created
23 divisions among care providers, that is, is there a
24 resistance or friction between doctors and
25 pharmacists?

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1 **A. Specific to chronic pain?**
2 Q. Yeah.
3 **A. No, not that I know of.**
4 Q. Do you from time to time have occasion to
5 speak with a doctor about a particular dosage or
6 quantity of prescription narcotic or prescription
7 pain medication?
8 **A. In my specific role, no. But in the**
9 **retail pharmacy setting, and I guess I do fill in in**
10 **our retail pharmacy and, sure, if there is a**
11 **question or a problem, you call that prescriber and**
12 **you get your issue resolved.**
13 Q. Has that been the way it's always been?
14 **A. Sure.**
15 Q. Is there something peculiar about 30
16 milligram oxycodone in the medical setting? Is it
17 unique or reserved?
18 **A. Well, that's a very large dose for a**
19 **single tablet of oxycodone. And, I mean, generally**
20 **that's a dosage that would probably be used in a**
21 **cancer patient or somebody with, you know, very,**
22 **very severe pain.**
23 Q. And then there has been a lot of
24 discussion about cancer pain, but what is it about
25 cancer that's so unique? Are they suffering pain

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1 that other people don't?
2 A. **That's a really good question. I think**
3 **some of that is societal. But the need or the want**
4 **to make end of life as comfortable as possible. I**
5 **think prescribers are much more comfortable to do**
6 **whatever it takes. And then there certainly, with**
7 **cancer especially, there is such an objective reason**
8 **for the pain with cancer and I just think everybody,**
9 **prescribers are more comfortable, pharmacists are**
10 **more comfortable saying oh, that person has cancer.**
11 Q. We're talking about terminal cancer?
12 A. **Correct. Right. End of life.**
13 Q. Now, we did hear some testimony earlier
14 about longer-acting versus shorter-acting
15 medications. In a chronic pain setting, which is
16 the medically preferred variety?
17 A. **In a chronic pain setting, the**
18 **longer-acting opioids are preferred.**
19 Q. And why is that?
20 A. **Less, you have less lows and highs, more**
21 **even pain management. The thought is they're less**
22 **abused, and because they are on a scheduled basis**
23 **versus an as-needed basis, they're easier to**
24 **control. A 30-day supply is very defined.**
25 Q. Is a 30 milligram oxycodone longer acting

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1 by virtue of its number of milligrams than a 10
2 milligram?
3 A. **No, it is not. Oxycodone immediate**
4 **release comes in 5 milligram, 10 milligram, and 30**
5 **milligram tablets, and the fact that one is a higher**
6 **dosage does not make it longer acting.**
7 Q. For purposes of diversion and street sale,
8 which is more attractive, longer acting or shorter
9 acting?
10 A. **Well, I would say both. But the shorter**
11 **acting are -- that's one of the reasons we like**
12 **longer acting is because the shorter acting are more**
13 **sought out for diversion.**
14 Q. Does that have a different euphoric effect
15 on the --
16 A. **Sure. A quicker, a more rapid high, yes.**
17 Q. We've had testimony previously about whole
18 families traveling from another city to Helena to
19 get 30 milligram oxycodone. Do you have any
20 experience with such a thing?
21 A. **I do. We've had a -- I mean, let me**
22 **correct that. It wasn't a family traveling from**
23 **another town, but there has been a family that has**
24 **come to St. Peter's all with high doses of**
25 **oxycodone, prescriptions for high doses of**

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1 **oxycodone.**
2 Q. That's your personal experience?
3 A. **Yes.**
4 Q. Do you know who the prescriber was?
5 A. **Yes.**
6 Q. Who?
7 A. **Dr. Christensen.**
8 Q. From a medical statistical standpoint, is
9 it likely that an entire family would have the same
10 intractable chronic pain?
11 A. **No, it is not.**
12 Q. All right. Now let's turn to the
13 pharmacist's expectations of treatment of chronic
14 pain, and these were things that you discussed in
15 your expert witness disclosure. Is it typical to
16 have a single sort of pain medication or some other
17 combination?
18 A. **It's most preferred to have multimodal**
19 **analgesia, which means different types of pain,**
20 **different types of medications with different**
21 **mechanisms of action. So you can have an opioid**
22 **which works on the opioid receptor to relieve pain;**
23 **then you can have an anti-inflammatory, like**
24 **ibuprofen, which relieves, takes down inflammation**
25 **and helps relieve pain by a different mechanism.**

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1 **And that is preferable so it helps you minimize the**
2 **dose of each.**
3 **And along with pharmacologic, meaning**
4 **drugs, to relieve pain, the nonpharmacologic, like**
5 **the ice and the heat and the elevation and all of**
6 **those things are important and really preferred if**
7 **the pain can be managed with those versus**
8 **pharmacologic methods.**
9 Q. In your expert disclosures you mentioned
10 NSAIDs. What are they?
11 A. **The acronym stands for nonsteroidal**
12 **anti-inflammatory drugs, and those are drugs like**
13 **ibuprofen, naproxen, which is Aleve.**
14 Q. Those are over the counter?
15 A. **They are. They are both prescription**
16 **strength and over the counter.**
17 Q. What's gabapentin?
18 A. **Gabapentin, the brand name is Neurontin,**
19 **and that is a medication that can be used to treat**
20 **seizures and it's also a medication that's used to**
21 **treat nerve type of pain, neuropathic pain.**
22 Q. And you also mentioned a product called
23 Lidocaine, what is that?
24 A. **Lidocaine is an anesthetic, it's a**
25 **numb-er, and it is available topically and a patch,**

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1 **and that can be very effective for certain types of**
2 **pain.**
3 Q. In your review of Dr. Ibsen's charts on
4 the nine patients, did you find that whole array of
5 medications being applied?
6 A. **In general, no. I mean, yes, there are**
7 **some examples where people were getting gabapentin**
8 **or people were on ibuprofen, but for most cases and**
9 **for the longest periods of time, patients might be**
10 **on and off different medications, opioids were**
11 **single agent.**
12 Q. Now, you mentioned nonpharmocological
13 therapies and gave us a couple of examples. Is
14 there a reason why you personally would not try
15 something as simple as heat and cold?
16 A. **Well, I don't know why you wouldn't.**
17 **Although if you want, if you want a pill to make**
18 **things better, I guess that's one reason. But if**
19 **you are, if you prefer to have medications for**
20 **whatever reason, diversion being one of them, then**
21 **you would ask for medications versus...**
22 Q. What other adjunct professionals would you
23 expect to contribute to a chronic pain management
24 program?
25 A. **Well, from a prescriber and then a**

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1 **pharmacist is frequently part of the team, physical**
2 **therapy can be part of the team, behavioral health,**
3 **nursing.**
4 Q. What do you mean behavioral health?
5 A. **Like a psychologist.**
6 Q. What about something as simple as weight
7 loss and exercise?
8 A. **Absolutely. Weight loss and exercise are**
9 **probably some of the best ways to help treat pain.**
10 Q. Did you see that commonly applied in
11 Dr. Ibsen's nine patients?
12 A. **No, I did not.**
13 Q. Were there instances of that?
14 A. **There was some referrals to physical**
15 **therapy in the patient records and very few -- much**
16 **more referrals than follow-ups. But there were also**
17 **some examples in the records where that physical**
18 **therapist then followed up with Dr. Ibsen's office**
19 **and gave a report of what was done, what the plan**
20 **was, what the treatment plan was.**
21 Q. Did you see a lot of follow-through on
22 that?
23 A. **No, I did not.**
24 Q. Obviously the doctor has a role, but does
25 the patient as well have a role?

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1 A. **Absolutely.**
2 Q. And who's responsible for holding the
3 patient accountable?
4 A. **Well, that's part of the patient and**
5 **provider relationship. I think the provider in**
6 **making those referrals and thinking that's important**
7 **needs to communicate that to the patient and help**
8 **hold them accountable for that.**
9 Q. Did you find any effort and chart it in
10 the notes about Dr. Ibsen counseling them on those
11 issues?
12 A. **No, I did not.**
13 Q. Medical marijuana is legal in Montana, is
14 it not?
15 A. **Yes.**
16 Q. And you hesitate and I know why. Because
17 it's still illegal in the federal system, right?
18 A. **Correct.**
19 Q. But under Montana state law, it's a
20 perfectly lawful part of a program.
21 A. **Okay.**
22 Q. We don't have to get into that. Some of
23 these patients were offered medical marijuana, were
24 they not?
25 A. **Yes, they were.**

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1 Q. Can that be part of a combination therapy?
2 A. **Yes.**
3 Q. Did you find that it was coordinated with
4 the other therapies?
5 A. **No, not -- no. Just that it was**
6 **authorized. But there was no documentation of**
7 **coordination.**
8 Q. Now, you have experience with disease
9 states and medical management of certain diseases,
10 right?
11 A. **Sure. Right.**
12 Q. You reviewed all of the notes in
13 Dr. Ibsen's charts, both in the smaller set and the
14 larger set?
15 A. **I did.**
16 Q. And we've already established when
17 Mr. Doubek asked you a question, that you aren't
18 here to testify about the standard of care for a
19 physician, right?
20 A. **Right.**
21 Q. But are you capable of recognizing
22 appropriate pharmacology for a certain disease?
23 A. **I'm highly qualified for that.**
24 Q. Were there instances where you saw
25 concerns or medical conditions identified but didn't

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1 see the expected follow-through?
2 A. **Yes.**
3 Q. Can you give an example?
4 A. **Sure. Sure. I will refer to my notes**
5 **here. There was Patient Number 1 in one of her**
6 **visits was concerned about her cholesterol, and a**
7 **lipid panel was ordered by Dr. Ibsen and that the**
8 **results came back and showed, indeed, her**
9 **cholesterol was high, her total cholesterol, her**
10 **triglycerides were high, her HDLs, which is the bad**
11 **cholesterol, was low, so that's not good. And**
12 **her -- did I say -- HDL is the good cholesterol was**
13 **low -- sorry about that -- and then her LDLs, which**
14 **is the bad cholesterol, was also high.**
15 **And those results came back and were**
16 **acknowledged by Dr. Ibsen and it says "follow-up"**
17 **with his initials. And then on her next visit,**
18 **which was the reason for the visit was documented**
19 **medication refill and lab results and there was**
20 **nothing, nothing charted that was done. There was**
21 **no medications prescribed or a trial noted that a**
22 **trial of lifestyle modification, diet, exercise was**
23 **recommended.**
24 Q. Okay. Were there other examples where
25 something seemed to trigger a medication response

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1 and he didn't find it?
2 A. **For one patient there were, there was a**
3 **couple notations where a DEXA scan was to be**
4 **ordered. A DEXA scan is a scan to check for the**
5 **health of your bones.**
6 Q. Excuse me. Do you have the patient
7 number?
8 A. **Sorry. I'm looking while I am talking.**
9 Q. Do you have the name? I don't want you to
10 say it, but you can...
11 A. **Sorry.**
12 Q. Do you want to set that aside and move on
13 to another one.
14 A. **Sure. I'm sorry. Here it is. It's**
15 **Patient Number -- well, this is actually a different**
16 **patient. So in one patient, who I can't recall the**
17 **number and I don't see it in my notes, though if I**
18 **need to I can find it, twice it was said DEXA scan**
19 **ordered.**
20 Q. Again, what is a DEXA scan?
21 A. **A DEXA scan is a scan to check on the**
22 **health of a person's bones. So you would do that**
23 **because you suspect maybe osteoporosis or weakening**
24 **of the bones. I don't know if that was ever**
25 **followed up on, there were no results. But I just**

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1 **questioned if you suspect that, wouldn't you treat**
2 **with that, it would be even calcium or recommend to**
3 **increase the calcium in your diet? You don't**
4 **necessarily have to take a supplement. But that was**
5 **not noted.**
6 **And then there is another patient, and**
7 **that is Patient Number 3, who visited the emergency**
8 **department at St. Peter's and had a lab test for low**
9 **calcium and recommendation from the ER physician**
10 **that that patient should have a Vitamin D level and**
11 **follow up with her primary care provider. That**
12 **patient also had risks for osteoporosis because she**
13 **had frequent fractures and she had frequent -- I'm**
14 **sorry, frequent falls, not frequent fractures,**
15 **frequent falls. And she was getting bursts, which**
16 **means a regimen of steroids, like Prednisone, and a**
17 **burst means you start out high and then you taper**
18 **down, she was getting that frequently for part of**
19 **her pain condition. And those notes from that ER**
20 **visit were in Dr. Ibsen's records but they never**
21 **followed up on.**
22 Q. Does Prednisone affect calcium or bone
23 strength?
24 A. **It can affect bone strength, yes.**
25 Q. Any other instances of charting that

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1 suggested necessary medication but you didn't find
2 it?
3 A. **Not specifically, no.**
4 Q. Were there instances when you found what
5 appeared to be inconsistent medication orders? For
6 example, I'm talking about Patient 4 and migraines
7 and sleep.
8 A. **Yeah. Patient 4 had a lot of, had**
9 **insomnia as one complaint, had migraines as another**
10 **complaint and was, in my opinion, was not getting**
11 **the right treatment for treatment of insomnia. He**
12 **was getting a benzodiazepine, multiple**
13 **benzodiazepines and chloral hydrate, which is**
14 **another -- it's not in the benzodiazepine family but**
15 **it's another sedative hypnotic and it is a**
16 **controlled substance. And then he was also getting**
17 **a drug called Zyprexa for sleep. This person also**
18 **had a diagnosis of bipolar disorder, but the**
19 **prescription would specifically say Zyprexa 10**
20 **milligrams at bedtime as needed for sleep and that**
21 **was, that would be an unusual medication to use for**
22 **sleep.**
23 Q. Ms. Blank, what I would like you to do is
24 say why the medications were not pharmaceutically
25 called for for those conditions. Is there some

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1 reason they were contraindicated or were
2 ineffective?
3 A. **No. I mean, A benzodiazepine is an**
4 **appropriate medication to help someone sleep, but**
5 **not two at a time. If one doesn't work, something**
6 **else needs to be tried. And a benzodiazepine at the**
7 **same time taking chloral hydrate, another sedative,**
8 **that's a duplication.**
9 Q. Is it hazardous?
10 A. **It can be, yes. It can cause**
11 **oversedation.**
12 Q. Was it effective in treating the patient?
13 A. **No, it was not. He suffered from insomnia**
14 **for a long time. That did seem to be better once he**
15 **was referred to a psychiatrist by Dr. Ibsen and in**
16 **treating his psychiatric issues his sleep did**
17 **improve. And at some point from the records it**
18 **looks like those visits continued for several months**
19 **and then it looks like that relationship was severed**
20 **between that psychiatrist and Patient 4 and Dr.**
21 **Ibsen assumed primary care for all of that patient's**
22 **needs.**
23 **He was later referred to another**
24 **psychiatrist, I believe, it wasn't a local person.**
25 **But that patient was put on a lot of different**

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1 **medications and I think, in my opinion, needed to be**
2 **referred, for the migraines. He was put on a lot of**
3 **different medications, preferably opioids and never**
4 **saw a neurologist or got a referral to a neurologist**
5 **to treat, to try and treat that.**
6 Q. That same patient you mentioned had had
7 some sort of chronic insomnia. Are there treatments
8 or studies that could have been done other than just
9 prescribing medications?
10 A. **Sure. For chronic insomnia, a referral**
11 **for a sleep study is one thing. Giving the -- even**
12 **as simple as having a discussion about sleep hygiene**
13 **and what somebody is doing around the time they're**
14 **sleeping and going -- you know, there is certain**
15 **steps that people can take to try to improve their**
16 **sleep or getting to sleep if they have problems, and**
17 **that wasn't documented.**
18 Q. In other words, measures short of
19 medications?
20 A. **Right.**
21 Q. Was that patient later put on
22 amphetamines?
23 A. **Yes.**
24 Q. What was that for?
25 A. **I don't know. I didn't see a**

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1 **documentation of why.**
2 Q. I think he testified yesterday he was
3 diagnosed with ADHD.
4 A. **That would be -- amphetamines are a**
5 **treatment for ADHD.**
6 Q. But you didn't find that charted in there?
7 A. **I did not.**
8 Q. I'm going to draw your attention to
9 Patient Number 5, and I believe that individual had
10 some sort of dental abscess. Are you familiar with
11 that one?
12 A. **Yes.**
13 Q. Did you consider the treatment for that
14 abscess?
15 A. **I did. I'm critical of Dr. Ibsen's**
16 **prescribing for that particular condition. She saw**
17 **not only Dr. Ibsen but some of the midlevel**
18 **providers, the physician assistants that work with**
19 **him, and they had prescribed -- I think she had a**
20 **couple of different courses of Clindamycin, which is**
21 **an antibiotic and commonly used to treat dental**
22 **types of problems, and appropriately so. It's a**
23 **medication that covers the bacteria that live in the**
24 **mouth, including those that grow in the absence of**
25 **air, anaerobes we call them.**

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1 **Dr. Ibsen had prescribed for her Rocephin,**
2 **which was given with a series of shots over three**
3 **days. Rocephin is a cephalosporin, that's a class**
4 **of antibiotic. And it's pretty broad spectrum but**
5 **it's not an effective, definitely not a first-line**
6 **drug for treating dental types of bacteria and**
7 **certainly does not cover anaerobes, those bacteria**
8 **frequently seen in the mouth that grow in the**
9 **absence of air.**
10 Q. Were there instances where patients had
11 reported certain allergies but were given drugs that
12 may have contained that agent?
13 A. **Yes.**
14 Q. I'm referring you to Patient Number 2,
15 just to hasten this along.
16 A. **Okay. Yes. Patient Number 2 had**
17 **acetaminophen as an allergy on her record but**
18 **routinely got Lortab or Norco, which is a**
19 **combination of Hydrocone and acetaminophen. That**
20 **said, she did tolerate those but then I have to ask**
21 **the question, well, then, why wasn't the record**
22 **corrected and why wouldn't you take that off?**
23 Q. I think I understood what you mean, but it
24 was noted in the record that she'd had an allergy to
25 that substance?

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1 **A. Correct.**
2 Q. Again, I'm charting note, on Patient
3 Number 3 there was a reference to fibromyalgia. Do
4 you recall that?
5 **A. I do. Yeah.**
6 Q. Did you see a development of that
7 diagnosis and care for that diagnosis?
8 **MR. DOUBEK:** Objection, beyond the scope
9 of the witness' disclosure and ability to
10 testify. She's testifying about medical care.
11 **MR. FANNING:** Okay. Actually what
12 occurred, in response to that, was that there
13 was a medical marijuana recommendation for
14 fibromyalgia but just no charting and no other
15 care for that. And that's the purpose of this
16 line of questioning.
17 **HEARING EXAMINER SCRIMM:** I'm going to
18 overrule the objection.
19 Q. (By Mr. Fanning) So with respect to that
20 patient, did you find any evidence of fibromyalgia
21 charted in the notes?
22 **A. That patient had visits documented, one at**
23 **the end of May and one in early June, one in**
24 **mid-June. The problem list included --**
25 Q. Of what year?

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1 **A. Of 2011. The problem list included**
2 **sciatica and chronic pain, that's it. But then on**
3 **August 15th of 2011, the medical marijuana**
4 **authorization was completed by Dr. Ibsen and it said**
5 **that fibromyalgia, chronic pain and fibromyalgia and**
6 **sleep disorder were the reasons that they was being**
7 **prescribed or authorized for medical marijuana.**
8 Q. So following that, did you see any
9 medication regimens that were consistent with those
10 diagnoses?
11 **A. Well, certainly for chronic pain, that**
12 **patient was getting lots of medications for chronic**
13 **pain and for sleep, she was also being medicated for**
14 **sleep. Fibromyalgia typically isn't treated with --**
15 **well, not that it's not treated with opioids but**
16 **they're really not effective.**
17 Q. We talked a little bit about a patient
18 with falls. Is this that patient?
19 **A. It is.**
20 Q. Can opioids contribute to falls?
21 **A. Absolutely. Sure.**
22 Q. Are falls a medical hazard --
23 **A. They are.**
24 Q. -- or is it just an inconvenience?
25 **A. Well, no. They can be very dangerous.**

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1 Q. What medical or pharmaceutical changes
2 occurred after this patient had a series of falls?
3 **A. None. This patient had multiple falls and**
4 **was on multiple medications that could contribute to**
5 **a fall, because they could affect level of**
6 **consciousness. That included medical marijuana, a**
7 **medication for anxiety called Buspar, a medication**
8 **for depression called citalopram, a sleep medication**
9 **called Ambien and then her opioid was Dilaudid. And**
10 **there was even a letter from a program through her**
11 **insurance kind of identifying all of her risk**
12 **factors for falls, including her medications, though**
13 **some of those were not listed on that letter, and**
14 **encouraged both the patient and the provider to have**
15 **a conversation about strategies they could use to**
16 **mitigate the risk of falls.**
17 Q. Did you note in the charts any then
18 responsive medication changes to that caution?
19 **A. No, I did not.**
20 Q. Just in general with respect to the nine
21 and chronic pain management, was there ever a
22 documented plan of any kind with respect to any of
23 the patients?
24 **A. There was not.**
25 Q. Would you expect to find that?

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1 **A. Yes. That is part of responsible opioid**
2 **prescribing in pain management, that you have a plan**
3 **that includes, you know, your pharmacologic, your**
4 **medications, your nonpharmacologic, exercise, weight**
5 **loss, what kind of activities, what are the**
6 **patient's goals, I mean, do they want to be able to,**
7 **you know, walk to the mailbox. I mean, some sort of**
8 **objective measures so that both the patient and the**
9 **provider know that the pain plan is working or it's**
10 **not working.**
11 Q. Is there a hazard to the absence of such a
12 plan?
13 **A. Yes, there is. It can lead to**
14 **inappropriate therapy, escalating doses, narcotic**
15 **dependence.**
16 Q. Now, you already testified that the
17 literature now says that chronic pain opioid
18 treatment really isn't effective, right?
19 **A. It's not -- yes, I mean, that's true but**
20 **it's not universal.**
21 Q. Sure.
22 **A. But, yes.**
23 Q. Is there a correlation between the
24 duration of a chronic pain treatment and the
25 likelihood of a successful outcome? That is, the

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1 longer you're on pain medication, does that instruct
2 on whether or not you're more likely to have a
3 successful outcome or unsuccessful?
4 **A. Well, if I understand your question**
5 **correctly, what the evidence has shown is that the**
6 **longer people are on opioids, the worse they tend to**
7 **do, that their activities decrease, their depression**
8 **increases, their sense of well0being decreases.**
9 Q. So is there then a drive to try to get
10 people off quicker?
11 **A. There should be if that patient -- again,**
12 **that's the importance of part of that plan. If what**
13 **you're doing isn't working, something else needs to**
14 **be done.**
15 Q. In some instances with regard to charting,
16 did you find that there was just a mention of
17 prescription refill and little else?
18 **A. Yes.**
19 Q. Were there any other charting
20 irregularities or anything that left you wondering
21 what was actually going on?
22 **A. Well, in many and really most of the**
23 **patients who were getting opioids for pain, there**
24 **were not assessments, pain assessments. You know,**
25 **there wasn't a plan. It was just reason for visit,**

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1 **medication refill, very little documented exam or**
2 **notes from Dr. Ibsen and then the medications were**
3 **refilled.**
4 Q. Now, we can't say from the chart whether
5 he did or did not perform a full exam, can we?
6 **A. It's very difficult to tell. And I will**
7 **say the midlevel providers, the physician**
8 **assistants, there is some very excellent assessments**
9 **in there. I mean, some of them have done a very**
10 **good job, but in general I did not see those**
11 **thorough assessments from Dr. Ibsen.**
12 **HEARING EXAMINER SCRIMM:** Can I interrupt
13 for just a minute? The gentleman with the
14 camera back there. We do have a number of
15 documents on the tables, and I don't know about
16 Ms. Blank's notes, that concern the medical
17 records of a number of people who have privacy
18 interests that we have determined outweigh the
19 public's right to now. So I would ask you to
20 not focus on any of those documents.
21 **NEWS REPORTER:** That's not a problem. No
22 recognizable text.
23 **HEARING EXAMINER SCRIMM:** I glanced -- my
24 wife showed me something about this hearing
25 last night on the news, and I did see a brief

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1 look at a document that wasn't one of those
2 type of documents. But I just wanted to make
3 sure that we are still doing what we can to
4 protect those patient's rights.
5 **NEWS REPORTER:** I'll make sure.
6 **HEARING EXAMINER SCRIMM:** Sorry to
7 interrupt.
8 Q. (By Mr. Fanning) What I began to say was
9 we had testimony yesterday from a number of patients
10 who said that thorough examinations occurred
11 regularly. There was a lot of history taken and a
12 great deal of exchange between Dr. Ibsen and them
13 over the course of fairly lengthy visits. Did you
14 find evidence of that in the charting?
15 **A. No, I did not.**
16 Q. In fact, there were a couple of quite
17 aberrant chart notes. I'm going to refer you to
18 Patients 1 and 9. Do you know what I'm talking
19 about?
20 **A. I do.**
21 Q. What were those aberrant chart notes? Go
22 ahead.
23 **A. Same shit, different day is what the note**
24 **said.**
25 Q. Did you find charting in the records of an

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1 effort to avoid any improper use or diversion of
2 opioids?
3 **A. No, I did not. Just the opposite. There**
4 **were records, in the records documentations of phone**
5 **calls from other providers giving information about**
6 **mutual patients where that patient had misled that**
7 **provider and the provider was letting Dr. Ibsen know**
8 **that there was documentation from insurance**
9 **companies informing Dr. Ibsen that a patient had,**
10 **you know, like -- I can find that -- had multiple**
11 **prescribers and multiple prescriptions for**
12 **controlled substances.**
13 **And it didn't appear -- in fact, one**
14 **patient, Dr. Ibsen caught that patient. They had**
15 **asked for a medication and he had found out that**
16 **they had just got it filled somewhere and he did not**
17 **fill that medication, but did fill -- and that was a**
18 **benzodiazepine -- but he did fill the opioids, an**
19 **opioid prescription for that same patient, so kind**
20 **of knowing that that patient was not being**
21 **completely truthful with him.**
22 Q. You mentioned then two instances where
23 outside sources were alerting to what might be
24 questionable practices, pharmacies, excuse me, other
25 providers and insurance companies?

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1 A. **Correct.**
2 Q. So could that same information have been
3 drawn from the MPDR once it went live?
4 A. **Yes, it could have been.**
5 Q. In your examination of the two sets of
6 records on the nine, the original set of 800 and
7 some and the expanded set of 2,800 and some, did you
8 find any MPDR records?
9 A. **I did not.**
10 Q. You personally, though, examined MPDR
11 records on those individuals, didn't you?
12 A. **Yes, I have.**
13 Q. Did you find instance of early refills?
14 A. **Yes, I did.**
15 Q. Just for the record then, what do you mean
16 by an early refill?
17 A. **An early refill would mean that if a**
18 **medication is prescribed as a certain dose and**
19 **quantity and that the day's supply would be**
20 **calculated based on that dose and quantity. So if**
21 **it's supposed to last -- a 30-day supply, for**
22 **example, but then another prescription would be**
23 **written for the same thing and another quantity so**
24 **that that person, that patient was getting extra**
25 **based on the plan of the first prescription.**

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1 Q. Now, in fairness, before the MPDR came
2 online, it would be difficult to know if somebody
3 was doctor shopping unless you really studied it,
4 right?
5 A. **Yes, that's true.**
6 Q. But was there ever an instance where
7 Dr. Ibsen had offered all of the prescriptions and
8 he, you know, he was the early, he was the sole
9 provider. Do you recall such an instance?
10 A. **Yes. There is lots of instances where he**
11 **says it's a 30-day supply or the prescription must**
12 **last until a certain date, but then another**
13 **prescription is subsequently written before that,**
14 **kind of overruling that first prescription.**
15 Q. There are other methods to assure that
16 somebody is compliant with a regimen, correct?
17 A. **Correct.**
18 Q. Did you ever see any instances of
19 urinalysis?
20 A. **I did. Urine drug screening.**
21 Q. Yes. Was that done regularly?
22 A. **No. But it was done for some patients.**
23 **And those were all qualitative tests, just meaning**
24 **the presence or absence of the drug, not**
25 **quantitative, meaning how much of the drug is**

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1 **actually in the urine. But, yes, there were some**
2 **urine drug screens.**
3 Q. Let's take that up a little bit. So if
4 suppose somebody was prescribed oxycodone, they
5 would test for the presence of oxycodone; is that
6 correct?
7 A. **Correct.**
8 Q. As a qualitative study but not a
9 quantitative study. So, for instance, suppose
10 somebody got a prescription for four a day, that
11 test would reveal they took perhaps two and the
12 other two were unaccounted for?
13 A. **Well, in a quantitative study.**
14 Q. But that was not done?
15 A. **Correct.**
16 Q. Did you find any evidence of pill counts?
17 A. **I did not.**
18 Q. Now, a great deal of the testimony has
19 centered on the concept of weaning. Do you know
20 what's meant by that term?
21 A. **I do.**
22 Q. What is it?
23 A. **Weaning would mean tapering off, so...**
24 Q. Do you participate in weaning or tapering
25 as part of your job today?

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1 A. **I do. With the pain team that I am**
2 **involved in, those providers are actively tapering**
3 **some of their patients.**
4 Q. So how does that happen in the team that
5 you just described?
6 A. **Usually I'm asked to do that and come up**
7 **with a regimen and make out a schedule, a sheet that**
8 **tells usually week to week what the dosage will be**
9 **and the tapers typically are between 8 to 10 to 12**
10 **weeks.**
11 Q. Who is on the team?
12 A. **My team specifically?**
13 Q. Yes.
14 A. **A pharmacist, a psychologist, the**
15 **physicians and nurses.**
16 Q. And that's a collaborative design?
17 A. **Correct. That team's input gets discussed**
18 **with every patient and the team's recommendations**
19 **are, again, discussed with the patient and followed**
20 **through.**
21 Q. Now, one person that you didn't mention as
22 part of the team is the patient. Are they a unit in
23 the group?
24 A. **Well, they don't participate in the group.**
25 **Good point. But they, again, what the team has**

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1 **decided is communicated with them and sometimes**
2 **they'll ask the committee to reconsider or, you**
3 **know, ask something of the committee. But they are**
4 **not physically present at the meetings.**
5 Q. But they're a participant in the program
6 then?
7 **A. Yes.**
8 Q. Is there a written design?
9 **A. Yes. There is a pain management agreement**
10 **or really a controlled substance agreement, because**
11 **the committee does, you know, all controlled**
12 **substances, so benzodiazepines as well. And that's**
13 **outlined in there that their cases will be reviewed**
14 **by this group and that the group's recommendations**
15 **are binding.**
16 Q. So I want to make sure we're talking about
17 the same thing. There is a pain agreement and is
18 there also a tapering agreement or is it all one?
19 **A. Yes, it's all one.**
20 Q. Did you find any evidence in any of the
21 nine charts in either set of records of a written
22 agreement such as that?
23 **A. I did not.**
24 Q. Did you find any notes about, whether or
25 not it was that formal, about how weaning was going

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1 to be accomplished?
2 **A. No. There were definitely notes about**
3 **weaning or need to wean or discussed weaning, but no**
4 **plan or follow-through.**
5 Q. Did you find that weaning actually
6 occurred?
7 **A. In general, no. In some cases there would**
8 **be an attempt but then several weeks to months later**
9 **that patient would be at or above what they started,**
10 **where they were at when that weaning note was**
11 **written.**
12 Q. Is there any evidence of the patient's
13 investment in weaning?
14 **A. There is some documentation that some**
15 **patients wanted to wean and there also is some**
16 **documentation that said not, you know, patient not**
17 **ready to wean.**
18 Q. Is the patient's investment a likely
19 outcome of success?
20 **A. Yes, it is.**
21 Q. Did you have a chance to review
22 Dr. Anderson's expert witness disclosure?
23 **A. I did.**
24 Q. And generally he concluded that Dr. Ibsen
25 achieved extraordinary weaning results; is that

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1 right?
2 **A. That was a good summation.**
3 Q. Did your evidence or your review of the
4 records or the MPDR bear that out?
5 **A. It did not, and not what was provided.**
6 Q. There was a substantial difference between
7 the records of the nine, which I think we're calling
8 28-1 through 9, and the records of the patients from
9 Dr. Christensen, which I think we've been calling
10 Exhibit 29-1 through 21. Did you note that
11 difference?
12 **A. A couple of things that I noticed were**
13 **that it appeared that Dr. Ibsen was actively using**
14 **the PDR. There were PDR records for those**
15 **Exhibit 29 patients frequently noted in the**
16 **materials. And I also noted that it appeared that**
17 **the office moved to electronic type of medical**
18 **records rather than, you know, check boxes and**
19 **handwritten, which these documents were. They were,**
20 **you know, typed out, electronically generated.**
21 Q. Did you find that the new records from the
22 electronics contained more information, more medical
23 data?
24 **A. Well, they definitely were -- they**
25 **definitely had volume, they had a lot of words. But**

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1 **in my review, which I do need to stipulate was not**
2 **in-depth, they didn't contain a lot of depth.**
3 Q. Are you familiar with the EMRs generally?
4 **A. I am.**
5 Q. Do you read a lot of them?
6 **A. I do.**
7 Q. You said with some regret it sounds like.
8 **A. Yeah. It's a frequent part of my job in**
9 **the hospital is to be reviewing patient records for**
10 **a multitude of reasons, for drug usage or adverse**
11 **drug events or medication errors.**
12 Q. So on those EMRs --
13 **HEARING EXAMINER SCRIMM:** I'm sorry. Can
14 you tell us what an EMR is?
15 **THE WITNESS:** Electric medical record.
16 **MR. FANNING:** Sorry.
17 Q. (By Mr. Fanning) Are those regenerated
18 each time or are those field of data auto-populated?
19 **A. Oh, it depends. There are some parts of**
20 **the EMR that are, you know, discrete fields that**
21 **must always be populated and there are some that are**
22 **kind of auto-populated and you fill in. It really**
23 **varies.**
24 Q. You mentioned that one material difference
25 between the sets was the appearance of the MPDR

1 records. Did you review those Dr. Christensen
2 patients thoroughly enough to determine whether or
3 not the MPDR informed Dr. Ibsen's treatment?
4 **A. In the brief scan that I did, it looked**
5 **like even if the patient was getting something**
6 **somewhere else, Dr. Ibsen was continuing to**
7 **prescribe. Much like the examples I gave where he**
8 **had a heads-up from other providers but still that**
9 **didn't seem to affect his prescribing.**
10 Q. In the face of that data that was in front
11 of him, was he still offering early refills?
12 **A. You know, I can't -- I don't have that**
13 **detail.**
14 **MR. FANNING:** That's all I have. Thank
15 you.
16 **MR. DOUBEK:** Yes.
17 **HEARING EXAMINER SCRIMM:** Mr. Doubek will
18 ask you some questions now.
19
20 CROSS-EXAMINATION OF STARLA BLANK, PHARM.D.
21 **BY MR. DOUBEK:**
22 Q. I'll try to be quick but I have a number
23 of questions. Dr. Kneeland said yesterday that
24 there were a number of legitimate reasons for early
25 refills. Do you agree?

1 **A. There can be. Sure.**
2 Q. He said the pill counts are perhaps
3 recommended but not required or considered standard
4 of care. Do you agree?
5 **A. They certainly aren't required, and I**
6 **guess the standard of care would depend on which**
7 **clinic you're working in. They may not be a**
8 **standard of care in his clinic, but I believe in the**
9 **St. Peter's pain agreement they are a part of the...**
10 Q. So does the standard of care change
11 depending upon the facility?
12 **A. Well, there are recommendations in the**
13 **instance of responsible opioid prescribing and pain**
14 **management. And I guess the standard of care, given**
15 **those recommendations, different places will adopt**
16 **different parts of those recommendations.**
17 Q. So the practice in one facility may be
18 different than the practice in another facility and
19 it doesn't mean that either facility is necessarily
20 violating standard of care, true?
21 **A. True. As long as some -- there is some**
22 **certain basic things that are a part of the standard**
23 **of care.**
24 Q. You made reference to quotes from a
25 Patient Number 9 and maybe you said Patient

1 Number 1, that same shit, different day, quote.
2 There were quotes around that, right?
3 **A. You know, I'm sorry. I don't remember.**
4 Q. Could that have been what the patient told
5 the doctor and he simply wrote it down?
6 **A. Perhaps.**
7 Q. Patient Number 3, you indicated that
8 fibromyalgia was listed as the reason for the
9 medical marijuana authorization but then you said
10 there was also notation that the patient had chronic
11 pain and sleep disorder. So all of those things
12 were noted.
13 **A. They were.**
14 Q. And as far as this same patient who fell,
15 you don't know what caused her fall, whether it was
16 ice on the pavement of a convenience store or
17 anything?
18 **A. Sometimes the details of those falls are**
19 **in the record, one said fell out of a truck, one**
20 **said slipped on ice but, no.**
21 Q. So you don't know whether the medication
22 caused her to fall, correct?
23 **A. I do know that medications can contribute**
24 **to falls.**
25 Q. Right. As does ice. And you don't know

1 whether it was a combination --
2 **A. True.**
3 Q. -- or the ice that caused her to fall?
4 All right. Thank you.
5 With regard to Patient Number 5, this is
6 the person who had a dental infection. You
7 recognize that the patient's antibiotic
8 prescriptions were changed, right?
9 **A. Uh-huh. Yes.**
10 Q. And the patient got better from her dental
11 infection, true?
12 **A. She did.**
13 Q. So the doctor was watching the situation,
14 determined it advisable to change the prescription
15 regimen, it was changed and the patient's infection
16 went away, right?
17 **A. I wouldn't necessarily agree with that. I**
18 **would say that probably the antibiotic she had been**
19 **taking prior to were becoming effective.**
20 Q. Do you remember the time frame or the time
21 lapse between the Clindamycin and the Rocephin?
22 **A. I don't. I'm sorry.**
23 Q. In any event, the patient was still
24 complaining about the infection and the doctor felt
25 it advisable to try a different antibiotic,

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1 something with a broader-based coverage?
2 **A. That's what the record shows, yes.**
3 Q. With regard to Patient Number 4, you
4 talked about the prescription of amphetamines.
5 Those were initially prescribed by the patient's
6 psychiatrist, Dr. Tollefson; isn't that true?
7 **A. The records that I show, I believe it was**
8 **Dr. Ibsen.**
9 Q. But after the patient had seen
10 Dr. Tollefson, if you know?
11 **A. I don't.**
12 Q. You don't have any evidence, do you,
13 whether any of these nine patients diverted any of
14 their prescription medications?
15 **A. Not from these records.**
16 Q. Did St. Peter's Hospital, the patients who
17 evidently sought some care from some of the doctors
18 at St. Peter's Medical Group I assume, is that what
19 happened? Did some of Christensen's patients seek
20 care from some of the doctors employed by St.
21 Peter's Hospital?
22 **A. I don't know the answer to that question.**
23 Q. All you know is that some of them sought
24 to have pain prescription medications filled at
25 St. Peter's pharmacy?

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1 **A. Correct. Written by Dr. Christensen.**
2 **Where the prescriptions were written by**
3 **Dr. Christensen.**
4 Q. And you don't know whether they also --
5 were there any doctors from St. Peter's who
6 prescribed pain medications for them, if you know?
7 **A. I don't know.**
8 Q. You're not here critical of any
9 prescription actually filled in this case by any or
10 all of the pharmacists, are you?
11 **A. I'm sorry?**
12 Q. Well, the prescriptions that are
13 referenced, for example, in the PDR were all filled
14 by pharmacists.
15 **A. Correct.**
16 Q. And before you had the PDR, the
17 prescriptions that these nine patients received were
18 dispensed, filled and dispensed by the pharmacists?
19 **A. Pharmacists, uh-huh.**
20 Q. You're not here critical of any
21 pharmacists who might have filled and dispensed
22 prescriptions for pain meds, are you?
23 **A. Not a specific pharmacist. But I have to**
24 **say why were they filling these medications so**
25 **frequently? And I don't have any more information**

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1 **than that. Maybe they made phone calls. But it**
2 **seems that the pharmacies were filling liberally, as**
3 **well as them being prescribed liberally.**
4 Q. Now, you talked about a shift in the focus
5 of taking care of and addressing folks with cancer
6 and that that sort of changed over a period of time
7 such that there was an emphasis put on patients with
8 chronic pain who were noncancer patients. Right?
9 **A. Right.**
10 Q. So at some point in time the medical
11 community was focusing on the fact that there are
12 some patients who had chronic pain?
13 **A. Sure.**
14 Q. And which was not caused by cancer?
15 **A. Sure.**
16 Q. And doctors' obligations, from your
17 pharmacy background, is to take care of those kinds
18 of patients; isn't that true?
19 **A. Sure.**
20 Q. And, in fact, do you know anything of the
21 statistics of suicides committed by chronic pain
22 patients?
23 **A. I do not.**
24 Q. I saw an article -- speaking of the
25 newspaper -- where an Ohio State football player

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1 killed himself and was found in a trash bin with a
2 note that said he couldn't stand the headaches and
3 so forth.
4 There are suicides amongst patients who
5 are not adequately medicated for their chronic pain;
6 isn't that true?
7 **A. I would -- I mean, I heard that story as**
8 **well and I believe that's why some of that pendulum**
9 **swung to more aggressively treat chronic pain, for**
10 **that very reason.**
11 Q. Doctor-patient relationship, there are
12 risks with these medications, these prescription
13 pain medications?
14 **A. Yes.**
15 Q. And because of that, these medications
16 really necessitate a close need for the doctor to
17 listen to his or her patients and for the patient
18 and the doctor to develop a real trust relationship;
19 isn't that true?
20 **A. That's optimal, yes.**
21 Q. Are you aware of any of these nine
22 patients who didn't have a good relationship with
23 Dr. Ibsen?
24 **A. No. I mean, that's -- I mean, it's hard**
25 **to tell from a record their relationship. But given**

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1 **the support that Dr. Ibsen has, his patients appear**
2 **to really like him and think he is a good provider.**
3 Q. Now, you said that the PDR in Montana went
4 live in October of 2012.
5 **A. Correct.**
6 Q. And I think when I deposed you previously
7 you told me that there were classes and courses for
8 the provider so they could learn about it and how to
9 use it, true?
10 **A. True.**
11 Q. And you said, I think you said it's still
12 not required for providers to use but certainly they
13 should?
14 **A. Correct.**
15 Q. And Dr. Ibsen uses it?
16 **A. He does now it appears from his more**
17 **recent records.**
18 Q. As I understand it, there is a lag time in
19 the pharmacy reporting prescriptions to the PDR, and
20 it might be eight days I think?
21 **A. Maximum of eight days. Some pharmacies**
22 **report daily, but the law says you have to report**
23 **within a week and so technically it could be eight**
24 **days.**
25 Q. In the usual course a pharmacist fills and

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1 dispenses a prescription as ordered by the doctor,
2 true?
3 **A. True.**
4 Q. If, however, the pharmacist has a
5 legitimate reason to question the prescription,
6 they're not obligated to fill it, right?
7 **A. Right.**
8 Q. It would be standard of care for a
9 pharmacist to communicate with the prescribing
10 doctor about the reasons for not filling and
11 dispensing an ordered prescription, true?
12 **A. Not in every case but, yes, yes.**
13 Q. Or if they had a serious question about
14 the prescription?
15 **A. Of course, yes.**
16 Q. Because when we're dealing with opioids,
17 prescription drug medications that have some serious
18 implications with their use and abuse, there should
19 be a close working relationship between the
20 pharmacist and the physician?
21 **A. There should be, yes.**
22 Q. And I believe I've asked you previously,
23 you're not aware of any case where Dr. Ibsen's
24 prescriptions exceeded any manufacturer's stated
25 limits, are you?

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1 **A. No.**
2 Q. And you're not -- all right. And with
3 regard to Patient Number 4, have you been advised
4 that that patient believes and has testified that
5 Dr. Ibsen was the only person to successfully
6 address and treat his headache problem?
7 **A. I did read that in the paper.**
8 Q. You don't know anything about that
9 patient's care before he began seeing Dr. Ibsen, do
10 you?
11 **A. I do not.**
12 Q. And you don't know whether that patient
13 had an oral agreement with Dr. Ibsen concerning his
14 medications, do you?
15 **A. I don't. But I will say that the standard**
16 **is oral agreements in health care, anything oral, if**
17 **it's not written down, it's not -- it didn't happen**
18 **or you can't say that it happened.**
19 Q. Unless the patient and the doctor both say
20 it did happen, right?
21 **A. (Shakes head.)**
22 Q. If the doctor and the patient say it did
23 happen, did it happen?
24 **A. Well, if they said it did but we don't**
25 **know any of the details of that.**

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1 Q. Unless they both fleshed it out for you?
2 **A. And can't verify that, yeah.**
3 Q. Now, you work at St. Peter's and also with
4 the St. Peter's Medical Group. Plans and pain
5 agreements are recommended for doctors treating pain
6 but it is not currently mandatory, nor do you know
7 whether that recommendation can be enforced by
8 St. Peter's; isn't that true?
9 **A. Well, and I did tell you that at the time**
10 **you deposed me. In the paper just the other day, on**
11 **Tuesday, the vice-president of medical affairs said**
12 **that that is a policy at St. Peter's, that there is**
13 **a pain agreement.**
14 Q. So that was just put -- that was just made
15 effective here a week ago?
16 **A. Well, I can't...**
17 Q. Did you get the memo?
18 **A. I didn't.**
19 Q. But it wasn't when I took your deposition
20 on October 6th, 2014, right?
21 **A. Well, I would say at least I wasn't aware.**
22 Q. But you are the head of pharmacy.
23 **A. Well, they don't talk to me about their**
24 **pain agreements at the clinic.**
25 Q. But you peer review and you're on a

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1 committee that reviews pain management care, right?
2 A. **Right.**
3 Q. And you didn't know about it until you
4 read it --
5 A. **Yes, yes. The group that I am working**
6 **with, which is not every provider in St. Peter's**
7 **Medical Group, I did review the pain management**
8 **agreement, had input into it and the plan had been**
9 **that that was going to be implemented clinic-wide,**
10 **but I know that the providers I'm working with are**
11 **using it. I do not -- I am not involved in**
12 **day-to-day clinic operations, I'm at the hospital.**
13 **So I can't answer that.**
14 Q. You're just working for a living?
15 A. **I am.**
16 Q. With regard to Patient Number 5, and I
17 know this is tough to throw a number at you, she
18 testified that Dr. Ibsen successfully addressed and
19 treated her pulmonary embolus. Is that condition a
20 painful condition or can it be a very painful
21 condition?
22 A. **Not having had a pulmonary embolism, I**
23 **can't speak from experience. But I have a lot of**
24 **experience in caring for people via their**
25 **anticoagulation management who have had and that is**

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1 **not something that they complain about the pain. At**
2 **the time they have it, of course, it's like a,**
3 **presents similar to a heart attack. But**
4 **subsequently after the acute event, I'm not aware**
5 **that that's a painful condition.**
6 Q. All right. If the patient said she was in
7 a lot of pain immediately after that, you don't have
8 any reason to doubt that, do you?
9 A. **No.**
10 **MR. DOUBEK:** I don't have any other
11 questions.
12 **HEARING EXAMINER SCRIMM:** Mr. Fanning, any
13 redirect?
14 **MR. FANNING:** Just very, very briefly.
15 Thank you.
16
17 REDIRECT EXAMINATION OF STARLA BLANK, PHARM.D.
18 **BY MR. FANNING:**
19 Q. Mr. Doubek asked you a number of questions
20 about the standard of care for physicians. Do you
21 recall that?
22 A. **Yes.**
23 Q. And he indicated, if I can paraphrase,
24 that some groups may have slightly different
25 expectations of patients within their care, right?

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1 A. **Correct.**
2 Q. But I thought you indicated that some
3 points were central.
4 A. **Correct.**
5 Q. Is that your testimony?
6 A. **Yes.**
7 Q. What points are central? Would an event
8 diagram be that intersection that always applies?
9 A. **For a pain management agreement, I would**
10 **say that the key elements, really as recommended by**
11 **the standards, are that patients agree to a**
12 **one-on-one relationship with their provider, so that**
13 **provider, that is the only person who is going to be**
14 **prescribing pain medications for that patient.**
15 **That's an agreement that that patient will only use**
16 **one pharmacy to fill their pain medications, so that**
17 **can be an easy way to follow up. And that patient**
18 **may be subject to urine drug screening.**
19 Q. Is it your understanding that that should
20 be in writing?
21 A. **Yes.**
22 Q. Do pill counts factor in that?
23 A. **Sure. Some agreements --**
24 Q. I'm just talking about central ones
25 though, not the variations group to group, but the

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1 ones that you view as essential to the standard of
2 care regardless of the practice.
3 A. **Pill counts should be in there. Does that**
4 **mean that all of that has to be done in that**
5 **agreement? No. But that should be -- the patient**
6 **should be made aware that they may be called upon to**
7 **do a urine drug screen or to bring in their pills**
8 **for a pill count.**
9 Q. What about some sort of risk assessment,
10 do you believe that should be part of it,
11 individualized risk assessments?
12 A. **Well, an individual risk assessment should**
13 **be done before the opioids are even prescribed.**
14 Q. Is that standard of care, or do you feel
15 comfortable saying?
16 A. **That is -- I know that that is an element**
17 **of responsible opioid prescribing.**
18 Q. There is a large stack of paper right in
19 front of you and I want you to turn to Exhibit 1,
20 page 63 of the larger of the two binders. Now, that
21 is a chart note on Patient 1 from October 20, 2011,
22 right?
23 A. **Yes. Correct.**
24 Q. And can you read for the Hearing Examiner
25 and for the record the chart note on that patient's,

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1 I don't know, examination?
2 A. **It says, "Same shit, different day," and**
3 **"Scar, left knee."**
4 Q. Is there any quotes around that?
5 A. **There are not.**
6 Q. Now, turn to page 740. That is Patient 9,
7 correct?
8 A. **Correct.**
9 Q. Do you see a date for when that visit is?
10 A. **3-29 of '13.**
11 Q. What is entered for that patient's
12 complaint for this day? Read the entirety of it.
13 A. **It says, "53-year-old female here to get**
14 **refill on meds," and that's in one handwriting, and**
15 **then in other handwriting consistent with**
16 **Dr. Ibsen's is, "SSDD."**
17 Q. Is it in quotes?
18 A. **It is not.**
19 Q. In other words, the chart is limited to
20 more refills, same shit, different day, basically?
21 A. **Yes.**
22 **MR. FANNING:** No other questions.
23 **MR. DOUBEK:** None on that.
24 **HEARING EXAMINER SCRIMM:** I may have a few
25 here. Let me just look through.

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1 EXAMINATION OF STARLA BLANK, PHARM.D.
2 **BY HEARING EXAMINER SCRIMM:**
3 Q. You said the Montana Prescription Drug
4 Registry became effective when?
5 A. **Late in October of 2012. And the**
6 **information in the registry, once it went live on**
7 **that October date, late October date, pharmacies had**
8 **to submit information starting in July of 2011. So**
9 **they had to submit a big batch back. So when it**
10 **went live, there was information back to July of**
11 **2011.**
12 Q. Now, who uses that?
13 A. **So there is an online access to the**
14 **Prescription Drug Registry and only prescribers, so**
15 **that would be physicians, nurse practitioners,**
16 **physician assistants, people with prescriptive**
17 **authority and pharmacists can access that**
18 **information electronically. Law enforcement can get**
19 **information on a single patient with a subpoena.**
20 Q. Would you be able to look up Mr. Fanning's
21 records?
22 A. **Well, I would but I wouldn't. I would**
23 **have no reason, unless he was under my care. Unless**
24 **I was filling a prescription for him, I would not**
25 **look up Mr. Fanning.**

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1 Q. There is nothing to prevent you from doing
2 anybody's records if you wanted to?
3 A. **Well, just like with an electronic medical**
4 **record, there is an audit trail and HIPAA rights**
5 **prevail and so that would -- I would be violating**
6 **privacy of anybody who I looked up who was not in my**
7 **care or who I was not, you know -- who I had not**
8 **some valid medical reason to be looking.**
9 Q. Do you know, are pain medications, are
10 they prescribed to the older part of our population?
11 A. **Certainly. Yes.**
12 Q. Is that the largest part?
13 A. **I don't have any information on the**
14 **demographics of who receives pain medication. But I**
15 **know from my experience with the St. Peter's Medical**
16 **Group, yes, there are a lot of very elderly people**
17 **who are getting pain medications. These patients**
18 **were relatively young patients, so...**
19 Q. There has been some talk about diversion
20 and about -- well, just people getting pills they
21 shouldn't and perhaps selling them or buying them
22 illegally. Are the pharmacies doing something to --
23 do they have cameras in the parking lot to see that
24 the people aren't getting the bottle of pills and
25 turning them over to somebody in the parking lot?

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1 Is that part of --
2 A. **Well, I can't speak to that for -- a lot**
3 **of pharmacies, you know, we don't at St. Pete's. I**
4 **mean, we have cameras outside our pharmacy. But**
5 **that's not -- there is not somebody actively**
6 **surveilling for what's going down in the parking lot**
7 **after somebody leaves.**
8 Q. And I'm just confused on -- we have had a
9 lot of discussion about 30 milligram oxycodone and I
10 think 30 milligram Hydrocone. Which one is the
11 slow-acting one and which one is the --
12 A. **So oxycodone is a generic name and that**
13 **drug has really being around for a long time. So**
14 **there is not a brand name per se that's commonly**
15 **recognized for immediate release oxycodone. But the**
16 **long-acting or the sustained-release oxycodone, the**
17 **brand name is Oxycontin, and we all know that name,**
18 **I think. That's the long acting.**
19 **And just for your information, oxycodone**
20 **30 milligrams is the immediate release, but there is**
21 **an OxyContin 30 milligram tablet and that is the**
22 **extended release.**
23 Q. And Hydrocone has nothing to do with any
24 of that, it's the --
25 A. **Hydrocone, yes, is just another opioid,**

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1 **but that's a separate entity from oxycodone.**
2 Q. In any of the pain treatment that you've
3 talked about, is the ability of a patient to get
4 their insurance to cover that a factor at all?
5 **A. If I understand your question, insurance**
6 **companies, prescription insurance plans, yes, they**
7 **cover, you know, pain medications. But what they're**
8 **very focused on -- and they may not cover, based on**
9 **a formulary, they may cover OxyContin but they won't**
10 **cover Zohydro, which is a new hydrocodone product.**
11 **But in general insurance companies cover pain**
12 **medications, but whenever an insurance company is**
13 **covering any drug, they have limits of how much a**
14 **person can get; usually it's a 30-day supply or a**
15 **90-day supply for chronic medications. So if**
16 **somebody is trying to fill something that's**
17 **conflicting with something else that's been filled,**
18 **they might deny payment.**
19 Q. And what about the alternative to
20 medications? Do you know if the insurance companies
21 regularly pay for massages and physical therapy and
22 chiropractic?
23 **A. I'm definitely not an expert in that area.**
24 **But, yes, they do pay. Some do; some don't. But I**
25 **will say that it is a challenge, because medications**

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1 **are more likely to be paid for, or easier to be paid**
2 **for in some cases than massage or especially some of**
3 **the alternative types of things that might be very**
4 **helpful to patients, acupuncture. But some**
5 **insurances do; some don't.**
6 Q. Is that just part of the curve, the
7 pendulum you talked about that maybe they will at
8 some point?
9 **A. Good question. I don't know a -- good**
10 **philosophical question.**
11 Q. How did the medical community deal with
12 pain before the rise in opioids?
13 **A. That's a very good question. Though I**
14 **couldn't quite remember when I graduated from**
15 **pharmacy school or how long I've been a pharmacist.**
16 **Since I've been practicing there really, I mean,**
17 **that was kind of the start in the very late '80s,**
18 **early '90s of that pendulum swinging. So in my**
19 **training I really learned that you treat pain and**
20 **pain is what the patient says it is. So I wasn't in**
21 **the medical field at the time when I guess we didn't**
22 **treat pain so aggressively.**
23 Q. Did we just suck it up back then?
24 **A. The old cowboy mentality. Yeah, I really**
25 **don't have a good answer to that question.**

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1 Q. Thank you.
2 **MR. DOUBEK:** No other questions.
3 **HEARING EXAMINER SCRIMM:** Any follow-up on
4 what I asked?
5 **MR. FANNING:** Only if it could be
6 instructed to the Hearing Officer. But, yes,
7 some questions about who has access to the
8 MPDR. I think I can clarify that a little bit.
9 **HEARING EXAMINER SCRIMM:** If you'd like
10 to.
11
12 FURTHER EXAMINATION OF STARLA BLANK, PHARM.D.
13 **BY MR. FANNING:**
14 Q. You had a lot to do with that law and the
15 subsequent regulations, didn't you, Ms. Blank?
16 **A. Yes, I did.**
17 Q. And one of the things that the legislature
18 was concerned about in denying it the first couple
19 of failures was confidentiality?
20 **A. Correct.**
21 Q. Were you able to overcome those concerns?
22 **A. Yes.**
23 Q. Are there built-in protections about who
24 can access the records?
25 **A. Yes, there are.**

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1 Q. And, in fact, there are regulations that
2 follow that up?
3 **A. Yes.**
4 **MR. FANNING:** And I'm going to cite the
5 Hearing Examiner to 37-7-1506 and its companion
6 regs.
7 Q. (By Mr. Fanning) In fact, only certain
8 individuals can access the MPDR, right?
9 **A. That's correct.**
10 Q. And among those individuals, the only
11 people who can access it are those with specific
12 training?
13 **A. That's correct.**
14 Q. Who designed the training?
15 **A. I did.**
16 Q. Yeah, you did. And you offered that
17 training to people, correct?
18 **A. Correct.**
19 Q. So once they've been trained on the
20 limits, they can access it?
21 **A. Correct.**
22 Q. For whom can a provider access records?
23 **A. Only for the patients who are in their**
24 **care or patients referred to them for their care.**
25 Q. So if they're considering adopting that

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1 patient?
2 A. **Yes.**
3 Q. Are there sanctions if somebody violates
4 those confidentiality rules?
5 A. **Yes, administrative sanctions, yes.**
6 Q. For their licensure?
7 A. **Yes.**
8 Q. As well as criminal violations?
9 A. **Yes.**
10 **HEARING EXAMINER SCRIMM:** I think you've
11 satisfied my interests.
12 **MR. FANNING:** Got it.
13 **HEARING EXAMINER SCRIMM:** Anything else?
14 **MR. DOUBEK:** No.
15 **HEARING EXAMINER SCRIMM:** Thank you,
16 Ms. Blank.
17 **MR. DOUBEK:** We'll call our next witness.
18 **HEARING EXAMINER SCRIMM:** We'll take a
19 ten-minute recess.
20 (Break taken.)
21 **MR. FANNING:** I rest. I mean, my case in
22 chief is over.
23 **HEARING EXAMINER SCRIMM:** I understood
24 that, but thanks for the --
25 **MR. FANNING:** Well, I just wanted to do

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1 that so we could say that we have just reached
2 a point of inflection.
3 **MR. DOUBEK:** Sounds good.
4 **HEARING EXAMINER SCRIMM:** We're back on
5 the record and you're going to call
6 Dr. Anderson.
7 **MR. DOUBEK:** And we would.
8 (Witness sworn.)
9
10 DIRECT EXAMINATION OF DR. CHARLES ANDERSON
11 **BY MR. DOUBEK:**
12 Q. Doctor, please state your name and
13 physical address.
14 A. **Charles Bradley Anderson. 729 North Ewing**
15 **Street.**
16 Q. And what is your current medical status?
17 A. **I am retired.**
18 Q. Congratulations. As of when?
19 A. **As of December 20th of 2012.**
20 Q. Doctor, I'd like you to trace your
21 post-secondary education, medical school, internship
22 and so forth.
23 A. **Okay. Graduated from Dartmouth College in**
24 **1969, and I attended Dartmouth Medical School for**
25 **two years, the first two years of my medical**

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1 **education. At that time Dartmouth was a two-year**
2 **basic sciences curriculum and then you transferred**
3 **somewhere else for your clinical years. And I**
4 **transferred back home to the University of**
5 **Minnesota. I grew up in Minneapolis. I got my M.D.**
6 **in December of 1972.**
7 Q. From the University of Minnesota?
8 A. **University of Minnesota. I did a one-year**
9 **internship. It was called a rotating medical,**
10 **interim internship in Portland, Oregon, Emanuel**
11 **Hospital. And then returned to the University of**
12 **Minnesota where I did a neurology residency from**
13 **July of '74 until July, or the end of June of 1977.**
14 Q. And what is involved in the -- or what was
15 involved in the residency attendant the specialty
16 area of neurology?
17 A. **Well, neurology is a medical specialty as**
18 **opposed to surgical, a medical specialty that is**
19 **involved with the diagnosis and treatment of**
20 **neurologic disorders, disorders of the brain, spinal**
21 **cord, peripheral nerves, muscles, that type of**
22 **thing.**
23 Q. And after you completed your neurology
24 residency, what did you do professionally?
25 A. **I was in the private practice of neurology**

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1 **in Fargo, North Dakota, and in that capacity I was**
2 **the neurologist that was part of the chronic pain**
3 **management team there. And then end of 1988,**
4 **basically 1989 through 1991 I was, I moved to**
5 **Jonesboro, Arkansas. I was with the Northeast**
6 **Arkansas Internal Medicine Clinic. I was with 20**
7 **other internists. And we kind of got the neurology**
8 **program rolling there.**
9 **And I yearned to be back north, maybe more**
10 **properly, out of the south, and decided to move to**
11 **Helena when I found that there was a position here.**
12 **So I've been here since 1991, almost all of the time**
13 **in private practice of neurology.**
14 Q. And your private practice was at offices
15 at the St. Peter's Hospital?
16 A. **Yes. I rented office space in the**
17 **basement of St. Peter's to begin with, and then when**
18 **they built the Maria Dean Medical Building, I moved**
19 **into that. And there were a couple of years in the**
20 **early 2000s that I had a partner. And then just**
21 **before I left St. Peter's in 2006, I was affiliated**
22 **with another neurologist another year and a half.**
23 Q. The first one would have been Dr. Dietz?
24 A. **Dr. Mark Dietz, yes.**
25 Q. And then Mulgrew?

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1 A. **And then Dr. Mulgrew, yes.**
2 Q. Doctor, out of your practice of neurology
3 at St. Peter's Hospital, can you describe the nature
4 of your practice?
5 A. **It was definitely a general practice of**
6 **neurology. I saw everything from strokes to**
7 **seizures to Parkinson's disease, multiple sclerosis,**
8 **spinal cord injuries, muscular diseases, peripheral**
9 **neuropathies, the whole gamut.**
10 Q. By the way, were you board certified in
11 neurology?
12 A. **Yes, I was.**
13 Q. And what is required to become a board
14 certified neurologist?
15 A. **Well, you have to have been in practice**
16 **for one year and then you pass the test.**
17 Q. There is an oral and a written component
18 to the test?
19 A. **Yes.**
20 Q. And did you pass that upon initial --
21 A. **Yes, I did. First time, luckily.**
22 Q. At that time were you required thereafter
23 to recertify in order to keep your board
24 eligibility?
25 A. **No. At that time we were not.**

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1 Q. That's good.
2 A. **It was... Yes, but, you know, in order to**
3 **keep up -- the American Academy of Neurology has**
4 **regular courses in usually April or late March of**
5 **each year and I tried to attend as many of those**
6 **things as I could, plus subscription courses. Of**
7 **course, now it's online, and I did that.**
8 Q. Was a component of your practice to help
9 manage pain that your patients were having?
10 A. **Yes, especially early in my career. Once**
11 **I came to Helena, as the only neurologist kind of in**
12 **a five county area, I basically was a consultant for**
13 **neurologic management, pretty much that was it. I**
14 **left the primary care management up to the referring**
15 **physician.**
16 Q. So you would act on a consultative basis
17 with that providing --
18 A. **Yes, sir.**
19 Q. -- with that provider?
20 A. **Yes, sir.**
21 Q. How did that work?
22 A. **It worked out pretty well. I was able to**
23 **keep -- I was able to get timely records to the**
24 **referring physician so that he or she knew, you**
25 **know, what my recommendations were. And those**

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1 **patients that required continued follow-up, which**
2 **was most of them, I would then see for follow-up**
3 **appointments at regular intervals.**
4 Q. And these were -- at least a part of these
5 patients were folks that were suffering from chronic
6 pain?
7 A. **Oh, yes.**
8 Q. How would you conduct your typical first
9 visit or your initial visit with these kinds of
10 patients?
11 A. **Well, my approach was to take a fairly**
12 **lengthy history. Generally these were patients that**
13 **were fairly complex. Since the physicians in Helena**
14 **were not really used to having a neurologist**
15 **available, they became quite sophisticated in their**
16 **management of neurologic problems, and so I pretty**
17 **much saw those that -- they reserved referring those**
18 **patients that were generally more complex to me. So**
19 **it took a long time to get a detailed history. Then**
20 **I would perform a neurologic examination. Of**
21 **course, I would have notes that I would get from the**
22 **referring physician, I'd review them first and go**
23 **over them with the patient. And then we'd come up**
24 **with a plan, and some of the plan I would carry out**
25 **myself and some of the plan would be recommended to**

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1 **the referring physician.**
2 Q. All right. Now, Doctor, in this case I
3 want to discuss with you how you went about
4 preparing the report that you did in this case, the
5 documents that you considered and what you did
6 generally in arriving at your opinions in this case.
7 A. **I had access to, remote access to the**
8 **medical records at Urgent Care, and I would review**
9 **those on my computer, print out those things that**
10 **needed to be printed out, like the medication lists.**
11 **I constructed for myself spreadsheets of the various**
12 **medications and the doses and that type of thing.**
13 **That was pretty much it. I spent I think about 16,**
14 **17 hours. It was close to 20 hours or so going over**
15 **these records.**
16 Q. Before you prepared your report?
17 A. **Yes. And that was, I think, eight**
18 **patients was the initial?**
19 Q. Well, eight and then nine.
20 A. **Yeah. It was a limited number. I hear**
21 **you talking about 2,800 pages and stuff and I'm**
22 **going whoa. I'm glad I was not part of that.**
23 Q. As I understand it, you reviewed about 850
24 pages initially anyhow?
25 A. **It was still quite a few, yes.**

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1 Q. And then you've reviewed, after preparing
2 your report, you've reviewed other records
3 concerning these patients?
4 **A. Yes. Subsequently I did receive the newer**
5 **electronic medical record of visits and also**
6 **obtained separate printouts of the MPDR that we've**
7 **discussed, or has been discussed previously.**
8 Q. Did you also visit with Dr. Ibsen about
9 his office protocols?
10 **A. Yes, I did, and with his office manager.**
11 Q. And was that helpful to you?
12 **A. Yes, it was. And I have had occasion to**
13 **go down to that clinic from time to time and see how**
14 **things work. But, yes, I was in contact with**
15 **Dr. Ibsen quite a bit. If I had questions about any**
16 **of these patients that I needed clarification, I**
17 **knew I could contact him.**
18 Q. And you did and he responded?
19 **A. Yes, I did.**
20 Q. Did you learn that there are other, or
21 that Urgent Care Plus and Dr. Ibsen typically had a
22 working relationship with other practice modalities
23 such as chiropractic, natural medicine and the like?
24 **A. Yes, I was.**
25 Q. What did you learn about that?

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1 **A. Well, that those other modalities were**
2 **available and were used, you know, chiropractors**
3 **would see Dr. Ibsen's patients. I couldn't**
4 **necessarily keep track of all the different**
5 **individuals, but there were midlevel practitioners**
6 **and there was naturopaths and, you know, kind of a**
7 **free flow of ideas. It's kind of nice to have.**
8 Q. Did you believe that he brought a
9 multidiscipline approach to address the patients
10 that he was caring for?
11 **A. It appeared that he did and that that was**
12 **available and that he did it.**
13 Q. And is that true relative to these eight
14 or nine patients that you specifically looked at?
15 **A. I can't recall specifically those patients**
16 **utilizing the chiropractors or the naturopaths, I'm**
17 **sorry.**
18 Q. That's okay. Doctor, do you have any idea
19 as to how much time you spent talking to Dr. Ibsen,
20 going to Urgent Care Plus and reviewing the
21 additional medical records after you reviewed those
22 you earlier records? Any good estimate as to the
23 amount of time you spent?
24 **A. Total time? Oh, boy. Altogether,**
25 **probably close to 50 hours, I suppose.**

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1 Q. Now, there has been -- the issues have
2 grown a bit in this matter. One of the issues that
3 has been listed is a criticism or the issue about
4 Dr. Ibsen's charting. In this regard have you had
5 experience reviewing charts from other doctors over
6 the course of your practice?
7 **A. Yes, I have. From 2000 to 2002 I was the**
8 **chairman of the credentialing committee at**
9 **St. Peter's, and from 2002 to 2004 I was the chief**
10 **of staff at St. Peter's. And during those years,**
11 **those four years, I had plenty of opportunity to**
12 **look at charts.**
13 Q. Is it nearly a truism that you never see
14 two doctors' charts that resemble each other?
15 **A. Yes, I think that's fair.**
16 Q. Why is that?
17 **A. Well, I think that most physicians tend to**
18 **be somewhat independent-minded. They have their own**
19 **idea of how things should be done and their patient**
20 **populations vary a lot. In my case a short, the**
21 **shortest appointment I had was 30 minutes, the**
22 **longest an hour and a half. Well, these days the**
23 **forces that are on physicians are such that, you**
24 **know, you don't find many doctors that can spend**
25 **that amount of time.**

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1 Q. Now when you say the forces involved are
2 at play, what do you mean by that?
3 **A. Well, the governmental regulatory forces,**
4 **the economic forces, the supply and demand forces**
5 **all tend to gang up on an individual practitioner or**
6 **combine so that it seems like less and less of the**
7 **time, the total time, is available for face-to-face**
8 **contact and more of it's being taken up by the**
9 **regimented documentation and that type of thing.**
10 Q. Sort of like the UPS driver has got to
11 make a certain number of deliveries each hour?
12 **A. It's getting to be that bad.**
13 Q. And you also see more and more involvement
14 of intermediaries, such as PAs, nurse practitioners
15 and the like?
16 **A. Midlevels, yes.**
17 Q. And you saw that in the records that you
18 reviewed from Dr. Ibsen's office from time to time?
19 **A. Yes.**
20 Q. True?
21 **A. Yes.**
22 Q. If you had questions about what the
23 records were telling you, were those the occasions
24 that you would seek Dr. Ibsen out and talk to him
25 about the records?

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1 **A. I knew I could call him, and I did. I**
2 **mean, I didn't know what the heck is MMJ, and I had**
3 **to find out it's medical marijuana. I learned a new**
4 **one today that SSDD, but I don't plan on using it.**
5 Q. I've also seen in a lot of doctors'
6 records the letters CRS. Is that something you've
7 also seen in medical records?
8 **A. CRS?**
9 Q. Can't remember stuff.
10 **A. Oh, yes, yes. And CRA.**
11 Q. In any event, did you have specific
12 concerns about Dr. Ibsen's charting?
13 **A. Well, they weren't the most legible**
14 **records. I would say that he was in the lower half**
15 **as far as legibility goes. Personally, it was**
16 **easier for me as a clinician to go through pre --**
17 **MR. FANNING:** Excuse me, can I object?
18 You haven't offered him as an expert and this
19 is beyond the scope of his disclosure, so I'm
20 going to object to that testimony.
21 **MR. DOUBEK:** Well, I'm offering him as an
22 expert.
23 **MR. FANNING:** Okay. Then I would like
24 permission to voir dire. But that doesn't
25 change the fact that that issue wasn't

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1 disclosed in your expert witness disclosure.
2 **HEARING EXAMINER SCRIMM:** Why don't we
3 deal with the expert witness aspect first and
4 then we'll go back to the question. And I'll
5 have you read it. Go ahead, Mr. Fanning.
6
7 VOIR DIRE EXAMINATION OF DR. CHARLES ANDERSON
8 **BY MR. FANNING:**
9 Q. Dr. Anderson, we just met a moment ago for
10 the first time.
11 **A. Yes.**
12 Q. I'm Mike Fanning. I'm the attorney for
13 the Board. Neurology, is that a --
14 **A. The board of?**
15 Q. Board of Medical Examiners.
16 **A. Okay.**
17 Q. Neurology is a specialty or a
18 subspecialty?
19 **A. Specialty.**
20 Q. And general practitioners would consult
21 with you on areas that were beyond their area of
22 expertise, I guess?
23 **A. Or if they just had questions.**
24 Q. Sure. And your training and your
25 certification and your experience gave you insights

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1 that they wouldn't have because of your focus,
2 right?
3 **A. I presume so.**
4 Q. But your focus never was chronic pain
5 management, was it?
6 **A. No.**
7 Q. You indicated though that there were --
8 **A. I must say, even when I was the so-called**
9 **director of this pain management program in Fargo,**
10 **it was only a part of practice.**
11 Q. In fact, if I got my notes right, that was
12 pretty early in your career?
13 **A. Yes, about 1978 to 1988. That was a**
14 **multidiscipline, we had psychiatry, psychology,**
15 **pharmacy was a big part, neurosurgery, orthopedics.**
16 Q. After you established your practice here
17 and began focusing more on neurology, was chronic
18 pain management part of your practice?
19 **A. No.**
20 Q. And I think you said that you came here,
21 what, around -- I'm sorry, what --
22 **A. 1991.**
23 Q. So that's not one of the things you
24 routinely diagnosed and treated?
25 **A. Only peripherally.**

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1 Q. Did you ever teach that, chronic pain
2 management, I mean, did you ever act as faculty
3 someplace?
4 **A. In Fargo I was an assistant professor of**
5 **neurology at the University of North Dakota Medical**
6 **School.**
7 Q. But, in short, over the last ten years or
8 so here in Helena, you didn't really focus on that
9 and it wasn't as though you were a professor of that
10 or an adjunct anywhere?
11 **A. No.**
12 **MR. FANNING:** Well, Mr. Hearing Examiner,
13 I'm going to object to him testifying as an
14 expert, and the grounds for that are that while
15 I have every bit of confidence in his skill as
16 a neurologist, the chronic pain management is a
17 specific subset of medicine that he's admitted
18 that he hasn't focused on. And while it's not
19 necessarily directly mandatory, 26-2-6O1
20 provides us guidance for when an individual is
21 qualified to testify as a medical expert, and
22 quoting from that, he must be licensed and, of
23 course, he is, and "Routinely treats or has
24 routinely treated within the previous five
25 years the diagnosis or condition that is the

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1 subject of the malpractice claim." Again, this
2 isn't malpractice but standard of care is the
3 standard of care.
4 The other option is, "is or was within the
5 previous five years an instructor of students,"
6 and such a thing. So he can't meet that
7 foundation and since he's unable to meet that
8 foundation, he should be precluded from
9 testifying as expert in this issue.
10 **MR. DOUBEK:** If I might respond. That
11 statute does relate to qualifications in a
12 medical malpractice trial, not in a proceeding
13 such as this. This doctor has testified that
14 he has cared for folks who have had chronic
15 pain conditions. Starla Blank, the pharmacist,
16 testified that they have a lot of family
17 practitioners that care for chronic pain
18 patients and, thus, I think this doctor is
19 qualified to address whether standard of care
20 was met, whether he feels that good practices
21 were met by Dr. Ibsen relative to the nine
22 chronic pain patients whose medical records he
23 reviewed.
24 **HEARING EXAMINER SCRIMM:** Well, in looking
25 at the Department's contentions, there are a

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1 number of areas that it contends regarding
2 monitoring patients, documenting charts,
3 incomplete record keeping and unprofessional
4 responses that would seem are not directly
5 related to excessive narcotic prescription.
6 But from what the doctor has testified to at
7 this point, he has not been really involved in
8 chronic pain treatment for at least some 20,
9 maybe 30 years. So I don't see qualifying him
10 as an expert in that area.
11 **MR. DOUBEK:** In which area?
12 **HEARING EXAMINER SCRIMM:** Well, through
13 your expert witness you are trying to defend
14 the doctor against contentions that he
15 excessively prescribed narcotic drugs.
16 **MR. DOUBEK:** Let me ask a few more
17 questions then, if I might.
18 **HEARING EXAMINER SCRIMM:** Sure.
19
20 DIRECT EXAMINATION OF DR. CHARLES ANDERSON
21 (Continued)
22 **BY MR. DOUBEK:**
23 Q. Dr. Anderson, do you have experience in
24 the management of patients who take prescriptive
25 pain medications?

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1 **A. Yes.**
2 Q. Would you describe your experience in that
3 regard?
4 **A. Well, as a co-caregiver for these**
5 **patients, I care what medications they're taking,**
6 **whether they're chronic pain medicines or**
7 **anti-coagulants.**
8 Q. And has that always been part and parcel
9 of your practice since arriving in Helena at
10 St. Peter's Hospital?
11 **A. Well, since time immemorial, yes.**
12 Q. So even before that, before 1990?
13 **A. Yes.**
14 Q. And do you feel competent to render an
15 opinion as to whether standard of care was or was
16 not met by Dr. Ibsen in caring for patients who were
17 receiving pain medications for their chronic pain?
18 **A. I believe so.**
19 Q. Based on what?
20 **A. Based on my overall medical knowledge and**
21 **my experience in at least treating patients who are**
22 **similarly treated.**
23 Q. As I understand, a significant amount of
24 your practice while at St. Peter's Hospital has been
25 in a consultative status, but you are involved, are

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1 you not, in the care of patients who are referred to
2 you by other doctors and you treat them concurrently
3 with those other doctors then?
4 **A. Yes. Yes.**
5 **MR. DOUBEK:** All right. Your Honor.
6 **HEARING EXAMINER SCRIMM:** Well, I'm just
7 going to ask a couple questions.
8
9 EXAMINATION OF DR. CHARLES ANDERSON
10 **BY HEARING OFFICER SCRIMM:**
11 Q. Do you treat them concurrently -- from
12 what I have heard, other doctors manage the pain,
13 you deal with some other aspect. You're
14 knowledgeable what those other doctors are doing but
15 you're not working with the patient directly on
16 caring for their chronic pain?
17 **A. Well, usually I would be involved in some**
18 **way with their pain, you know, whether it's**
19 **suggesting that they also go to physical therapy or**
20 **whether they be tried on one of the newer**
21 **anticonvulsant pain management drugs that have been**
22 **referred to, the Lyrica, the Gabapentin, the**
23 **Cymbalta, those medications which would frequently**
24 **overlap with my dealings with the patient,**
25 **especially those that might have epilepsy and if**

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1 **they had a head injury and they've got chronic pain**
2 **and they've also had seizures, there would be**
3 **considerable overlap there.**
4 **You know, it's something you really can't**
5 **get away from if you're going to practice medicine.**
6 **I did not primarily prescribe narcotics recently but**
7 **many of my patients would be on narcotics. I guess**
8 **that's what I can say.**
9 **HEARING EXAMINER SCRIMM:** Mr. Doubek, why
10 don't you offer your expert with some -- I
11 believe Mr. Fanning limited -- well, I think
12 there are topics that he may not be an expert
13 in but there may be topics he is an expert in
14 and I would prefer that you offer him for a
15 more limited purpose than a general purpose.
16 **MR. DOUBEK:** Your Honor, I would offer him
17 for the purposes outlined in his report, which
18 is Exhibit E.
19 **HEARING EXAMINER SCRIMM:** I don't see how
20 that statement limits the scope of his
21 expertise. So help me out here with what you
22 intend to get him to opine about.
23 **MR. DOUBEK:** Well, I think this doctor is
24 an expert in pain management. It's been part
25 and parcel of his concurrent care of patients

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1 since, as he said, the beginning of his
2 practice. He knows what kind of care needs to
3 be rendered, he knows what kind of care has
4 been rendered, and he's able to give an opinion
5 about whether Dr. Ibsen's practice conformed
6 with that or not.
7 As far as narcotic overuse or such issues,
8 he's also familiar with that and can opine
9 about that. I can certainly ask the doctor
10 about his experiences with prescription pain
11 medications, but I presumed it was simply
12 implicit in the nature of his practice and has
13 been for many years.
14 **HEARING EXAMINER SCRIMM:** Why don't we
15 explore that a little more.
16
17 DIRECT EXAMINATION OF DR. CHARLES ANDERSON
18 (Continued)
19 **BY MR. DOUBEK:**
20 Q. Doctor, what has been your experience with
21 the use of pain medications?
22 **A. I assume you are talking now about opiate**
23 **derivatives.**
24 Q. Yes. Hydrocone and such.
25 **A. Well, you know, they are not first-line**

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1 **drugs for treatment of other than moderately severe**
2 **acute pain, but many patients with chronic pain at**
3 **some point end up on them if for no other reason**
4 **than a trial basis. You know, I guess Mr. Fanning**
5 **and was it Ms. Blank?**
6 Q. Yes.
7 **A. Were talking about the whole scenario of**
8 **the sociopolitical scene and the pendulum and this**
9 **and that. But back in the late '70s and the early**
10 **to mid '80s, you know, the pressures, the same**
11 **pressures were there. I mean, we weren't the first**
12 **people to come up with a multidiscipline pain**
13 **management program back in the late '70s, we weren't**
14 **the first ones. And we had plenty of experience to**
15 **draw on from other large centers in the country.**
16 **The issues have always been related to the**
17 **fear of addiction, the reality of dependency,**
18 **dependence, medical dependence, and avoiding the**
19 **complications of the use of these medications with**
20 **the understanding that for whatever reason, they are**
21 **often necessary.**
22 **So you would try to structure a program**
23 **back then that would bring as many resources**
24 **available to the management of the chronic pain**
25 **patient.**

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1 Q. So you're familiar about how it is you go
2 about treating folks with chronic pain?
3 **A. Yes. Yeah. I think that I have had a**
4 **fair amount of experience with that.**
5 Q. And through the time of your tenure at
6 St. Peter's Hospital?
7 **A. Yes.**
8 Q. In working with other physicians,
9 oftentimes I take it you would let them prescribe
10 the narcotic medications but you would have to be
11 familiar with what they were doing so that you could
12 participate and make sure patients were receiving
13 the best care possible?
14 **A. That's correct.**
15 Q. And that's something, again, you've done
16 since the beginning of your medical practice as a
17 neurologist?
18 **A. Yes.**
19 Q. Have you prepared a report back in
20 February about your initial review of the medical
21 records of Dr. Ibsen?
22 **A. Yes, I have.**
23 Q. And that's based upon what we've already
24 talked about, true?
25 **A. Yes.**

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1 Q. Did you come to any opinions about
2 Dr. Ibsen's care of those eight or nine patients?
3 **MR. FANNING:** Objection.
4 **HEARING EXAMINER SCRIMM:** We haven't
5 qualified him yet as an expert.
6 **MR. DOUBEK:** I'm sorry.
7 **MR. FANNING:** I still don't believe there
8 is any foundation under that standard announced
9 26-2-601. And even if they gained a little
10 ground, there is another Subsection 3 that
11 requires a person in one medical specialty or
12 subspecialty to adduce evidence that the
13 standard of care overlaps, and we haven't even
14 heard that. So I don't think he's capable of
15 doing that based on his own history, but we
16 haven't even embarked on the second part. So I
17 still maintain my objection. And if it's
18 useful, I can offer you a copy of the code, I
19 happen to have it here.
20 **HEARING EXAMINER SCRIMM:** Do you have any
21 case law that that statute is applicable in
22 licensing cases?
23 **MR. FANNING:** No, other than the fact that
24 as -- and Mr. Doubek knows better than the rest
25 of us -- a standard of care is the ultimate

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1 issue in all of these questions or the standard
2 of care in one setting can't be any different
3 than the standard of care in another because a
4 patient deserves what a patient deserves.
5 **HEARING EXAMINER SCRIMM:** I'm not going to
6 qualify the doctor as an expert with regards to
7 chronic pain management. I have not heard
8 anything from him where he was directly
9 managing pain care or even -- well, period.
10 And then he does, he is qualified regarding the
11 practice of medicine, regarding other
12 allegations of the Board of Medical Examiners
13 regarding some failures with those records and
14 other things, but I cannot qualify him as an
15 expert on chronic pain.
16 **MR. DOUBEK:** Let me ask one or two more
17 questions, if I might.
18 **HEARING EXAMINER SCRIMM:** Okay. And then
19 we need to move on.
20 Q. (By Mr. Doubek) As a part of your
21 practice, have you been involved in the management
22 of care for patients with chronic pain?
23 **A. Yes.**
24 Q. And would you describe that in as much
25 detail as you can, please?

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1 **A. I'd say it would be basically diagnosis.**
2 **First of all, trying to arrive at a diagnosis, a**
3 **causation and then determining from the records what**
4 **has worked and what hasn't worked in the past, which**
5 **is often very useful but sometimes it's not given**
6 **enough emphasis. Once the diagnosis was fairly**
7 **certain or as clearly defined as possible, then it**
8 **would be recommendations with regard to the**
9 **modalities used to treat such pain, with use of**
10 **narcotics being just one of them. And simple**
11 **recommendations with regard to overlapping**
12 **medications, you know, the simultaneous use of other**
13 **potentially psychoactive medications as I would call**
14 **them, including benzodiazepines, phenothiazines.**
15 **There is a whole host of drugs that are used**
16 **primarily by psychiatrists, which then might overlap**
17 **the use of the narcotics. The mechanism or reaction**
18 **of the narcotics, whether the narcotics are given**
19 **intrathecally through a pump, a pain, opioid pump.**
20 **You know, following the results, I guess that's --**
21 Q. Making adjustments during that course of
22 time that you're caring for the patient?
23 **A. If not making them myself, then at least**
24 **recommending that my best judgment is that, you**
25 **know, this drug be tapered and this one be**

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1 **emphasized. You know, the previous witness talked**
2 **about multimodality drug use, looking at drugs with**
3 **different, not only efficacy profiles but also**
4 **mechanism of action and, you know, making sure that**
5 **whatever drug was chosen was used to the maximum**
6 **before deciding that it wasn't working.**
7 Q. And are those issues that you're familiar
8 with and have been involved with in the course of
9 your 30 years of practice?
10 **A. Yes.**
11 Q. Dr. Ibsen is board certified in family
12 medicine and emergency medicine. You are board
13 certified in neurology. Dr. Kneeland is board
14 certified in anesthesiology. Does that make you and
15 Dr. Kneeland, in your view, less qualified to talk
16 about pain management issues than Dr. Ibsen, or is
17 there some commonality involved here?
18 **A. The commonality is pain, yes. Pain is so**
19 **ubiquitous that it hits all specialties. You really**
20 **can't avoid it. Some doctors try, they say I don't**
21 **want to hear it. If you hurt, see someone else or**
22 **see your primary care doctor or whatever.**
23 Q. But you haven't done that in the course of
24 your practice?
25 **A. I haven't been able to.**

1 Q. So you've cared for patients with chronic
2 pain, have been involved in the management of their
3 chronic pain for 30-something years now?
4 A. **Yes.**
5 Q. Okay.
6 **HEARING EXAMINER SCRIMM:** Perhaps this is
7 something we'll ultimately end in briefing, but
8 I'm going to qualify him as an expert here.
9 **MR. DOUBEK:** Thank you.
10 **MR. FANNING:** And I understand the ruling,
11 I accept that. But typically qualifications of
12 an expert have some parameters, he can't be an
13 expert on everything.
14 **MR. DOUBEK:** Well, I hope he qualifies an
15 expert on the areas that I'm going to go into
16 with him.
17 **HEARING EXAMINER SCRIMM:** What are those
18 areas? Why don't we define this. I think
19 Mr. Fanning is correct.
20 **MR. DOUBEK:** I think that Dr. Anderson is
21 an expert in chronic pain management. I think
22 he's an expert and able to testify about
23 whether there has been overprescription. I
24 think he is an expert in issues pertaining to
25 the care required of Dr. Ibsen going forward

1 with each of these patients. I don't know if
2 anybody is an expert on charting, but I
3 certainly think that he can talk about his view
4 of the charting and whether it was adequate to
5 inform him so as to allow him to form an
6 opinion about these other issues;
7 overprescribing, whether, you know, there was
8 good pain management as per the records, and I
9 think that's about it.
10 I have to say that the issues grew after
11 the time of Dr. Anderson's initial report but
12 they are what they are and I'm not objecting to
13 that now. But I think he should be qualified
14 to address the same issues that Dr. Kneeland
15 addressed.
16 **HEARING EXAMINER SCRIMM:** I think we may
17 need to go back to that particular language
18 again and again in the ensuing testimony. So
19 you might want to mark that so we can return to
20 it.
21 **MR. FANNING:** If I can be heard on one
22 little follow-up issue. And, again, I heard
23 the Hearing Examiner's ruling, but charting is
24 a whole different issue than anything to do
25 with pain management. And when I submitted the

1 Notice of Proposed Department's Action based
2 upon the medical board's directive, on July 9
3 of 2013 I wrote that one of the issues was
4 failing to properly document patient charts,
5 and I don't believe that you're going to find
6 that in Dr. Anderson's expert disclosure. So
7 that goes beyond his disclosure and should have
8 been updated if he was going to testify about
9 that. And since he didn't, that should be
10 precluded.
11 **HEARING EXAMINER SCRIMM:** And Exhibit E is
12 his expert witness disclosure?
13 **MR. DOUBEK:** Yes.
14 **MR. FANNING:** That's not in evidence but
15 that's what it is, yes.
16 **MR. DOUBEK:** I don't think you put any of
17 your witness disclosures in. Did you, Mike?
18 **MR. FANNING:** No.
19 **MR. DOUBEK:** Okay.
20 **MR. FANNING:** Other than that they're
21 pleadings in the record.
22 **MR. DOUBEK:** As is this. Okay.
23 **HEARING EXAMINER SCRIMM:** Overruled.
24 Let's move on.
25 Q. (By Mr. Doubek) Doctor, based upon your

1 review of all the records, talking to Dr. Ibsen and
2 staff and observing his practices at his clinic, do
3 you have an opinion whether any of these patients
4 were overmedicated with opioids?
5 A. **Yes.**
6 Q. And what's your opinion?
7 A. **I think that in all honesty there were --**
8 **I mean, I cannot tell for sure if there were times**
9 **when they were receiving too much or too little. I**
10 **don't know for sure. I only know the numbers that**
11 **were provided to me by I presume the MPDR. And my**
12 **impression was that, again, at that time that I, the**
13 **slice of time that I was looking at things, most of**
14 **those patients were either tapered or were in the**
15 **process of being tapered from their doses of**
16 **narcotics and other psychoactive medications like**
17 **benzodiazepines.**
18 Q. And is that the objective that the doctor
19 tries to achieve for patients on chronic pain
20 medications?
21 A. **Yes. I think that that is the objective**
22 **that we would all have, no matter what our specialty**
23 **is, that the less medication the better, but we have**
24 **to -- each patient has his own time line. I heard**
25 **talk about 8 to 12 weeks. You know, that would be**

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1 **great, some patients can be tapered faster than**
2 **that. Some patients will require a great deal of**
3 **trust and interaction. It may take a year or two to**
4 **taper them from their medication.**
5 Q. Doctor, have you ever had patients that
6 you managed or assisted to manage their chronic pain
7 who have never been able to wean themselves
8 successfully from narcotic pain medications?
9 **A. Unfortunately, yes.**
10 Q. Is an alternative to permanent narcotic
11 pain medication other things such as pain pumps and
12 implantable pain pumps and the like?
13 **A. Yes.**
14 Q. Is that why they do the pain pumps, is to
15 avoid and be able to better regulate the flow of
16 narcotic?
17 **A. Yes. And theoretically -- there is some**
18 **practical problems. But theoretically by giving the**
19 **pain medication within the spinal column -- well,**
20 **it's certainly true you need much, much less pain**
21 **medication to do that and theoretically at least you**
22 **avoid the systemic complications, the constipation,**
23 **the dry mouth, blurred vision and all the other**
24 **things that a person might get from some of these**
25 **drugs. If you just deliver a small amount**

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1 **intrathecally, which is to say the fluid surrounding**
2 **the spinal cord and brain.**
3 Q. So it gets to where it needs to go in
4 order to address the pain better?
5 **A. Yes. At the price of having to put this**
6 **thing in, this device, which, of course, is**
7 **expensive, like everything, it has to be refilled**
8 **from time to time and there are complications,**
9 **potential infection.**
10 Q. I guess the only point I'm trying to ask
11 about is it seems that if you go the route of an
12 implantable pain pump, that decision is made in
13 recognition of the fact that this patient is going
14 to have a permanent problem?
15 **A. Yes.**
16 Q. And you have had pain patients who have
17 permanent pain problems, correct?
18 **A. Like I say, unfortunately, that's true.**
19 Q. And do those people who have permanent
20 pain problems sometimes require opioids on a
21 permanent basis?
22 **A. Yes. And, again, what we're looking at is**
23 **their overall level of function. We want them to**
24 **work, interact with their family, have a social life**
25 **and looking at their life, we want them to have a**

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1 **life. Now, some people unfortunately to have a life**
2 **require indefinite use of narcotics.**
3 Q. Doctor, in your experience have you seen a
4 trend whereby a lot of doctors just shy away from
5 assuming care for folks who have chronic pain?
6 **A. I have seen that trend. Apparently the**
7 **witness before me indicated that she wasn't aware of**
8 **that trend. But just in my look at the Helena**
9 **community, I would have to say that you're correct.**
10 Q. Dr. Kneeland yesterday testified that his
11 success rate at weaning patients from narcotic pain
12 medication approaches 10 percent. How does that
13 compare with what you've seen in the case of these
14 nine patients?
15 **A. Well, at the slice of time I looked at, I**
16 **would say that Dr. Ibsen was batting better than**
17 **that, considerably better. I wouldn't realize that**
18 **was Dr. Kneeland's testimony.**
19 Q. How in the course of your practice would
20 you treat a patient who the diagnosis was chronic
21 pain? What kinds of things would you do for them?
22 **A. Well, as has been discussed by other**
23 **people, I guess, you try to utilize as many**
24 **resources as you have available. Now, that may be**
25 **other practitioners from psychologists and**

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1 **psychiatrists to orthopedists, whatever. It may**
2 **have to have -- you may have counselors on board.**
3 **And then, of course, you have other**
4 **modalities, as the pharmacist testified. You've got**
5 **the contrasting hot and cold packs, you've got**
6 **anti-imflammatories, NSAIDs, you have steroid bursts**
7 **that you can use for acute pain flare-ups, which in**
8 **my experience are generally shorter than I think**
9 **what she was talking about, but that's just my**
10 **experience.**
11 **Chiropractic, you know, naturopathic**
12 **treatments. I mean, any resources that you can**
13 **bring into this situation, discussions with the**
14 **family. You try to gather as many resources as you**
15 **possibly can.**
16 **HEARING EXAMINER SCRIMM:** Can we pause
17 there for a minute?
18 **MR. DOUBEK:** Certainly.
19 (Off the record briefly.)
20 Q. (By Mr. Doubek) Doctor, in your review of
21 the records, did you find any instance where any of
22 these nine patients overdosed or diverted any of
23 their narcotic medications?
24 **A. No, I didn't.**
25 Q. In your view did the documentation lead

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1 you to the conclusion that Dr. Ibsen spent
2 considerable time with his patients?
3 **MR. FANNING:** Objection, leading.
4 **HEARING EXAMINER SCRIMM:** Sustained.
5 Q. (By Mr. Doubek) Do you have any opinion
6 whether the documentation shows the amount of time
7 Dr. Ibsen spent with his patients?
8 **A. It does.**
9 Q. And what does it indicate to you?
10 **A. From time to time certainly. I wouldn't**
11 **say every visit, every patient, but certainly there**
12 **are mentions of, you know, spent a long time**
13 **discussing this issue, whatever the issue.**
14 Q. Did the documentation that you reviewed
15 indicate that alternatives to narcotics were offered
16 to the patients?
17 **A. Yes.**
18 Q. Do you think that's appropriate?
19 **A. I think it's very appropriate.**
20 Q. Do you think it's appropriate that
21 considerable time was spent on various occasions
22 with the patients?
23 **A. Yes.**
24 Q. And is it essential in the care of
25 patients with chronic pain that there develops a

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1 trust relationship between doctor and patient?
2 **A. Absolutely. It's very important.**
3 Q. And why is that?
4 **A. The patients must understand that you're**
5 **on their side. Because so many of them have been,**
6 **I'll use the word fired by other physicians or**
7 **otherwise fall through the cracks, that they need to**
8 **have someone that they can trust that they know is**
9 **interested in their case, they're interested in the**
10 **patient and not necessarily the numbers.**
11 **And I have to say that's kind of my issue**
12 **with these pain contracts, pain management**
13 **contracts, is they set things up as us, physicians,**
14 **versus them. It's kind of like the assumption of**
15 **guilt, you know, until proven otherwise. We don't**
16 **count the pills of people taking Digoxin or, you**
17 **know, an anticoagulant. We don't demand that**
18 **they're on time for their appointments. I don't**
19 **know. I think that in principle it's an interesting**
20 **and probably a good idea. It's certainly good to**
21 **explain the options and explain what you're doing,**
22 **the risks and benefits. But having a signed,**
23 **written agreement is, it can cause an ethical**
24 **dilemma because patients may lose their trust if**
25 **they feel that they're --**

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1 Q. Well, and if a patient is still in pain,
2 it's your ethical duty to provide care for that
3 patient?
4 **A. Yes. The onus is already on the**
5 **physician, yes.**
6 **Anyway, I have mixed feelings about these**
7 **pain management contracts for that reason. And I**
8 **know there are bioethicists that also share those**
9 **feelings, so it's not like I'm just coming up with**
10 **this.**
11 Q. Now, up until the time that you retired in
12 2012, did you use written pain contracts?
13 **A. No, I did not.**
14 Q. Or did you see the other doctors that you
15 were concurrently working with use written pain
16 contracts?
17 **A. I saw some but I can't give you any**
18 **specifics. I don't even remember which physicians,**
19 **frankly.**
20 Q. Doctor, in your report I see that you
21 stated that patients requiring narcotics have
22 somewhat limited treatment options. By that what do
23 you mean?
24 **A. Well, I think that what I meant there is**
25 **limited options with respect to their caregivers,**

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1 **which we discussed previously. I think that that**
2 **is -- access is a problem. Again, it's my feeling**
3 **that finding a sympathetic physician who is willing**
4 **to work with you on prescribing medications and**
5 **follow up and decriminalizing the interaction is**
6 **unusual. I think that's, you know, I'm just going**
7 **to say it's hard to find in Helena. It isn't that**
8 **there isn't sympathetic doctors here, but the**
9 **regulatory demands and the legal implications and**
10 **the concerns about overprescription and such are --**
11 **most doctors, I'd have to say most in my experience**
12 **don't want to mess with that unless they absolutely**
13 **have to.**
14 Q. Doctor, do you have an opinion as to
15 whether Dr. Ibsen practiced medicine within
16 appropriate boundaries and guidelines of his
17 license?
18 **A. I believe so.**
19 Q. And your opinion in that regard is what?
20 **A. Well, he's a licensed -- he's a physician**
21 **licensed to practice medicine in Montana and so he**
22 **can prescribe the medications and have the other**
23 **interactions with patients that are necessary within**
24 **the scope of a license. I think that's --**
25 Q. Do you feel he met standard of care in the

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1 respects of his practice relative to these nine
2 patients?
3 A. **I think he did.**
4 Q. Do you believe that these nine patients
5 should be categorized as difficult patients with
6 complex chronic pain symptoms?
7 **MR. FANNING:** Objection, leading.
8 **HEARING EXAMINER SCRIMM:** Sustained.
9 **MR. DOUBEK:** That's fine.
10 Q. (By Mr. Doubek) Doctor, with regard to
11 these nine patients, can you categorize them as
12 patients with simple disorders or more complex
13 disorders or what?
14 A. **Yes.**
15 Q. And how would you categorize them?
16 A. **Well, I think the majority, if not all,**
17 **they are complicated, there are complex issues**
18 **involved. I guess that's it.**
19 Q. Okay.
20 **MR. DOUBEK:** Those are all the questions I
21 have.
22 **HEARING EXAMINER SCRIMM:** Mr. Fanning?
23 **MR. FANNING:** Thank you.
24
25

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1 CROSS-EXAMINATION OF DR. CHARLES ANDERSON
2 **BY MR. FANNING:**
3 Q. We got a stack of records, Dr. Anderson,
4 that I've just placed on the table and that
5 represent the records for the nine patients. There
6 is also another stack of records that's L-1 through
7 L-9 is the big stack and our 1 through 9 is a small
8 stack. Did you ask to get the complete set of
9 records?
10 A. **I did not ask to get any of the records.**
11 Q. Well, was it important to you to have full
12 access to everything?
13 A. **Yes.**
14 Q. And it would probably be unfair to just
15 study part of it without having access to
16 everything?
17 A. **I understood I had access to everything.**
18 Q. Do you know which stack you considered
19 when you completed your opinion back in February?
20 A. **I didn't have a physical stack. I had**
21 **access to the records that were online.**
22 Q. So Dr. Ibsen had everything then available
23 to you electronically?
24 A. **Everything that I needed. I'm not sure I**
25 **had -- I don't know what I didn't have, put it that**

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1 **way.**
2 Q. So you can't say with any certainty
3 whether or not you had the 800-page stack or the
4 2,800-page stack?
5 A. **No.**
6 Q. Who had control of the records?
7 Dr. Ibsen, right?
8 A. **I don't know if he had ultimate control.**
9 **I was given free access to whatever was available in**
10 **their clinic that could be retrieved electronically.**
11 Q. And when did you get that?
12 A. **January.**
13 **THE WITNESS:** Was it January?
14 **MR. DOUBEK:** December.
15 Q. (By Mr. Fanning) So you began your study
16 in January, but you can't say with any certainty
17 what the collection actually amounted to because it
18 wasn't physical?
19 A. **Yeah. Again, I just reiterate. I know**
20 **what I have. I don't know what I didn't have.**
21 Q. So could there have been things that you
22 didn't have?
23 A. **There could have been.**
24 Q. In the course of your long career as a
25 neurologist, did you ever have to sit down with the

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1 DEA and get coaching on how to prescribe narcotics?
2 A. **Sit down with the DEA to coach them?**
3 Q. No. For them to coach you on prescribing
4 narcotics.
5 A. **Oh, no.**
6 Q. Would you find that unusual?
7 A. **Well, it would be unusual for me.**
8 Q. Any of your colleagues ever have that
9 happen to them?
10 A. **I don't speak for my colleagues. I don't**
11 **know.**
12 Q. Did you ever have occasions to have
13 discourse with a pharmacist about a course of
14 medication?
15 A. **Yes.**
16 Q. How did that play out?
17 A. **I've had pharmacists call me and notify**
18 **me -- this the pre-PDR days -- do you realize that**
19 **Joe Blow is getting stuff from someplace else? No,**
20 **he didn't tell me about that. Or I may say I did**
21 **know about that, in which case I oftentimes have a**
22 **discussion with the patient.**
23 Q. So if the pharmacist had access to a point
24 of view that you didn't, it was your experience that
25 they'd share that with you?

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1 **A. Well, again, I know the times they did**
2 **share it. I don't know when they didn't share it.**
3 Q. Of course.
4 **A. Yeah.**
5 Q. So did you find their point of view
6 helpful? I mean, was that useful in your medical
7 management?
8 **A. Well, if I found out that they were, for**
9 **example, if a medication that I prescribed would**
10 **interfere somehow, I have to say most often I had**
11 **considered that but there was a good reason for it,**
12 **you know, because of some overriding concern. But**
13 **sometimes, you know, we can always learn, and**
14 **especially if I found out in the case of pain**
15 **medication that they were getting it elsewhere, that**
16 **raised a different dimension.**
17 Q. And I expect you appreciated that, didn't
18 you?
19 **A. Yes.**
20 Q. Did you find that there was friction
21 between you and the pharmacist when they alerted you
22 to those facts?
23 **A. I don't recall that there was.**
24 Q. So you --
25 **A. They were pretty benign interactions.**

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1 Q. Sure. Are you familiar with legal
2 requirements about prescribing narcotics? I'm sure
3 you are, right?
4 **A. As far as like the schedule and the**
5 **triplicate and things like that?**
6 Q. Yes.
7 **A. I'm aware of some of those things, yes.**
8 Q. And you practiced for 30 years, I'm sure
9 you have lots of experience. Is it permissible for
10 a patient to transfer their drug to somebody else
11 when it's prescribed to their name only?
12 **A. I would think unless in very unusual**
13 **circumstances, that's not cool. I mean, if someone**
14 **runs out and a friend of theirs has -- and I'm not**
15 **talking about narcotics necessarily, but --**
16 Q. I am.
17 **A. Okay. All right.**
18 Q. It probably happens, but is it lawful?
19 **A. No, I don't think it is.**
20 Q. Is that generally understood by doctors?
21 **A. I think so.**
22 Q. I'm going to hand you what's been marked
23 as -- wait a minute. These sets of records we might
24 refer to, Doctor. Could I get you to grab that
25 other stack too?

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1 I've handed you what's been admitted as
2 the Department's 17 and you'll see that that's a
3 photocopy of a prescription label. Do you see that?
4 **A. Uh-huh. Yes.**
5 Q. Can you read the little cautionary
6 instruction on the bottom left corner?
7 **A. "Caution: Federal law prohibits the**
8 **transfer of this drug to any person other than the**
9 **patient for whom it is," something, something.**
10 Q. Sure. Do you see who the patient is?
11 **A. Mark Ibsen.**
12 Q. Would it be proper in your opinion for
13 Dr. Ibsen to just hand that over to another
14 individual?
15 **MR. DOUBEK:** Objection, assumes a fact not
16 in evidence. That isn't what happened and,
17 furthermore, the matter was dismissed by the
18 Board of Medical Examiners screening panel.
19 **MR. FANNING:** Okay.
20 **HEARING EXAMINER SCRIMM:** Sustained.
21 Q. (By Mr. Fanning) Can Dr. Ibsen
22 represcribe that in any fashion to a third party?
23 **A. Represcribe it?**
24 Q. Yes.
25 **A. You mean write another prescription?**

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1 Q. Yeah. Now, you said that in a way that
2 you looked puzzled. It's just not ordinary for
3 someone to have a prescription and then represcribe
4 it to somebody else, is it?
5 **MR. DOUBEK:** Objection. Go ahead.
6 **A. It's not ordinary. So what are the**
7 **circumstances? What happened? Can you fill me in**
8 **on that?**
9 Q. (By Mr. Fanning) Well, I can if you'd
10 like. The testimony has been that Dr. Ibsen had a
11 patient who was desperate for pain medications so he
12 wrote out a script for his medication to transfer it
13 to that patient.
14 **MR. DOUBEK:** Objection, that's only a part
15 of the story.
16 Q. (By Mr. Fanning) Is that lawful?
17 **HEARING EXAMINER SCRIMM:** Overruled.
18 Q. (By Mr. Fanning) Is that lawful?
19 **A. It's not lawful.**
20 Q. Okay.
21 **A. Is it humane? I don't know the**
22 **circumstances.**
23 Q. Right. And we can debate that part.
24 **A. Yeah. Certainly if a patient is about to**
25 **go into withdrawal because they can't get any**

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1 **other -- I don't know the circumstances. I'm not**
2 **privy to that, so...**
3 Q. Now, what I want to do next is talk about
4 your view of what's expected in responsible opioid
5 prescribing. Okay?
6 A. **Okay.**
7 Q. Again, we're going to talk about the
8 standard of care in responsible opioid prescribing.
9 And you already testified that it's your judgment,
10 your medical opinion, that a written controlled
11 substance agreement is not necessary; is that
12 correct?
13 A. **That's correct.**
14 Q. Are there any other restrictions that
15 should be employed to prescribe within the standard
16 of care?
17 A. **I think the standard of care would require**
18 **a doctor to discuss the options.**
19 Q. Would that be charted?
20 A. **May or may not be.**
21 Q. And under the standard of care, best
22 practices, should there be documentation in the
23 chart that alternatives and risks were discussed
24 with the patient?
25 **MR. DOUBEK:** Objection to the form of the

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1 question. It's compound. Is he talking about
2 standard of care or best practices?
3 Q. (By Mr. Fanning) Okay. Eliminate the
4 best practices part.
5 A. **Standard of care. You know, it would have**
6 **been my standard of care.**
7 Q. To chart it?
8 A. **To chart it.**
9 Q. And it's kind of like any other informed
10 consent, those are in writing, aren't they?
11 A. **Yes.**
12 Q. What other essentials are there to a
13 chronic pain management protocol within the standard
14 of care?
15 A. **I think that routine follow-up is**
16 **required.**
17 Q. And by follow-up, what does that include?
18 A. **At the time of the expiration of the**
19 **prescription, if the consideration is that this**
20 **might be something that's going to be used long**
21 **term, there needs to be some continued cooperation**
22 **between the patient and the physician or prescriber.**
23 Q. But should there be assessments of
24 efficacy?
25 A. **Yes.**

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1 Q. That should be charted, shouldn't it?
2 A. **Ideally.**
3 Q. Ideally or under the standard of care?
4 A. **You know, I think the standard of care**
5 **would suggest that somewhere in that chart there is**
6 **an indication of how the patient is doing.**
7 Q. Okay. What other expectations do you
8 have, just elemental, to meet the standard of care?
9 A. **Well, we talked about informed consent, we**
10 **talked about routine follow-up. That would include**
11 **monitoring for side effects and part of the informed**
12 **consent would be discussing options, other options.**
13 **I already mentioned using other modalities, other**
14 **available resources. I'm not sure what you're**
15 **getting at. If you want to give me a multiple**
16 **choice, I can say yes or no.**
17 Q. All right. Those are the ones off the
18 cuff. Do you understand what a pill count is?
19 A. **Yes.**
20 Q. Do you believe that a pill count should be
21 part of the standard of care?
22 A. **I don't personally believe that.**
23 Q. Okay. What about urinalysis?
24 A. **I think if you have a question as to**
25 **whether the patient is taking their medication or**

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1 **other, or more importantly perhaps, if they're**
2 **taking other nonprescribed medications, those are**
3 **the main reasons for doing the urinalysis.**
4 Q. Should that be a qualitative assessment or
5 a quantitative assessment?
6 A. **Well, in the real world they're mostly**
7 **done qualitatively because it is very difficult to**
8 **correlate a blood level with a certain dose.**
9 Q. Is it important to have just a single
10 provider, that is to say, only one person writing
11 that individual opioids?
12 A. **Again, I think that's the ideal.**
13 Q. I don't want to talk about ideals. I'm
14 sorry, Doctor. I want to talk about standard. I
15 don't want to talk about some unreachable optimum,
16 just the standard of care expected of an ordinary
17 doc in Montana.
18 A. **Prescribing the same medication?**
19 Q. No.
20 A. **Or all medications?**
21 Q. All pain substance or pain control
22 medications for sure.
23 A. **Yes, I believe that that is -- there**
24 **shouldn't be other prescribers prescribing narcotic**
25 **pain medications.**

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1 Q. And if there were, a doctor would want to
2 act upon that; would he not?
3 **A. Yeah. And I think that's part of the**
4 **reason for the Physician Drug Registry.**
5 Q. The Prescription Drug --
6 **A. The Prescription Drug Registry.**
7 Q. Yeah, or MPDR. So sure, absolutely. In
8 whatever records you looked at, how many times did
9 you find MPDR records contained within?
10 **A. All of the patients I looked at I had a**
11 **flow sheet showing, it must have been MPDR records.**
12 Q. Okay. Now take that large ring binder
13 that's in front of you, Doctor, and that, again,
14 I'll represent, is a collection of records supplied
15 by Dr. Ibsen's office. We're calling it Exhibits 1
16 through 9, and within it the document you just
17 opened is Exhibit 28-1. Do you see that on the
18 bottom right?
19 **A. Yeah, I had these things.**
20 Q. Disregard that for a second.
21 **A. Okay.**
22 Q. Just look at the records. Apart from
23 those other exhibits that are included in there for
24 convenience, do you find any, I mean any MPDR
25 records in those 850 pages? Thumb through it. Are

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1 there any?
2 **A. Well, Mr. Fanning, all I can tell you is**
3 **that when I reviewed the records, I had those. I**
4 **don't know that they are a part of this binder or**
5 **what, but I had them in order for me to come up with**
6 **my opinion.**
7 Q. Okay. And I appreciate that.
8 **A. Okay. Isn't that the point?**
9 Q. Here is another stack of records, and this
10 is the 28 that Respondent has labeled Exhibits L-1
11 through L-9. You can randomly grab any of these and
12 tell me, is there any one MPDR record contained
13 within that? Just go ahead and help yourself.
14 **A. Well, I'll take your word for it. I can**
15 **only speak to what I reviewed. That's what I used**
16 **to come up with my report.**
17 Q. So when you got your report, you had
18 access to MPDR records on those people?
19 **A. Yes.**
20 Q. All right.
21 **A. I remember it very strikingly because I**
22 **wasn't aware that it existed. It was not there when**
23 **I was prescribing medication. This is a new, fairly**
24 **new development and I thought this is really a neat**
25 **thing to have.**

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1 Q. And that was back in January when you
2 first started --
3 **A. Right.**
4 Q. -- analyzing it? Okay. Now, let's take a
5 look at the stack that you have in front of you.
6 And, again, we've been all really cautious about not
7 mentioning names so I'm going to talk about people
8 in terms of their exhibit number.
9 **A. Okay.**
10 Q. And it's tabbed for each patient. Would
11 you turn to Tab 2 and there at the beginning of that
12 we have Exhibit 28-2.
13 **A. Are you talking about this thing?**
14 Q. I am. One of the things that we talked
15 about --
16 **A. Just so you understand, I only had access**
17 **to the entries on the second page, of these anyway.**
18 **Well, I shouldn't say that. Yeah, from December of**
19 **'13 on back is what I had access to.**
20 Q. But one of the things we talked about
21 earlier is how, one of the essentials is to only
22 have a single provider for narcotics or chronic pain
23 drugs, right?
24 **A. Uh-huh.**
25 Q. Now, if you look back at a couple of

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1 pages, can you tell me how many providers are there?
2 It will be in the second or third column from the
3 right. Just read them out. Can you see the
4 columns?
5 **A. Yep. Okay. Mitchell, Mitchell, Mitchell,**
6 **Mitchell, Mitchell, Williams, Rabold -- no, no, no,**
7 **Mitchell.**
8 Q. You don't have to read all of them, just
9 every line. There are a number of doctors, aren't
10 there?
11 **A. Mulgrew, Mulgrew, Mulgrew, Mitchell. Yes.**
12 Q. Knowles, Sinling, (phonetic) Lay, Coyle,
13 Jorstad. Right? Go back a page, please, Doctor.
14 Ellis, Gallis, Rabold. I mean, there are many.
15 Harper. Did you have access to that when you did
16 your analysis?
17 **A. I would have.**
18 Q. Does anything about that suggest that this
19 patient should have special scrutiny to make sure
20 that they don't behave like a doctor shopper?
21 **A. Yes.**
22 Q. Was there anything in Dr. Ibsen's chart
23 that suggested he was attentive to that and
24 responded to it appropriately?
25 **A. Frankly, Mr. Fanning, I do not recall this**

1 **specific patient in the references that you're**
2 **talking about.**
3 Q. Let's do this again one time. Would you
4 turn, Doctor, to Tab 5? And, similarly, you'll find
5 Exhibit 28-5 in front of that. Now, I'll ask you to
6 just follow along with me to the last page.
7 **A. To the last page. Okay.**
8 Q. Yes. And we're just going to go from the
9 last page forward.
10 **A. Okay.**
11 Q. If you look at the date of that very first
12 prescription entered, it was January 13th of 2012.
13 Do you see that?
14 **A. Yes.**
15 Q. And from there did you note the number of
16 physicians that that patient saw?
17 **A. That she received prescriptions from?**
18 Q. Correct.
19 **A. Three.**
20 Q. On that page?
21 **A. On that page.**
22 Q. How many the next page? Page forward one,
23 please. It's hard to keep track. Isn't it, Doctor?
24 **A. Yeah. You lump the ER physicians**
25 **together, since those are ER visits.**

1 Q. Is it fair to say there is 10 or 12?
2 **A. I think that's probably a good guess.**
3 Q. And if we turn the page, we're going to
4 find something similar? Are we're talking about
5 different physicians now, right?
6 **A. Right.**
7 Q. Okay. Going back to that elemental point
8 about -- talking about that elemental point about
9 having just a single prescriber, was there anything
10 in Dr. Ibsen's chart that noted that this person
11 should deserve special attention?
12 **A. Well, again, without going through, it's**
13 **been almost a year since -- I'd have to go through**
14 **it.**
15 Q. But you can't say that there was, can you?
16 **A. I can't say that there was.**
17 Q. All right. Would a person who has this
18 difficult history deserve particular attention?
19 **A. I think, yes.**
20 Q. And that attention should be recorded in
21 the notes, wouldn't you think?
22 **A. Well, I think it would be nice to know**
23 **that there are multiple physicians prescribing**
24 **medications for this patient. That would be useful**
25 **for any of these doctors to know.**

1 Q. Just one more of these exercises. Let's
2 turn to Tab 6, please. Now, on the last page, as
3 we've done before, there are a number of different
4 prescribers offering controlled substances, correct?
5 **A. Yes.**
6 Q. And among those Dr. Ibsen, true?
7 **A. Yes.**
8 Q. But then on the second page, or the middle
9 page, at some point, you see at the top, there is a
10 change in the quality of that, isn't there? They
11 all are from Dr. Ellis?
12 **A. Yes.**
13 Q. Do you know who Dr. Ellis is?
14 **A. I do not.**
15 Q. At that point that patient is receiving
16 exclusively Suboxone prescriptions. Do you see
17 that?
18 **A. Yes.**
19 Q. And then that continues on through 2014
20 principally, doesn't it?
21 **A. Yes.**
22 Q. What is Suboxone?
23 **A. Suboxone is a narcotic antagonist-**
24 **agonist.**
25 Q. Meaning what?

1 **A. Meaning it has properties of an opiate**
2 **blocker and an opiate stimulator.**
3 Q. And what is it used for?
4 **A. It's used for maintenance therapy. It's**
5 **basically another narcotic. It's like Methadone in**
6 **the way that you can move someone from heroin to**
7 **Methadone. You can move them from Hydrocone to**
8 **Suboxone, although they may withdraw but, yeah.**
9 Q. But who is entitled to prescribe Suboxone
10 for maintenance therapy?
11 **A. I'm not sure these days who is...**
12 Q. It's a special qualification under the DEA
13 registrations, isn't it?
14 **A. Okay.**
15 Q. You know that or you don't know?
16 **A. I'll take your word for it.**
17 Q. But it's used for addiction treatment,
18 isn't it?
19 **A. Yes.**
20 Q. So pretty clearly this patient had
21 multiple prescribers over many months and then
22 finally settled into an outpatient addiction
23 treatment plan. We can tell that from these
24 records, can't we?
25 **A. Yeah, I guess until February.**

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1 Q. Okay.
2 A. **And then she got prescriptions from two**
3 **other doctors.**
4 Q. That's all I have of that right now.
5 Thank you, Doctor.
6 So the hallmark I think of your expert
7 witness disclosure was that you were applauding
8 Dr. Ibsen on his unusual skill in weaning patients,
9 correct?
10 A. **Yes.**
11 Q. And it's your testimony that the evidence
12 reflects that he's doing a good job of weaning
13 patients?
14 A. **Again, the records I had, the slice of**
15 **time ending in January and not necessarily aware of**
16 **what's happened since, but at that time the majority**
17 **of the patients had been, their doses, total doses**
18 **of narcotics had been decreased and in some cases**
19 **stopped.**
20 Q. But, again, the records that you saw were
21 the ones that were offered to you, the access that
22 was offered by Dr. Ibsen, correct?
23 A. **I don't know who chose those patients.**
24 Q. In your testimony or, excuse me, in your
25 disclosure, the very first paragraph -- do you have

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1 it handy?
2 A. **Yes.**
3 Q. The very first sentence says you got to
4 review spreadsheet and current documents from the
5 Montana Prescription Drug Registry, right?
6 A. **Yes.**
7 Q. Did that bear on your opinion?
8 A. **Yes, it did.**
9 Q. But, again, we don't have that in either
10 Exhibit 1 through 9 or L-1 through 9, if you know?
11 A. **You mean minus these?**
12 Q. No. Those are Exhibit 28.
13 A. **Okay. Again, without wading through, I'll**
14 **take your word for it. I don't know.**
15 Q. Which of Dr. Ibsen's patients are now
16 entirely off of narcotics? Now, again, be careful,
17 just the number, please.
18 A. **Yeah. And I didn't keep track of which**
19 **ones were as of January.**
20 Q. But a more important bit of evidence would
21 be the current MPDR records; do you agree?
22 A. **Well, they would include the other ones.**
23 Q. But --
24 A. **The ones I saw should be incorporated in**
25 **here, wouldn't they?**

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1 Q. Right. But this is Exhibit 28, that
2 series, is up until mid-November. So that would be
3 a better indication of who is off of narcotics than
4 anything you might have studied in January, correct?
5 A. **So as of now you want to know who is off**
6 **narcotics?**
7 Q. Yeah. And you can't say?
8 A. **I can't say.**
9 Q. All right. Did you study Dr. Ibsen's
10 records with an eye towards discussions about
11 weaning?
12 A. **Well, I looked for them, yes.**
13 Q. And you found those discussions, right?
14 A. **Yes.**
15 Q. Is there any reason that a person is
16 medically required to wait for some event to start
17 weaning or could you start immediately?
18 A. **I would say that depends on the person and**
19 **depends on the event. I mean, if you -- I'm just**
20 **thinking if I know someone is going to have to pack**
21 **up from one house and move to another, maybe now is**
22 **not the time to start weaning.**
23 Q. But that would be in the chart.
24 A. **You're kind of setting yourself up for**
25 **failure. I mean, you want to get the situation**

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1 **where things are stable for a long period of time.**
2 Q. Because you have to deal with an
3 individual's circumstance. But if a chart note just
4 says wean without any further definition, is that
5 complete, is that adequate?
6 A. **Well, if it just says wean, it's just**
7 **saying wean...**
8 Q. So it doesn't explain why we're delaying,
9 because of some social or job-related issue, that
10 would not be good enough; is that right?
11 A. **Well, if it just says wean, it just says**
12 **wean. It doesn't say why, it doesn't say why.**
13 Q. But in your medical judgment is that
14 adequate charting?
15 A. **Well, it wouldn't be for me.**
16 Q. Is that adequate medicine to just posit
17 wean followed by three exclamation points?
18 A. **Well, at least I know what's going through**
19 **the mind of the physician.**
20 Q. You do? Well, what can you glean from
21 that?
22 A. **Well, I can glean that he's thinking about**
23 **weaning.**
24 Q. Is there a difference between thinking
25 about weaning and executing it?

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1 **A. Sure.**
2 Q. And obviously what we're trying to do is
3 execute it, not talk about it?
4 **A. But one has to precede the other.**
5 Q. Agreed. Let's do an exercise with
6 Exhibit 8. And I'm going to ask you to turn to the
7 back of it more near Tab 9, to page 737. The only
8 thing I want to note on this is it appears to be the
9 beginning of this set of records, because it's the
10 last date. And its date is February 20th, 2011,
11 correct? It's up at the top.
12 **A. Oh, February 20th. Yes.**
13 Q. And this patient embarks on a course of
14 care with Dr. Ibsen. And then let's page back to
15 709 if you would, please.
16 **MR. FANNING:** Do I need to give you the
17 dates so you can keep up? I'm sorry. That's
18 February 21, Mr. Doubek.
19 **MR. DOUBEK:** Thanks, Mike.
20 Q. (By Mr. Fanning) So are you with me,
21 Dr. Anderson?
22 **A. Uh-huh.**
23 Q. Can you read that chart note?
24 **A. It says, "Recheck in four to six weeks.**
25 **Hope to begin weaning." I think.**

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1 Q. Yeah, I think that's what it says too. So
2 that is February 21. Now let's page back to 672.
3 And that is November 20th, 2012. Have you arrived?
4 **A. Yep.**
5 Q. What's the chart note for November 20th of
6 2012?
7 **A. It says, "Wean," two exclamation points.**
8 Q. Anything else?
9 **A. No. Well, it says, "Colitis," something,**
10 **"anxiety, chronic pain."**
11 Q. In other words, nine months have passed
12 and we have no indication of what the assessments
13 were, what the changes were, why the delay, it's
14 just now we're still exclaiming wean, right?
15 **A. That's true.**
16 Q. All right.
17 **A. I haven't looked at the intervening notes**
18 **to see what all happened in there.**
19 Q. Fair enough. Now page back to 690 at
20 December 21 of 2012.
21 **A. I've got June 22nd.**
22 **HEARING EXAMINER SCRIMM:** Do you mean 590?
23 Q. (By Mr. Fanning) I meant to say 670. I
24 don't know what I said.
25 **HEARING EXAMINER SCRIMM:** It wasn't close.

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1 Q. (By Mr. Fanning) Are you there, Doctor?
2 **A. Yes.**
3 Q. And you see that there is a number of
4 entries in that handwritten note. But midway
5 through it can you read the chart note that
6 Dr. Ibsen provided?
7 **A. It says, "I want to wean off. Coloscopy**
8 **pending. Dr. Cortese. See Roush."**
9 Q. That's all I need you to touch. So now
10 we're ten months into it and we're still just
11 anticipating weaning.
12 **A. Okay.**
13 Q. Now page back --
14 **A. What's with the coloscopy shell?**
15 Q. Now we're at 655 and February 5th of 2013.
16 Are you with me?
17 **A. Not yet. 655. Okay. "Refill meds."**
18 Q. Are you having trouble reading it?
19 **A. Fentanyl, Lortab. I'm not quite sure.**
20 Q. Following that?
21 **A. "Wean after colonoscopy and biopsy.**
22 **Wean."**
23 Q. So now it's been a full year and all we've
24 done is anticipate weaning but apparently no
25 progress, right?

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1 **A. No progress with that.**
2 Q. Now, the last thing I want you to do with
3 respect to Patient Number 8 is look at the MPDR
4 records that are printed on Exhibit 28-8. It will
5 be right there.
6 **A. Okay.**
7 Q. At the very top you'll see the last
8 charted one, it's October 30th of 2014. Do you see
9 that?
10 **A. Right.**
11 Q. Is this person still on narcotics?
12 **A. Yes.**
13 Q. And from that page it looks like a very
14 regular program of steady doses, doesn't it?
15 **A. Yes.**
16 Q. Now, after studying that, can you still
17 stand by your opinion that Dr. Ibsen is particularly
18 skilled in weaning patients?
19 **A. Well, again, that was a statement based on**
20 **the records I had at the time and some of these**
21 **patients that were doing well a year ago are not**
22 **doing so well now. I don't know the reasons why and**
23 **I can't really comment on that.**
24 Q. So your opinion that he met the standard
25 of care was based on information that was provided

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1 to you by Dr. Ibsen some ten months ago?
2 A. **Yes.**
3 Q. And if there is information that might
4 undermine that, your opinion would have to change,
5 wouldn't it?
6 A. **Well, as far as being particularly**
7 **skilled, you know, again, his record was pretty darn**
8 **good back then.**
9 **MR. FANNING:** No other questions. Thank
10 you.
11 **MR. DOUBEK:** Just a few.
12
13 REDIRECT EXAMINATION OF DR. CHARLES ANDERSON
14 **BY MR. DOUBEK:**
15 Q. With regard to this patient that you just
16 looked at, the reference to narcotic medications
17 prescribed after May of 2014 were prescribed by
18 another doctor, weren't they?
19 A. **Yes.**
20 Q. Not Dr. Ibsen?
21 A. **That's correct.**
22 Q. And that doctor prescribed levels at least
23 as high or higher than Dr. Ibsen, true?
24 A. **For the most part higher.**
25 Q. And you haven't looked at the cause or the

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1 reasons why that's the case and nor has that doctor
2 here at this proceeding, correct?
3 A. **No.**
4 Q. Now, as I understand your record review,
5 Dr. Ibsen and his office made everything available
6 to you, whatever you wanted they made available to
7 you?
8 A. **Yes.**
9 **MR. FANNING:** Objection, leading.
10 Q. (By Mr. Doubek) And you --
11 **HEARING EXAMINER SCRIMM:** Sustained.
12 A. **I stated that though earlier on, so...**
13 Q. (By Mr. Doubek) Right. I know. And when
14 you agreed to take a look at the records in this
15 case, did you insist upon having access to
16 everything you wanted to have access to?
17 A. **Yes.**
18 Q. And I thought you testified, I just want
19 to clarify, that when you did your initial review,
20 you reviewed a lot of records, and then at some
21 point in time after you prepared your report, you
22 reviewed even more records. Is that true?
23 A. **Yes.**
24 Q. At the time you prepared your report, you
25 spent maybe 16 to 20 hours of time reviewing, and

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1 when you were all done and you had reviewed
2 everything later on, you put in about 50 hours of
3 time?
4 A. **Total, yeah.**
5 Q. And I want to ask you about testimony
6 relative to informed consent for prescription pain
7 medications. You don't typically have the -- or did
8 you in your practice have a patient sign an informed
9 consent form, much like a surgical informed consent
10 form for prescription pain medication?
11 A. **No, I did not.**
12 Q. But you would discuss the efficacy, the
13 limitations, the risks, associated with the pain
14 medications?
15 A. **Certainly.**
16 Q. You don't have any reason to believe
17 Dr. Ibsen didn't do the same thing, do you?
18 A. **No, I do not.**
19 Q. And when a patient gets a pain medication
20 filled at a pharmacy, typically do they not receive
21 a lot of information about that medication's use,
22 limitations, contraindications?
23 A. **I certainly get a lot.**
24 Q. And that's usually information that comes
25 from the PDR?

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1 A. **I would imagine. Yeah, it seems like some**
2 **of it's also interpreted by an English-speaking**
3 **person so that we can understand it, yes.**
4 Q. All right.
5 **MR. DOUBEK:** Those are all the questions I
6 have. Thank you.
7 **HEARING EXAMINER SCRIMM:** I have two, I
8 think.
9
10 FURTHER EXAMINATION OF DR. CHARLES ANDERSON
11 **BY HEARING EXAMINER SCRIMM:**
12 Q. Doctor, the testimony you offered was that
13 this was based on your experience and training; is
14 that correct?
15 A. **Yes.**
16 Q. And any opinions you offered, were those
17 based on a reasonable medical certainty?
18 A. **To the best of my knowledge. I mean,**
19 **opinions I offered are, I offer are mine. I mean,**
20 **they're the best I can do at the time.**
21 Q. Okay. All right. Thank you very much.
22 **MR. DOUBEK:** Thank you.
23 **HEARING EXAMINER SCRIMM:** Why don't we
24 take a lunch break.
25 (Lunch break.)

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1 **HEARING EXAMINER SCRIMM:** Where are we
2 now?
3 **MR. DOUBEK:** We're going to ask Dr. Ibsen
4 to resume testifying.
5 **HEARING EXAMINER SCRIMM:** Okay.
6
7 DIRECT EXAMINATION OF DR. MARK IBSEN (Continued)
8 **BY MR. DOUBEK:**
9 Q. I'm not sure exactly where I left off, so
10 I'll just start anew.
11 **MR. FANNING:** Objection.
12 **HEARING EXAMINER SCRIMM:** No need. I've
13 got that one covered.
14 **MR. DOUBEK:** I'm not sure what my last
15 question was so I'll just start with a
16 different question is what I meant.
17 **HEARING EXAMINER SCRIMM:** Not all of them
18 over again.
19 **MR. DOUBEK:** No, please.
20 Q. (By Mr. Doubek) Doctor, tell me about
21 your office practices relative to patients who
22 present for care for their pain, chronic pain.
23 **A. Well, that's an evolving process.**
24 **Regarding the nine patients, I think you could say**
25 **that each one of those had a unique presentation.**

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1 **Patient 4 presented with lack of sleep and a**
2 **tremendous upset in their life, and then later on**
3 **had some issues that required pain medication and**
4 **then was off -- each patient had a different type of**
5 **presentation. The way I handle everybody is, the**
6 **motto is the healing begins when you walk through**
7 **the door. They come in, they register, they say**
8 **they want to be seen, they identify who the**
9 **practitioner is that particular day. Once they're**
10 **registered, unless they're acutely ill and need to**
11 **lie down, then we do bedside registration. But once**
12 **they're registered, they'll be taken through a vital**
13 **sign station, go to a room, have an evaluation by**
14 **one of the medical assisting staff.**
15 **There are protocols to follow in case,**
16 **like if somebody has a problem urinating, they'll**
17 **get a urinalysis before they see me. We want to**
18 **keep the flow going. Being it's an urgent care, one**
19 **of the measures of patient satisfaction is how long**
20 **the wait is and how long it is to get in there and**
21 **out of there.**
22 **So there is some lab protocols to follow,**
23 **there is picking the appropriate room to go in. And**
24 **then hopefully I get to that room fairly quickly.**
25 **And then I introduce myself and I say, "I'm Dr.**

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1 **Ibsen. How can I serve you?" and it goes from**
2 **there.**
3 Q. Before we get to that point, do you have
4 monthly staff meetings?
5 **A. Yes.**
6 Q. And what is covered insofar as long term
7 or chronic pain patients are concerned?
8 **A. Well, we cover everything at our staff**
9 **meetings, everything is up for grabs. The**
10 **departments of our business are empowered to invent**
11 **their protocols so that they own them. So around**
12 **the area of nursing, for example, someone may or may**
13 **not have a question or some input about a patient.**
14 **Let's discuss Patient 3. What are we up**
15 **to with that patient? So we go over -- we don't go**
16 **over every patient that we've seen. Now, we call**
17 **back everybody we've seen, so we do have an idea**
18 **what's happened three days after they've been seen.**
19 **So all of the staff is involved in that kind of**
20 **process.**
21 **But if one of the employees has a**
22 **question, we'll discuss it. If we have a difficult**
23 **case, we'll discuss it. If we have a grief-inducing**
24 **case, we'll really discuss that. So there is a lot**
25 **of things that we have to process and deal with in**

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1 **our day-to-day work.**
2 Q. Are you familiar with the Substance Abuse
3 and Mental Health Services Administration?
4 **A. Yeah.**
5 Q. SAMHSA?
6 **A. SAMHSA. Yeah.**
7 Q. Do they have materials that you utilize in
8 your practice?
9 **A. At some point during this process, that**
10 **booklet was recommended and I said, "Sure, we'll**
11 **look at that." And it didn't really particularly**
12 **change anything we were doing so we brought that in**
13 **and had everybody sign it.**
14 Q. So you had your staff review it?
15 **A. Yes.**
16 Q. Do you have your, all of your health care
17 providers at Urgent Care Plus complete the MPDR
18 online training?
19 **A. Yes.**
20 Q. And are you registered and have been
21 registered for online access to patient histories
22 and report appropriate pharmacy prescription data to
23 the MPDR?
24 **A. Yes.**
25 Q. And are there others in your clinic that

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1 are similarly registered?
2 A. **Yeah. Every practitioner we have is**
3 **registered.**
4 Q. And as I understand it, it went online in
5 October of 2012 and there was some time that it took
6 for the practitioners, such as yourself, to learn
7 how to use it, get registered and so forth. Were
8 you registered shortly after the first of the year?
9 A. **I think January or February of '13.**
10 Q. And you've used it --
11 A. **Regularly since.**
12 Q. When would you use it? What would
13 occasion your using the Prescription Drug Registry?
14 A. **Well, initially I wasn't used to using it,**
15 **so I would use it on a case where I didn't know**
16 **where someone was coming from or if they'd seen a**
17 **previous practitioner. And then it became clear to**
18 **me that it was such a great tool that I instituted a**
19 **policy where I think I'm using it in almost every**
20 **case. So I don't know when I wouldn't use it. It's**
21 **that good a tool.**
22 Q. And we'll look into that in a little more
23 detail.
24 I'm going to show you what's been marked
25 as Exhibit J. Would you identify that, please?

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1 A. **This the Pain Resource Guide.**
2 Q. What is that?
3 A. **It was -- I spent a lot of time educating**
4 **patients about what their possible options are and**
5 **there was a lot of repetitive information involved**
6 **in that and the staff was wondering -- you know, I**
7 **would discharge a patient and I'd say, "Well, get**
8 **them this handout and get them that handout. And**
9 **I'm going to make this over here and I'm going to**
10 **write this out," and not be able to read it. So the**
11 **staff kind of wanted us to have something more**
12 **systematic that I could point to or circle. And**
13 **that's what this is. It's about five pages of**
14 **resources that are available for people in Helena**
15 **who are in pain.**
16 Q. Do you hand that out to patients then?
17 A. **Well, someone who is in acute pain, a**
18 **chronic pain patient who suddenly came through the**
19 **door that didn't have any other conversations about**
20 **this in the past we would talk about it. Some**
21 **patients are extremely empowered and in charge of**
22 **their pain management and they don't need this.**
23 Q. When did you start handing that out to
24 patients?
25 A. **About a year ago.**

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1 **MR. DOUBEK:** I'd offer Exhibit J.
2 **MR. FANNING:** No objection.
3 **HEARING EXAMINER SCRIMM:** J is admitted.
4 Q. (By Mr. Doubek) Is this something that
5 goes into a patient's chart or is there a reference
6 made to the fact you've given a copy of this
7 Exhibit J to a patient, or how does that work?
8 A. **I would say that I referenced Pain**
9 **Resource Guide. I think if we totaled up the number**
10 **we've passed out, it would probably be in the five**
11 **hundreds.**
12 Q. But it's your standard approach now to
13 give them this unless for some reason they decline
14 to receive it?
15 A. **Well, yeah. The staff usually injure**
16 **themselves by rolling their eyes with yet another**
17 **Pain Resource Guide.**
18 Q. Doctor, some time ago there was a doctor
19 in Hamilton, Dr. Christensen, who had a large
20 practice devoted primarily to taking care of pain
21 patients, folks that were in chronic pain. The
22 witness from the DEA testified at the earlier
23 portion of this hearing that he had thousands of
24 patients, there was a newspaper account that said he
25 had about 850 chronic pain patients. Whatever the

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1 number is, I understand that when his practice
2 closed, some of those folks came to you to receive
3 care. Is that true?
4 A. **I wasn't there when all of the stuff**
5 **happened with Dr. Christensen, but I was there when**
6 **the patients came to see me, yes.**
7 Q. Approximately how many patients?
8 A. **I think 21, 22.**
9 Q. So 21 or 22 out of 850 is about, a very
10 small, 2.5 percent?
11 A. **2.5 percent, yeah.**
12 **MR. FANNING:** Well, object to the question
13 because there is no established figure.
14 **MR. DOUBEK:** I agree.
15 **MR. FANNING:** But we will agree that there
16 were 21 or 22 for sure.
17 **MR. DOUBEK:** I agree.
18 **HEARING EXAMINER SCRIMM:** Sustained.
19 Q. (By Mr. Doubek) How were you contacted by
20 these folks?
21 A. **They came in and registered.**
22 Q. Did they come in all together or --
23 A. **No. No.**
24 Q. -- or some at a time? Over what period of
25 time?

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1 A. **No. Well, it was in April of 2014, yeah.**
2 **So the first patient came in and he was pale and**
3 **sweaty and started telling me his story, and I was**
4 **moved by his dilemma.**
5 Q. What was his dilemma?
6 A. **He had been a patient of Dr. Christensen.**
7 **He stated that he went over there to the office,**
8 **encountered a closed office with crime scene tape**
9 **up, tried to make some phone calls and there was no**
10 **one answering the phones. He was out of his**
11 **medications and he was having pain and symptoms of**
12 **withdrawal, he was having abdominal pain, cramping,**
13 **sweating, restless legs and goose flesh.**
14 Q. What's that?
15 A. **You know, goose bumps.**
16 Q. Did you refuse to see these patients
17 because their doctor had had a problem with the
18 Board of Medical Examiners?
19 A. **Well, I had no idea what Dr. Christensen's**
20 **problem was and it was none of my business. I**
21 **thought I had a patient that had a problem right in**
22 **front of me.**
23 Q. So why did you agree to see these
24 patients?
25 A. **My ethical agreement called me to see**

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1 **these patients.**
2 Q. Why?
3 A. **Well, there is only two things I can do.**
4 **I can sometime occasionally, maybe, impact someone's**
5 **life expectancy and save their life. The rest of**
6 **the people I see, it's about suffering, and this guy**
7 **was suffering.**
8 Q. Did each patient present a different
9 condition?
10 A. **Oh, yeah, yeah. The first guy that came**
11 **in, he had had failed neck surgery, had a lot of**
12 **back pain. He was on this mix of short-acting and**
13 **long-acting opiates that seemed like it was huge.**
14 Q. So were these patients folks who brought
15 with them a stack of medical records?
16 A. **No. Apparently -- no, they didn't. The**
17 **records were apparently confiscated, so they were**
18 **not available.**
19 Q. So how did you learn what you needed to
20 learn about these patients in order to adequately
21 care for them?
22 A. **I don't know. I think there is a legal**
23 **term, res ipsa loquitur. I was looking at this guy,**
24 **he was really sick. Then it was clear to me, oh,**
25 **wait, there is a Prescription Drug Registry. I can**

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1 **refer to that and see what he's been on. So it**
2 **turns out that the availability of the Prescription**
3 **Drug Registry gave me a tool to see exactly who he**
4 **had been seeing and what medications he had been on.**
5 **And then I had the opportunity to take a history and**
6 **examine the patient, the scar on his neck, moving**
7 **stiffly and physical exam clearly had him in opiate**
8 **withdrawal.**
9 **I was so moved by the drama of this I was**
10 **trying to contact the TV stations. This is news**
11 **here. Here is a guy here who is in withdrawal and**
12 **somebody put him in withdrawal and it wasn't me.**
13 Q. The fact that he hadn't had care
14 available?
15 A. **Yeah.**
16 Q. And have some of these patients, these 21
17 or 22 patients, now moved on and received care
18 elsewhere, to your knowledge?
19 A. **Yes.**
20 Q. They're not all active patients of yours
21 presently?
22 A. **Oh, no.**
23 Q. Does that happen typically in your
24 practice, you see patients for a time and then after
25 a time they move on?

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1 A. **Sometimes the miracles are quick and**
2 **sometimes they take a while.**
3 Q. With regard to these 21 or 22 persons, did
4 you ever report any medication or prescription
5 abuses relative to any of them?
6 A. **Yes.**
7 Q. Tell us about that.
8 A. **At the time, I don't know if you recall**
9 **the testimony of Mr. Gardipee, he talked about the**
10 **high number of oxycodone pills that were being**
11 **taken. And we had an evolving process about that**
12 **where Mr. Gardipee refused to fill any more of**
13 **those, which I concurred with.**
14 **The next few visits people were going**
15 **from -- they initially started on Methadone and**
16 **oxycodone. When I saw them, I didn't give them any**
17 **Methadone, I just gave them the oxycodone. I didn't**
18 **feel like I was familiar enough with Methadone to**
19 **continue that process. So they were on maybe 360**
20 **milligrams of oxycodone a day. Most of them weaned**
21 **down to maybe 120 milligrams of oxycodone.**
22 **When the barrier that Mr. Gardipee put in**
23 **at 30 milligrams, I respected that boundary that he**
24 **set and I immediately started to write for 10**
25 **milligram either Percocet or oxycodone. At that**

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1 **point two of those patients I wrote a prescription**
2 **for oxycodone 10 milligrams, two of those patients**
3 **altered that prescription. One of them actually had**
4 **it filled at 30 milligrams, changed a 10 to a 30.**
5 **The other person was stopped and the prescription**
6 **wasn't filled.**
7 **The reason -- the way we ascertained that**
8 **that had happened is we take every Schedule II**
9 **prescription, fax it to a destination pharmacy. So**
10 **they get a fax; then the patient brings the hard**
11 **copy with them. I don't see how I could in good**
12 **conscience give a hard written prescription to**
13 **someone who may be about to commit a felony and not**
14 **do something to prevent it. So I just fax**
15 **everything to the pharmacy so they can see a fax and**
16 **then when that hard copy comes and matches up, we're**
17 **good. If it doesn't match, we're not.**
18 Q. So in the case of the person who altered
19 the prescription, you had faxed an accurate copy of
20 the prescription to the pharmacy but they relied
21 upon the hard copy?
22 A. **Correct.**
23 Q. Evidently didn't look at the faxed copy?
24 A. **Perhaps.**
25 Q. Who knows. Okay. To your knowledge, is

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1 that something you're required to do?
2 A. **No.**
3 Q. And to whom did you report the
4 prescription abuses?
5 A. **I called Shane Hiett, who is the person**
6 **I'm related to at the Missouri River Drug Task**
7 **Force. He and I have worked together investigating**
8 **several of my patients who have been accused of**
9 **fraudulently attempting to obtain narcotics.**
10 **So I have -- his predecessor was Tom**
11 **Clark, I had a great relationship with him as well.**
12 **And I also called Agent Tuss and Agent Addis from**
13 **the DEA.**
14 Q. And Agent Tuss testified earlier in this
15 proceeding?
16 A. **Yes.**
17 Q. Tell me about your, the reason why you
18 first visited with the DEA.
19 A. **It wasn't my reason.**
20 Q. Okay. What led you to meet with the DEA?
21 A. **They came to my office and I said, "Here I**
22 **am."**
23 Q. Did they say why they were coming to your
24 office?
25 A. **Well, I asked them and they said the Board**

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1 **of Medicine asked them to come.**
2 Q. What was the substance of the meeting with
3 the DEA at that time?
4 A. **That was the first time I had met both**
5 **agents. It was myself on one side of the table and**
6 **Ellen Stinar, the office manager, on the other and**
7 **Agent Addis and Agent Tuss. And Agent Addis and I**
8 **talked about dog mushing, actually. He actually had**
9 **looked at the house of my dog mushing coach up in**
10 **Lincoln. So we had something in common. We talked**
11 **mushing for a while.**
12 **He told me he had been in Afghanistan for**
13 **the previous seven years and he has now come to**
14 **Montana. He asked me -- after all the icebreaking**
15 **preliminaries were done, he asked me, well, what's**
16 **our usual practice style, and I responded to him**
17 **similar to how I'm responding to you. I told him**
18 **how people come through the door, how they get**
19 **processed, if they're here for a particular**
20 **complaint we take care of whatever complaint, they**
21 **have to deal with. We refer them when it's**
22 **appropriate.**
23 **And gave them a tour of the whole place.**
24 **Took them down to Natural Medicine Plus so they**
25 **could see we have an open relationship and**

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1 **multidisciplinary hallway. I don't know if they**
2 **went over to see the physical therapy area or not.**
3 **We spent about an hour and a half together.**
4 Q. Were they critical of your practice in any
5 respect?
6 A. **No.**
7 Q. Did you ask them questions as to what you
8 could do so that any concerns they might have had
9 and not expressed to you could be alleviated?
10 A. **Well, the fact that they were there was**
11 **anxiety-producing, so I knew that something was up.**
12 **I was surprised to see them and I was being a little**
13 **bit cautious about what I was really wanting to**
14 **discuss with them, because they didn't tell me what**
15 **they were up, other than they wanted to interview me**
16 **and review some of my practicing techniques. They**
17 **didn't review any records, they didn't ask to see**
18 **any records, they didn't carry any subpoenas. They**
19 **did carry themselves with their badges. And there**
20 **is two things I remember very intently, because it**
21 **was repeated quite often, they said, "You must be**
22 **careful not to prescribe medications to people who**
23 **might divert them." And I said to them, "Well, how**
24 **would I know if they might divert them?" They said,**
25 **"Well, there are red flags," and they pointed out**

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1 **the various red flags, traveling a long distance,**
2 **traveling in a pod or group, having had multiple**
3 **previous physicians before, asking for particular**
4 **medications by name, gaming, such as not being able**
5 **to give a urinalysis if I asked for it, having beady**
6 **eyes, et cetera, et cetera. So that was all there.**
7 **And then the other thing they said to me when I**
8 **asked them, "How should I be managing this, if you**
9 **have some advice for me?" and they said, "We can't**
10 **advise you. We're not physicians."**
11 Q. Did the way in which you went about
12 prescribing pain medications for these patients of
13 Dr. Christensen's differ from the way you went about
14 prescribing medications for these nine patients?
15 **A. Oh, yeah. It differed a lot.**
16 Q. How so?
17 **A. Well, the patients that had seen**
18 **Dr. Christensen were on -- I mean, they were on**
19 **enough medication to put a city to sleep. So I've**
20 **never prescribed 30 milligram oxycodone before in my**
21 **life, and I saw those numbers and I was quite**
22 **shocked by them. And then when I looked at the**
23 **Prescription Drug Registry, it was clear to me that**
24 **this was somewhat habituated to that dose and they**
25 **were clearly tolerating it because they're not dead.**

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1 **And this patient in front of me is withdrawing and**
2 **I've got to -- I'm ethically obligated to do**
3 **something about that patient.**
4 Q. Are you skilled to recognize that?
5 **A. Yes.**
6 Q. How about other patients of these 21 or 22
7 who came to your office who weren't necessarily
8 exhibiting signs of withdrawal, what did you do for
9 them?
10 **A. Several of them did exhibit signs of**
11 **withdrawal and several of them didn't. There was**
12 **probably, you know, out of all those 21, I was**
13 **feeling kind of overwhelmed by the complexity of**
14 **this whole thing and, yet, I was -- it was clear to**
15 **me that these patients had no place else to go. So**
16 **I considered it my ethical moral obligation to take**
17 **care of them.**
18 **The ones who weren't in withdrawal, they**
19 **still told a very good story about -- and they would**
20 **show me a scar or something like that indicating**
21 **that they had a previous surgery. You know, one of**
22 **the guys was a veteran, was grown up in Iraq. I**
23 **thanked him for his service and I said to him, "I**
24 **don't think you went to Iraq and served our country**
25 **and then came back here to be characterized as a**

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1 **drug-abusing narcotic patient who is a criminal, did**
2 **you?" and he said, "No." He said, "I'm just trying**
3 **to get by in life."**
4 Q. And so with regard to each of these folks,
5 did you take a history and conduct a physical
6 examination?
7 **A. Yes, sir.**
8 Q. Is it reflected in your records?
9 **A. Yes, sir.**
10 Q. And we'll spend some time on the nine
11 patients in that regard. What kind of conversation
12 did you have with these folks concerning the
13 medications that you would agree to prescribe?
14 **A. Well, first of all, I was alarmed that**
15 **this had happened and I was in a -- I was disturbed**
16 **that this had happened, that this could happen, and**
17 **that patients in a country that stands for human**
18 **rights would actually do this to people. So I had**
19 **to deal with all that.**
20 **I called my office manager and I said,**
21 **"You've got to come in here because I need a**
22 **witness." And then we started to film some of these**
23 **interactions, and I said, "This patient is going to**
24 **be on -- I've got to put this patient on something**
25 **to help them with the withdrawal and pain. They've**

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1 **been on Methadone, we're not going to do that. So**
2 **we're going to use the amount of oxycodone that they**
3 **were on and then we're going to find out what their**
4 **usual doses are. And then we're going to -- once we**
5 **figure out what their needs are then we're going to**
6 **taper them. I said that to the patient. I said**
7 **that to the office manager. I said it to the rest**
8 **of the team. It's like we're going to take some**
9 **patients on here that are going to be challenging.**
10 **I don't see an option. Do you guys?" And they all**
11 **agreed but, of course, they're used to agreeing with**
12 **me.**
13 Q. Did your care -- how many of these 21 or
14 22 remained patients at your clinic?
15 **A. I don't know. I'd have to look. I think**
16 **I might be seeing one or two or three of them still.**
17 Q. But most of them have moved on?
18 **A. Yes.**
19 Q. Did any of these patients, were they the
20 cause of your subsequent conversations with the
21 pharmacist at Osco?
22 **A. Yes.**
23 Q. Tell me about how that led to the
24 conversation with Mr. Gardipee.
25 **A. Well, over the last year and a half, I've**

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1 gotten a lot of phone calls from pharmacists and the
2 same questions would be asked, "Is this the
3 medication you intend to prescribe?" And my
4 response was somewhat routine, "Yes." So at some
5 point I had fewer and fewer conversations with the
6 pharmacists about a question like that because the
7 answer was always the same. So I didn't hear much
8 from Bob until he said to, he called the office and
9 talked to Ellen and said, "I'm not going to
10 prescribe these 30 milligrams Oxycodones anymore."
11 I thought it was pretty clear the patients
12 were tapering and some of them tapered and strictly,
13 steeply, a couple people only saw me once or twice.
14 Some of them, when I gave them the 360 oxycodone a
15 day without the Methadone they didn't -- they
16 weren't able to make it a month. So some of those
17 patients got an increased dose the next several
18 times.
19 Q. Of the OxyContin?
20 A. Of the oxycodone, but not of Methadone.
21 So most of their pain medicine was in the Methadone.
22 So even if they made it through weeks on 360
23 oxycodone, I thought that was great compared to what
24 they were on, and I'd never prescribed medication in
25 that level before in my life.

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1 Q. So what was the reason why you decided to
2 contact Mr. Gardipee?
3 A. Well, he was -- it was clear by his strict
4 statement and boundary that he was not going to
5 prescribe those anymore, that we had a problem we
6 needed to talk about. And I was willing to
7 acknowledge to him at that point that my
8 communication hadn't been so great. It had been
9 pretty much routine, like, "Do you want to give
10 this?" "Yes." And my whole career I've given a lot
11 of thought to the prescriptions that I write and if
12 I write a prescription, it's because that's the
13 prescription I want to write.
14 Other communications from pharmacists have
15 been, well, they're allergic to this, you can't give
16 them that. Of course, we'll give them a
17 substitution. But these were different kinds of
18 questions.
19 So at that point he's saying, "No. I want
20 to know why." And I also thought that with this
21 uncertainty about the DEA, like I wasn't quite sure
22 why they were here other than the fact that the
23 Board had sent them and I'm in the middle of this
24 investigation from the Board. I wanted to know
25 exactly the best way to problem solve an issue with

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1 a bunch of different stakeholders, and the only way
2 I know to do that is to put all the stakeholders in
3 the room and talk about it.
4 So I called the DEA and invited them to
5 this meeting and I called Bob and, well, actually, I
6 didn't, Ellen did at my direction. And so we
7 decided to have a meeting. Bob wasn't able to go
8 offsite so we met at Osco.
9 Q. And you had your meeting, was that in
10 about June?
11 A. Somewhere late June.
12 Q. Of this year?
13 A. Yeah.
14 Q. And tell us about the meeting.
15 A. Well, the meeting was, I thought,
16 productive. I wanted to get a clear idea of where
17 Bob was coming from in his, you know, strict no more
18 30 milligram oxycodone. I wanted to learn what he
19 had to say. I wanted to get the DEA related to a
20 doctor and a pharmacist working together. Like
21 maybe I even wanted to demonstrate that I'm actually
22 interested in being proactive about this. Here is a
23 problem, let's deal with it.
24 So the perceived problem that Bob had was
25 his corporate office had said that he dispensed more

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1 30 milligram oxycodone than they had in forever, and
2 I got that. I wrote more than I'd ever written in
3 forever. I had never written that prescription
4 before April 14th of this year. So it was all new
5 to me too, and I figured, well, if we're inventing
6 this together, we should all talk about it and see
7 if there isn't some way to come to some agreements
8 that would help us get this done.
9 Q. So going forward, there was an agreement
10 to prescribe the 10 milligram?
11 A. There was no agreement. Bob said what he
12 was going to do and he's not going to fill them.
13 So, okay, so -- and he also said that he had called
14 all of the other pharmacists in town and talked to
15 all of them and had agreement from all of them.
16 Now, I did not survey all of those. So I took him
17 at his word that no one else in town was going to
18 fill these either. So I considered it a limit and a
19 boundary, and I think my main thing was to consider
20 it that it's the patient's got the pain, it's not my
21 pain. If there is a limit, then there is a limit.
22 So I immediately started to prescribe
23 Percocet 10 milligrams to those patients and some of
24 them were intolerant of acetaminophen and Tylenol,
25 part of Percocet, so some of them got 10 milligrams

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1 **Oxycodones.**
2 Q. Other than the acetaminophen, is there a
3 fundamental difference between a Percocet and an
4 oxycodone?
5 A. **Yes.**
6 Q. What is that?
7 A. **Well, Percocet is harder to abuse than 10**
8 **milligram oxycodone. I think it's pretty much --**
9 **it's pretty well know that the acetaminophen**
10 **component, if people are intolerant, that's probably**
11 **a red flag for people who really just want to get**
12 **the oxycodone and sell it, snort it, shoot it, all**
13 **the other illegal stuff that happens with**
14 **prescription narcotics.**
15 Q. Did the DEA weigh in on any aspect of the
16 meeting?
17 A. **Yes. The only thing that I was told, I**
18 **did hear probably ten more times, that we're not**
19 **doctors and we can't tell you how to prescribe. And**
20 **I also heard numerous times that you shouldn't**
21 **prescribe to patients like these and I would say, "A**
22 **patient like who?" "Patients who might be**
23 **diverting." And I said, "Do you have any evidence**
24 **that there has been diversion?" And they didn't say**
25 **yes and they didn't say no. They said that was**

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1 **their prerogative to share with me or not. So they**
2 **didn't share with me any evidence that everyone had**
3 **been diverting.**
4 **Bob did say that one of his staff had seen**
5 **two trucks next to each other and something change**
6 **hands between them. And he promised to get that**
7 **video and he got it to the DEA, didn't get it to me.**
8 **But I didn't really need to see it anyway. I didn't**
9 **think that was -- I'm no law enforcement person, but**
10 **I didn't think that was anything more than a rumor.**
11 **So the DEA, the last thing they said to me**
12 **was, "Dr. Ibsen, you are not only risking your DEA**
13 **license by prescribing to these folks, you are**
14 **risking your freedom."**
15 Q. So --
16 A. **That got my attention and I said, "All**
17 **right. I want to do this right. How can I do it?"**
18 **"I can't tell you. We're not doctors."**
19 Q. So going forward, Osco continued to fill
20 prescriptions for those persons, albeit it at the
21 lesser amount?
22 A. **Correct. Osco and other pharmacies in**
23 **town.**
24 Q. How about the contact that you had with
25 Mr. Otteson at Walgreens? Tell us about that. What

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1 led to your filing a complaint against Walgreens
2 over that?
3 A. **This is my first interaction, you know.**
4 **In retrospect, I can see very clearly what happened,**
5 **but at the time it was, I was in the dark. So I had**
6 **a patient who had -- this was in February. This is**
7 **not one of the nine patients. She has fibromyalgia**
8 **and had been seeing another physician who released**
9 **her from care. I think she was three or four days**
10 **early on a couple refills and they decided that they**
11 **didn't want her anymore.**
12 **So she came to see me and she was on**
13 **Hydrocodone for her fibromyalgia. We had extensive**
14 **conversations about how to get off of that. And she**
15 **had weaned a little bit or not at all. So in**
16 **February she went and had a dental procedure, a**
17 **crown or something like that done. And her dentist**
18 **left town and she got an infection. And here is**
19 **another dental thing. But, anyway, her face was**
20 **swelled out to here and she was having a lot of**
21 **pain. So we intervened with her dental infection,**
22 **gave her several series of different antibiotics,**
23 **similar to what you heard about on Patient 5. And**
24 **she got better.**
25 **In the meantime, she had used up her 130**

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1 **Hydrocodone on my recommendation and she had also**
2 **gotten several days of Percocet, because her pain**
3 **had, was way higher from the teeth than it was from**
4 **the fibromyalgia.**
5 Q. All right.
6 A. **At the end of the month, well, March 1st**
7 **comes along and she came to me saying, "Thank you.**
8 **My dental infection is better. I appreciate it so**
9 **much. It's time for my 120 Hydrocodone." So we**
10 **talked about the different options and the Pain**
11 **Resource Guide and all that kind of stuff. And she**
12 **said, "Thank you, and I'm not quite ready to wean**
13 **yet," and I agreed with her. She had just gotten**
14 **over this horrible dental infection. So I wrote her**
15 **a prescription for her usual 120 of Hydrocodone.**
16 **And she had gotten that from me for about five**
17 **months running and from the previous doctor for a**
18 **couple years, I think.**
19 **So she went up to Walgreens and came back**
20 **an hour and a half later in tears and she said they**
21 **wouldn't fill it. And I said, "Why?" They said,**
22 **"Well, it's too much for -- the pharmacist said it**
23 **was too much." And I thought, "Wow, that's**
24 **interesting." And the staff started to talk. We**
25 **had a busy day, so I had the staff look into it.**

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1 **They were told that the pharmacist wasn't**
2 **comfortable with that amount. And I'd never**
3 **actually heard that term before, so it was the first**
4 **day I'd ever heard that term, I'm not comfortable.**
5 **My response was the pain medication is for the**
6 **comfort of the patient, not the pharmacist.**
7 Q. Well, had the pharmacist ever contacted
8 you --
9 **A. No.**
10 Q. -- to that point?
11 **A. No.**
12 Q. Or thereafter?
13 **A. Well, there was one interaction that**
14 **terminated the conversation. But up until that**
15 **point, no.**
16 Q. Did you try to find out why the pharmacist
17 would not fill the prescription?
18 **A. I did. He just said he wasn't**
19 **comfortable.**
20 Q. So ultimately did you file a complaint
21 against him with the Board of Pharmacy?
22 **A. I did. I thought that the -- I thought it**
23 **was an inauthentic presentation to state that he**
24 **wasn't comfortable. I had a sense that there was**
25 **something else behind his lack of comfort. I think**

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1 **I was taking it somewhat personally, frankly,**
2 **because I had never had a pharmacy refuse a**
3 **prescription from me that wasn't written -- that was**
4 **written at my direction that didn't have an allergy**
5 **or other contraindication.**
6 **So I thought he was saying by refusing the**
7 **prescription that I was somehow bad or wrong or**
8 **incompetent or not legitimate in some way. So I was**
9 **a little stunned. And I thought it would be best**
10 **that maybe the pharmacies, the pharmacists and I**
11 **could all get together, we could have an adult sort**
12 **of lead the whole program, because we were at**
13 **loggerheads.**
14 Q. You learned later on that Walgreen's
15 corporate had had a difficulty with prescription
16 drugs down in Florida?
17 **A. Yes. They had a $70 million fine**
18 **apparently for some malfeasance around keeping track**
19 **of all their opioids.**
20 Q. So from headquarters came the news that
21 they had to deal with this in a certain way,
22 prescription medications?
23 **A. Well, yeah. It turns out there is a**
24 **checklist that the pharmacists have been given that**
25 **worked for Walgreens and it's called the good-faith**

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1 **dispensing policy.**
2 Q. But you hadn't been given a copy of that
3 ever?
4 **A. No. That's hard to find. I didn't find**
5 **that until quite recently on the Internet.**
6 Q. In any event, did the pharmacist at
7 Walgreens ever tell you precisely why he was
8 refusing to fill that prescription?
9 **A. Well, yeah. He said it was -- he wasn't**
10 **comfortable with that number of pills and the**
11 **patient had been filling that for months.**
12 Q. I understand that. But did he ever inform
13 you why he was uncomfortable with that much
14 medication?
15 **A. No.**
16 Q. Okay. And to this day you've not heard
17 otherwise?
18 **A. To this day in testimony he attested that**
19 **it was too many pain pills for a toothache. But I**
20 **never attested it was for a toothache. It was for**
21 **her monthly fibromyalgia prescription for her**
22 **Hydrocodone.**
23 Q. Which Hydrocodone she had been receiving
24 for a couple years before her toothache?
25 **A. Right.**

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1 Q. Doctor, I'd like to talk to you about the
2 nine patients. First of all, do you run a pain
3 clinic?
4 **A. No.**
5 Q. Is taking care of pain patients the
6 majority of your practice?
7 **A. Well, if they're not coughing and they're**
8 **not having diarrhea, they're having pain. So I**
9 **would say taking care of these kind of complex pain**
10 **patients, no. But everybody who comes to the door**
11 **has something that's bothering them that they want**
12 **to have adjusted.**
13 Q. And I'm talking about chronic pain
14 patients. Does that comprise the majority of your
15 practice?
16 **A. Oh, no, no, no. It's all about the**
17 **sprained ankles, sinus infections, pneumonia,**
18 **abdominal pain, ectopic pregnancies, the usual.**
19 Q. How do you approach a patient who presents
20 for the first time with a complaint of pain? And
21 I'm not talking about the sprained ankle, blah,
22 blah, blah.
23 **A. So the key thing to find is what's the**
24 **pain generator. So what's this pain about? How did**
25 **it get going? Is this a pain pattern that's got a**

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1 **pathway established? If pain persists at a certain**
2 **pattern and it wears like a pathway in the nervous**
3 **system, it's called a neuroplasticity system. But**
4 **basically if you have pain that isn't addressed,**
5 **then that pain itself becomes a problem, like its**
6 **own separate problem on a problem list. If you have**
7 **pain from a neck injury and your pain gets better,**
8 **then you had acute pain. If you have pain from an**
9 **injury that doesn't get better, that pathway**
10 **develops and gets its own life to itself.**
11 **So I'm going to find out what's the pain**
12 **generator, how long have they had it, what have they**
13 **been treated for, what are they doing now already,**
14 **what works, what doesn't, why are you here, who**
15 **fired you and why. Essentially patients would come**
16 **through my door because they've been on pain**
17 **medication before. I don't initiate pain**
18 **medications for a chronic pain patient.**
19 Q. And is that true in the case of these nine
20 patients, they had other providers prior to seeing
21 you for the first time?
22 A. **For the most part, yes.**
23 Q. And when a patient comes to you and
24 informs you that they've been on pain medications
25 from some other provider previous, what do you do in

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1 order to satisfy yourself that that is, indeed, the
2 fact?
3 A. **Well, I might do a urine drug screen to**
4 **see if there is any in their urine. Prior to the**
5 **Prescription Drug Registry it was a little bit**
6 **difficult, I would get the old records from the**
7 **previous provider.**
8 Q. When you get old records, do you include
9 them in your records?
10 A. **Yes.**
11 Q. All the time?
12 A. **No.**
13 Q. In the general case, other than these nine
14 people then, what do you do as far as conducting a
15 physical examination, if you do?
16 A. **Oh, yeah, I do a full physical**
17 **examination.**
18 Q. What does that consist of?
19 A. **Well, first of all, the physical**
20 **examination is paired with a history. So 80 percent**
21 **of diagnosis comes from the history. So there is a**
22 **conversation, a lot of these patients are upset, a**
23 **certain amount of listening to get their upset**
24 **settled down. And then a physical examination is**
25 **exactly what it is, it's an examination of the body**

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1 **to find out what physiologic process is going on**
2 **such that they're having pain.**
3 **Sometimes something is found, sometimes**
4 **not. Sometimes you can do a diagnostic study or a**
5 **lab test. Sometimes you're limited to what you**
6 **might find on physical examination.**
7 Q. Every time a patient comes in to see you
8 after that initial visit, do you take a history and
9 conduct a physical examination?
10 A. **Yes.**
11 Q. Might the physical examination and history
12 taking be somewhat more abbreviated than that
13 initial visit?
14 A. **Well, it depends on what the patient is**
15 **saying, yes. If they said I fell down the stairs**
16 **and I injured my knee, I'm on the knee. If they**
17 **said it's my usual neck pain, I'm on the neck. If**
18 **something else has changed, I may be reevaluating**
19 **that. I probably am not listening for the subtle**
20 **heart murmur every time I'm seeing that patient, and**
21 **sometimes the schedule doesn't allow it. If the**
22 **patient would come to see me and it's really busy**
23 **and they're going to withdraw without their**
24 **medications, I'm going to make a quicker visit than**
25 **I would if I had the time to spend some time with**

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1 **them.**
2 **So sometimes I spend a great deal of time**
3 **with patients and I catch a lot of flack from my**
4 **staff about it. And other times it's clear there is**
5 **ten patients to be seen and I'm not spending an hour**
6 **with anybody at that point.**
7 Q. I'm going to give you -- I don't know if
8 you need this. These are initials and numbers. Do
9 you have a pretty clear recollection of each of
10 these nine patients?
11 A. **I do.**
12 Q. You've studied their records?
13 A. **Yes.**
14 Q. Not only in preparation for this but you
15 know your patients?
16 A. **I do.**
17 Q. Tell me about Patient Number 1. What is
18 your recollection as to how that patient presented
19 initially?
20 A. **I've known this patient for over two years**
21 **now. This patient came to me with some pain in the**
22 **left knee. There had been numerous procedures done,**
23 **complicated by Methicillin-resistent staph aureus.**
24 **The patient was upset that her surgical procedures**
25 **had led to a lot of complications. The patient was**

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1 **highly intense in her personal presentation. She**
2 **had a great big scar on her left patella. She**
3 **limped a lot. She also was agitated. She was**
4 **tapping her knee, or tapping her right leg quite**
5 **vigorously. I remember she would do that regularly.**
6 **She gave a history with a lot of complexity, bipolar**
7 **disorder, lots of medications and, wow.**
8 Q. Just in case you need it, that's our
9 Exhibit L-6.
10 **MR. DOUBEK:** Sorry I didn't coordinate the
11 numbers.
12 Q. (By Mr. Doubek) In any event, take a look
13 at those records. Is that the patient we're talking
14 about?
15 **A. Yeah.**
16 Q. When you first --
17 **A. But I've got to make a correction. If**
18 **this is the first visit she presented after having**
19 **had a fall and she had a large hematoma on the side**
20 **of her trunk.**
21 Q. And I don't know that that page in front
22 of you is the first visit.
23 **A. Okay.**
24 Q. These are the records as we received them.
25 But let's take a look at the first page of that

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1 exhibit, Doctor. What's the page number at the
2 bottom right?
3 **A. Bottom central is 1832.**
4 Q. Go through and tell me what is reflected
5 on that first page.
6 **A. Well, this the general history, medication**
7 **list, prior history, family history and review of**
8 **systems. This would be all in the subjective part.**
9 Q. Is that form a form created by a company
10 called Practice Velocity?
11 **A. Yeah. That's -- Practice Velocity is our**
12 **billing company and they provide charting for us to**
13 **use. They're I think the most-used urgent care**
14 **documentation system in the country.**
15 Q. In that regard, your company is called
16 Urgent Care Plus. I think you covered this
17 yesterday?
18 **A. I did.**
19 Q. But is there a difference between an
20 urgent care facility and your facility, Urgent Care
21 Plus?
22 **A. Just the fact that I'm there.**
23 Q. That's the plus part?
24 **A. Yeah.**
25 **HEARING EXAMINER SCRIMM:** Excuse me just

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1 one second. Ma'am, as a remainder, the
2 documents we're talking about here are sealed
3 from public view. So please don't get them
4 into your shot, any of these documents that are
5 in front of me or in front of the doctor or any
6 of the attorneys. Thank you.
7 **MR. DOUBEK:** Thanks again.
8 Q. (By Mr. Doubek) So tell me what's on that
9 first page.
10 **A. So there is a main problem, it says in**
11 **parentheses, "List only one," and it checkmarks as**
12 **other, specified, and written in there by Dori is**
13 **hematoma. Then below that is the date of onset,**
14 **6-20 of '11 and this is 6-22 of '11. She's been**
15 **taking ibuprofen, last dose two hours ago. Pain at**
16 **six out of ten. Radiates downwards. She has a**
17 **history of MRSA not related to a motor vehicle**
18 **injury and not work-related. Chronic active**
19 **conditions bipolar. Medications are listed.**
20 **Previous surgeries are listed. And family history**
21 **is left blank. Quit tobacco in 2011. Alcohol**
22 **checked never. And street or unprescribed drugs are**
23 **checked no. That's down the left side of the chart.**
24 **On the right side of the chart, recent abnormal for**
25 **use symptoms. Boxes are checked nothing**

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1 **constitutional, such as fevers, chills, sweats,**
2 **fatigue, or weight loss. Nothing in neurologic.**
3 **Nothing in the head, except for what's in her head,**
4 **of course. Eyes, skin. Musculoskeletal is checked**
5 **and that she has pain in one or several areas.**
6 Q. Excuse me. But if something is not
7 checked, does that mean it's something that you
8 didn't consider or you just didn't check it because
9 there is nothing abnormal about it?
10 **A. If it's not checked, it wasn't considered.**
11 **If it's checked negative, it was considered and**
12 **rejected as a symptom.**
13 Q. Go ahead and continue.
14 **A. So allergies to latex. Where did injury**
15 **occur? That's left blank because there is not an**
16 **injury. And then the subjective, 33-year-old female**
17 **here complaining of right lower quadrant pain with a**
18 **hematoma that started on Monday. Nurse signature.**
19 **Allergies. No known drug allergies. And then**
20 **written over there is APAP. Pregnant isn't checked.**
21 **Last tetanus shot isn't checked because it's not**
22 **related.**
23 Q. And these records are in the typical
24 format that they were in back in at least 2011,
25 right?

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1 **A. Correct.**
2 Q. The second page, what is the information
3 and why is that form different?
4 **A. This says 1833. This is the objective**
5 **part. So subjective is what the patient attests to,**
6 **objective is what we find on physical examination.**
7 **The vital signs are written in. Oxygen saturation,**
8 **and then boxes to check either normal or abnormal**
9 **depending on -- psychiatric she's oriented. Her**
10 **mood and affect are appropriate. Down the line,**
11 **down to skin it says erythema, cyanosis, ecchymosis**
12 **or laceration. And over to the right is a diagram**
13 **written that says six by ten centimeter superficial**
14 **ecchymosis area, tender, nodular, no fluctuans.**
15 Q. And that's the objective that relates to
16 her presentation with a sore knee, I take it?
17 **A. Actually she presented this time with an**
18 **abdominal complaint. So, yeah, sorry about that.**
19 Q. All right. And then the third page of
20 that chart, what is intended to be covered or
21 addressed there?
22 **A. That's the assessment and plan. So in the**
23 **old SOAP note it would be subjective, objective,**
24 **assessment, and plan. So in the scientific model it**
25 **would be hypothesis, theory and action plan.**

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1 Q. So this is the plan part?
2 **A. This is the plan part.**
3 Q. What's the plan part for that abdominal
4 pain?
5 **A. It says hematoma, ABD, abdomen, and US,**
6 **ultrasound, in a.m. Check labs. Lortab.**
7 Q. You did an ultrasound on that occasion?
8 **A. Yes.**
9 Q. Do you have an ultrasound machine?
10 **A. Yes.**
11 Q. Do you typically use your ultrasound
12 machine on patients with pain?
13 **A. Yes. It turns out that this particular**
14 **time she was seen by Todd Moore, the midlevel, and**
15 **he doesn't do ultrasounds, so she was sent over to**
16 **Sound Health Imaging for an ultrasound of this**
17 **hematoma, where it was determined that there wasn't**
18 **anything else besides hematoma, and then she was**
19 **given a total of 20 Lortab.**
20 Q. So that's a Lortab what level?
21 **A. Hydrocone 5.**
22 Q. So that's a lower level for a short period
23 of time?
24 **A. Uh-huh.**
25 Q. Was she on other medications at that time?

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1 **A. Yes, Seroquel, Klonopin and a Mirena IUD.**
2 Q. And she was not receiving the Hydrocodone
3 at that time?
4 **A. I don't know.**
5 Q. This is a patient who you did take care of
6 for longer term pain?
7 **A. Yes.**
8 Q. Do you have a recollection of the
9 conversation with this patient about what you would
10 be willing to do for her to address her long-term
11 pain?
12 **A. Yes.**
13 Q. Tell us about that.
14 **A. Well, she has a lot going on. So the**
15 **bipolar is probably the biggest issue for her is she**
16 **was seeing a psychiatrist for that. And as she**
17 **talked to me more and more about her knee, it became**
18 **clear that that hadn't worked well for her at all**
19 **and that was a pain generator for her on an ongoing**
20 **basis. So the options given to her were continue**
21 **the pain medication, look forward to possibly**
22 **weaning, keeping her functionality up, taking care**
23 **of anything that would cause her to fall and have**
24 **this hematoma happen, that sort of thing.**
25 Q. When you first began prescribing pain

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1 medications for this patient, did you have her sign
2 a written plan?
3 **A. No. I had no intention that this was**
4 **going to last a long period of time.**
5 Q. So when she initially presented to you,
6 you didn't anticipate or you didn't know whether
7 this was going to be a chronic pain situation?
8 **A. Correct.**
9 Q. At the point in time when you determined
10 that the patient is going to have chronic pain, do
11 you then at that point employ written pain
12 contracts?
13 **A. Now, yes. Then, no.**
14 Q. Why not?
15 **A. Well, like I said, her third visit was**
16 **still working up this hematoma on her abdomen, which**
17 **was slowly resolving. It became clear to me that**
18 **she had an awful lot of pain for a hematoma on her**
19 **abdomen and so she didn't tolerate pain very well**
20 **and I was kind of wondering why. There is some**
21 **studies that show if you're on opioids for a long**
22 **period of time they actually decrease your ability**
23 **to tolerate pain. So that was kind of a clue that**
24 **maybe this opiate thing needs to be interrupted. So**
25 **we talked at length about what would happen if she**

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1 **were to be off the opiates.**
2 Q. Did you record that you talked at length
3 with her?
4 A. **There is a -- you mean in terms of how**
5 **many minutes I spent with her?**
6 Q. Well, not necessarily how many minutes but
7 the fact that you feel you talked to her at length
8 about that issue.
9 A. **That length.**
10 Q. Well, specifically on the visits --
11 **HEARING EXAMINER SCRIMM:** Excuse me. Just
12 so the court reporter -- you told about the
13 length and --
14 A. **Okay. So 230 pages worth.**
15 **HEARING EXAMINER SCRIMM:** Thank you.
16 A. **And subsequently she had been -- here I**
17 **can find out her previous medical doctor. So the**
18 **abdominal thing resolved, now she's having ongoing**
19 **knee pain. She's coming -- it's clear that she's**
20 **going to be coming to see us because of the knee**
21 **pain and now it's time for some conversation. So**
22 **this is on 8-15 of 2011.**
23 Q. (By Mr. Doubek) Page number?
24 A. **1855, 56, 57 and onward.**
25 Q. So is that when she was -- is that the

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1 time when you considered she might be a patient with
2 chronic pain?
3 A. **Yeah.**
4 Q. So what kind of recording do you do of
5 that?
6 A. **Well, as I look at this, I can see that**
7 **there is multiple diagnoses, one new and one new**
8 **with a workup plan, prescriptions are written. A**
9 **lot is written in the assessment page and then a lot**
10 **of diagnoses are written down, chronic pain left**
11 **knee, bipolar, insomnia, medical marijuana.**
12 Q. Did you have a conversation with her about
13 how you were going to address her long-term pain?
14 A. **I did.**
15 Q. And is that recorded there?
16 A. **Well, I gave her a total of 60 of Ultram,**
17 **which is a lower pain reliever than Hydrocodone, but**
18 **I gave her enough to last, for two a day it would be**
19 **a month. So it was an agreement to kind of have**
20 **that happen. I diagnosed her with complex regional**
21 **pain syndrome, which is kind of a chronic pain**
22 **diagnosis that you would see. You wouldn't see that**
23 **in an acute pain setting.**
24 Q. Before you, or incidental to you
25 prescribing the Ultram, did you have any

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1 conversation with her about such things as where she
2 would get her medications, you know, whether she
3 could get them from other prescribers and those
4 types of things?
5 A. **Right. She told me that she was going to**
6 **come see us now and I just said, "Well, if you're**
7 **going to do that, you can't see previous people that**
8 **you're not satisfied with." And she was happy with**
9 **that, she wasn't satisfied. So she was doctor**
10 **shopping when she came to me. So she was not**
11 **getting the kind of relief that she felt that she**
12 **deserved. And she was upset, angry, and I did not**
13 **feel that that was a good thing to have persist in**
14 **terms of being able to tolerate her pain. The more**
15 **raw you are emotionally, the less likely you are to**
16 **be able to tolerate a painful stimulus. So I could**
17 **see that that was going to be an issue for her and**
18 **she's had her bipolar issues, that sort of thing, so**
19 **I could tell that I was going to get involved.**
20 Q. What kinds of things would you tell this
21 patient and patients in general who you were going
22 to treat for chronic pain in terms of where they
23 could get their meds, how much meds, what your plan
24 was going to be for them, so forth?
25 A. **What conversation would I have with them?**

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1 Q. Yes.
2 A. **So here I am on page 872 and I say, "Scar**
3 **left patella." The rest of the physical exam is**
4 **checked, and I write down here, "Tearful/joyful/**
5 **despondent/hopeful." She went through all those**
6 **different fields of emotional projection while she**
7 **was talking with me. That indicates to me that I --**
8 **in order to get that from somebody you have to spend**
9 **a certain amount of time opening up her emotional**
10 **capacity to express all that.**
11 Q. You said though with regard to this
12 patient you didn't use a written pain contract,
13 right?
14 A. **Correct.**
15 Q. Do you feel you had an agreement though
16 with her --
17 A. **Yeah.**
18 Q. -- about pain?
19 A. **Yeah.**
20 Q. What was part and parcel of your oral
21 agreement with this patient?
22 A. **Oh, well, you can't go to a bunch of**
23 **different physicians. You can't just come here for**
24 **a few pills and go to Dr. Skillman for more pills.**
25 **You have to stick with one area. Pharmacy shopping**

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1 **at that time was verboten. These days everybody**
2 **is -- there is a shortage of pain medications and**
3 **everybody is going to a lot of different pharmacies**
4 **and the Prescription Drug Registry allows for**
5 **accommodating that. But at that time it was, you**
6 **know, you can't go to multiple pharmacies, you can't**
7 **do any forgeries.**
8 Q. Are these all conversations that -- is
9 this the kind of conversation you typically had with
10 patients like this, that is, patients who are going
11 to have long-term pain problems?
12 **A. Sure. Just in the same way that if**
13 **someone is hypertensive I'm going to say, "Well,**
14 **here's a problem you might have with Atenolol. It's**
15 **going to put a ceiling on your ability for your**
16 **heart rate to go up; it's a beta blocker. The side**
17 **effects of beta blockers are blah, blah, blah. You**
18 **might want to get off that at some point. If not,**
19 **if you tolerate it, we'll continue it. If not,**
20 **we'll adjust it," et cetera.**
21 Q. Do you record that conversation anywhere
22 in your record?
23 **A. No, usually I'm having the conversation.**
24 Q. And just as though you were prescribing
25 the beta blocker, Atenolol, you wouldn't necessarily

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1 write down the pros and cons of that drug or the
2 limitations of that drug?
3 **A. No, no. The pharmacists do that really**
4 **well and much better than I do.**
5 Q. Let's take a look at the next patient,
6 Number 2. Number 2 is --
7 **A. I'm not seeing her in this file.**
8 Q. I've got it. Mark, it's L-7.
9 **A. Got it.**
10 Q. With regard to that patient, what do you
11 recall her initial presentation was?
12 **A. Oh, she was complex. She came in, she had**
13 **back problems, stomach ulcers, depression, anxiety.**
14 **She had had abdominal cancer, I think she'd had a**
15 **splenectomy for. She had had a hysterectomy, a**
16 **hernia operation, gallbladder out, a gastric bypass,**
17 **lost 100 pounds, two back surgeries. She was having**
18 **chronic back pain with a plan to go down and see**
19 **Dr. Johnson in Los Angeles to have another back**
20 **procedure.**
21 Q. So she had a number of -- she was
22 postsurgical many times?
23 **A. Yes.**
24 Q. And in a lot of pain?
25 **A. Yes.**

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1 Q. Would you have the same conversation with
2 her as you had with Patient Number 1?
3 **A. Yeah.**
4 Q. In terms of where she gets her
5 prescription, you're the only provider?
6 **A. Right.**
7 Q. Those types of things?
8 **A. Well, yeah. And, again, each prescription**
9 **that I write is photocopied and faxed, so there is a**
10 **copy in the chart. So my records -- I don't write**
11 **what prescription I'm going to write because I've**
12 **written the prescription and copied and made it a**
13 **part of the record.**
14 **So here she goes to Safeway with Flexeril**
15 **20 and Lortab 10/325 180, which is enough for her to**
16 **take six a day for a month.**
17 Q. Now, as I understand, this patient
18 ultimately transferred her care to another doctor or
19 two; is that correct?
20 **A. Yeah.**
21 Q. And we talked about it a little bit
22 different, a little bit yesterday, and I noted that
23 Dr. Sargent gave her 168 Hydrocodone on 4-14-12,
24 Dr. Ellis gave her 180 on 4-12-12 and 54
25 Hydromorphone on 4-12 and 180 on 5-3-12. She was

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1 not one of your success stories; is that true?
2 **A. Right. I actually did talk to her at**
3 **length about weaning multiple times. There was a**
4 **period of time where she actually got off pain**
5 **medications, and it was my recollection that around**
6 **the time that this complaint was filed she was not**
7 **on any medications. Maybe she wasn't seeing me, but**
8 **my recollection was she had gotten off any pain**
9 **medication at that time. Subsequent to that, like**
10 **what you're saying, she's used a lot of pain**
11 **medications, but she has a lot of pain generators.**
12 Q. And you don't know whether she had other
13 acute situations requiring subsequent surgeries, do
14 you?
15 **A. Right. It says here on 2047, "Law**
16 **enforcement investigated."**
17 Q. And I see that --
18 **A. And a urine toxicology screen was done on**
19 **page 2048.**
20 Q. And I see in the Montana PDR that she was
21 under the care then of Dr. Tom Winer, who is an
22 oncologist. You don't know what that relates to?
23 **A. She told me he had treated her before. I**
24 **think that's what the splenectomy was about.**
25 Q. All right. Next patient, Number 3. Do

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1 you have L-5?
2 A. **Got it.**
3 Q. Do you remember that patient's presenting,
4 presentation initially?
5 A. **This starts off with the assessment page,**
6 **so let me get -- it looks like she had a laceration**
7 **on her right fifth finger.**
8 Q. Had she had a history of multiple
9 neurosurgical procedures and orthopedic procedures?
10 A. **Yes.**
11 Q. And when she initially presented, then did
12 you learn about those things by talking to her?
13 A. **Not the time we did the finger wound.**
14 Q. She just had a finger laceration and you
15 took care of that?
16 A. **Yeah. But on May 28th, on page 1433, the**
17 **patient had back surgery on 4-1-2011, which was I**
18 **think was six weeks, or eight weeks prior to**
19 **presenting, and has back pain in her legs since.**
20 **And it talks about the Hydromorphone that she's on,**
21 **the Morphine, Gabapentin, estrogen, Ambien, and it**
22 **lists her back surgery and the fact that she's got**
23 **hardware in her spine. Later on I discovered that**
24 **she had had a traumatic brain injury, that she had**
25 **signs and symptoms of fibromyalgia. She had a lot**

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1 **going on.**
2 Q. Did you enter into any kind of a written
3 pain contract with her?
4 A. **No, she was acutely post-op. She was**
5 **still within the eight weeks of the previous**
6 **surgery. So it seemed to me like she was a**
7 **candidate for a bolus of some Prednisone, trying to**
8 **get her pain under control, see if we can get her --**
9 **I wasn't even anticipating weaning her that soon**
10 **from her surgery. And she was still not doing well.**
11 **I didn't know if this was going to turn into some**
12 **failed back surgery syndrome.**
13 Q. At some point in time she was under your
14 care for chronic pain?
15 A. **Yeah.**
16 Q. And at some point in time she was able to
17 wean off of all narcotic pain medication?
18 A. **Yes.**
19 Q. And then I see within the past month she
20 received a short, a small amount --
21 A. **Like 30 or something.**
22 Q. -- Endocet?
23 A. **Yeah.**
24 Q. What's Endocet?
25 A. **It's like Percocet basically, so it's**

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1 **oxycodone and acetaminophen.**
2 Q. But in terms of getting off the narcotic
3 pain medications, that was a success story?
4 A. **Yes.**
5 Q. Take a look at patient --
6 A. **Now, for just a quick second.**
7 Q. Go ahead.
8 **MR. FANNING:** Objection, nonresponsive.
9 **HEARING EXAMINER SCRIMM:** Sustained.
10 Q. (By Mr. Doubek) Do you have anything else
11 you'd like to add regarding this patient?
12 **MR. FANNING:** Objection to the form of the
13 question. It's open-ended and seeks a
14 narrative.
15 **HEARING EXAMINER SCRIMM:** Sustained.
16 A. **So I'm not to answer the question?**
17 Q. (By Mr. Doubek) No. Just wait. I'll ask
18 a bunch more.
19 This patient, what do you recall about
20 discussions relative to pain management that you
21 were going to provide for this patient?
22 A. **And this is on Patient 3?**
23 Q. Yes.
24 A. **Yeah. Well, the fact that someone has**
25 **decreased their pain medication down to zero and**

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1 **substituted other modalities for taking care of**
2 **their pain generators, that doesn't mean they're not**
3 **going to need an opioid pain medication at some**
4 **other time. She has tremendous amount of pain**
5 **generators. So it's a triumph and I'm proud of her**
6 **for the work she did to get off those pain**
7 **medications. I'm proud of our partnership that we**
8 **did together. But what's happening right now is no**
9 **guarantee of what might happen two weeks from now.**
10 **She could fall, have a car wreck, she could have**
11 **another reason and her pain generation would go**
12 **crazy again.**
13 Q. And I understand from her testimony
14 yesterday that she did utilize other modalities, the
15 natural medicine, I think physical therapy --
16 A. **Yes.**
17 Q. -- and other modalities. Are those things
18 that you recommended?
19 A. **Yes.**
20 Q. So what is bringing the multidisciplinary
21 approach to these people all about?
22 A. **Well, I never intended to have a**
23 **multidisciplinary pain clinic and I don't. But what**
24 **I do have is Urgent Care Plus right next to Natural**
25 **Care Plus with a physical therapy department in the**

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1 **same building. So we do have a little bit of**
2 **one-stop shopping.**
3 **I do -- since I've had pain myself, I**
4 **realize that pain is manifested in a lot of**
5 **different levels. The reflex of your hand on the**
6 **stove and it hits to spine, the second level would**
7 **be the level of the brain where your brain says**
8 **don't put yourself in that situation again. The**
9 **next step would be the level of the mind where your**
10 **mind is being judgmental of you for being such an**
11 **idiot that you got injured in the first place. And**
12 **then the fourth level of dealing with pain is what's**
13 **happened at the soul level. What really happens to**
14 **a patient who is having pain ongoingly day to day,**
15 **not sleeping, not able to relate to their friends**
16 **and loved ones, not able to work, not able to**
17 **actually have a life, like Dr. Anderson was saying.**
18 Q. Is money a limiting factor in terms of
19 these people being able to resort to other
20 modalities?
21 **A. Mine or theirs?**
22 Q. Theirs.
23 **A. Theirs. It would be essentially a lot of**
24 **the -- well, I like to say that Dr. Roush's patients**
25 **are the healthiest patients in town because they can**

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1 **afford to have the expensive urine. So, yeah, they**
2 **take a lot of nutritional supplements. It's kind of**
3 **hard to tell, are they healthy because they take all**
4 **these supplements or are they wealthy because they**
5 **take all these supplements and can spend all this**
6 **money? I don't know. They're really healthy**
7 **patients. So I look towards that as a goal for some**
8 **of my patients who aren't so healthy.**
9 **The problem is exactly what you said, that**
10 **the insurance companies don't pay for cranial sacral**
11 **therapy. They don't pay for prolotherapy on the**
12 **part of Dr. Roush. They do pay for some physical**
13 **therapy. They may or may not pay for chiropractic.**
14 **They'll never pay for a massage. They wouldn't pay**
15 **for a hot tub, and they won't pay for a healthy**
16 **diet.**
17 Q. Special bed, pillows, et cetera?
18 **A. Yeah.**
19 Q. Let's take a look at the next patient,
20 Number 4. That would be L-2. Do you have that?
21 **A. Yeah.**
22 Q. This patient testified yesterday. Would
23 you consider him a success --
24 **A. Yes.**
25 Q. -- in terms of weaning him off of all

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1 narcotic pain medication?
2 **A. Yeah. My interest is in people's**
3 **well-being. This patient is doing well.**
4 Q. Was he on pain medication when he first
5 came to see you?
6 **A. Yes.**
7 Q. For what reason?
8 **A. Well, he had occasional pains in his neck.**
9 **He had numerous injuries to his neck before. His**
10 **visit with me was about a psychiatric problem and**
11 **that pretty eclipsed the other pain issues until we**
12 **got that under control. Once his psychiatric issues**
13 **were under control, then his pain issues reared**
14 **their head.**
15 Q. When was he first put on pain medication
16 by you?
17 **A. Oh, boy. This is not necessarily in**
18 **order. So I'm sorry, I can't tell by looking at**
19 **this stack.**
20 Q. Do you remember when it was approximately
21 that you first saw him?
22 **A. These charts are out of order. It looks**
23 **like they're going earlier as I thumb back though.**
24 **So maybe -- I'm just going to -- it looks like 9-8**
25 **of '11.**

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1 Q. Did you get him in contact with a
2 psychiatrist?
3 **A. I did. Well, two psychiatrists as a**
4 **matter of fact.**
5 Q. And did you and the psychiatrists then
6 work to provide concurrent care for this fellow?
7 **A. Yeah.**
8 Q. And how does that work, logistically are
9 you in contact with the psychiatrists?
10 **A. Yes.**
11 Q. Do you exchange emails or faxes or letters
12 or do you just get on the phone and talk?
13 **A. Mostly phone and talk.**
14 Q. Do you record all of those conversations?
15 **A. No.**
16 Q. Do you note them in your file?
17 **A. Yes.**
18 Q. All of them?
19 **A. No.**
20 Q. So how was it that you and this patient
21 determined that he needed to be off the pain
22 medications?
23 **A. It was the patient's insistence that he**
24 **get off the pain medications. He didn't like how he**
25 **felt on them.**

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1 Q. Did that seem appropriate with you?
2 A. **I was all in line with that.**
3 Q. And is that sort of your standard
4 approach, that you don't want these people on pain
5 medications indefinitely?
6 A. **Yeah. Are you kidding me? 350 people die**
7 **a year in Montana from prescription drug overdose.**
8 **I'm against that.**
9 Q. So how did you go about the weaning
10 process in order to enable this fellow to be off of
11 the pain meds?
12 A. **Well, this was complicated. He had all**
13 **this I think neck-generated headache, so I think the**
14 **pain generator was in his neck. He had a lot of**
15 **degenerative changes in his neck. He wasn't**
16 **interested in a surgical procedure. We didn't**
17 **really work that up any further. But what he was**
18 **interested in was an improvement of his headaches.**
19 **I did prescribe medical marijuana for him.**
20 **I also had him go and see Dr. Roush. He actually**
21 **did, regretfully, have a chiropractic adjustment, in**
22 **spite of his anxiety about it, and I was standing by**
23 **holding his hand when he had the adjustment.**
24 Q. It didn't do him any good?
25 A. **It didn't do him any good.**

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1 Q. It did him some bad possibly?
2 A. **It did him some bad. So he was willing to**
3 **try stuff I suggested. He ultimately went to**
4 **Dr. Roush and he had an injection procedure called**
5 **prolotherapy. The theory of prolotherapy is you**
6 **inject an irritant, it becomes its own pain**
7 **generator. The body's five-way anti-inflammatory**
8 **cascade kicks in and the ligaments actually tighten**
9 **up. It would be the opposite of a steroid**
10 **injection, in other words. And there is a lot of**
11 **pain generated by that inflammatory injection.**
12 **And then once that pain creates an**
13 **anti-inflammatory response in tightening up the**
14 **ligaments, they're better. He performed exactly**
15 **like that. He hated the injections.**
16 Q. But, in any event, you were able to get
17 him off the pain medications?
18 A. **Yeah. It's great. He's pleased.**
19 Q. Patient Number 5 is L-1.
20 A. **She has her own binder.**
21 Q. Yeah.
22 A. **That's pretty cool.**
23 **HEARING EXAMINER SCRIMM:** Are we going to
24 have a session -- Never mind.
25 **MR. DOUBEK:** Time is a problem.

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1 Q. (By Mr. Doubek) When this lady presented
2 to you, she testified yesterday that she had like
3 six gynecological surgeries and then she had
4 pulmonary embolus?
5 A. **Yeah.**
6 Q. Is pulmonary embolus in your experience
7 supposed to be a painful event?
8 A. **Pretty much.**
9 Q. And, of course, the six GYN surgeries. So
10 she was on pain medications for those conditions?
11 A. **Yes.**
12 Q. Were you able to wean her off of the pain
13 medications?
14 A. **Yes.**
15 Q. And for what period of time?
16 A. **Well, she was really only -- she wasn't**
17 **really in chronic pain, she had a stacked-up series**
18 **of acute pains. So each surgical procedure she'd**
19 **have she'd tend to have some pain post-operative to**
20 **that, her surgeon would prescribe enough that he**
21 **thought it was appropriate. She had more**
22 **discomfort. I'd work it up and sometimes I'd find**
23 **something, sometimes I wouldn't. Then she would be**
24 **back to her surgeon for another procedure. So that**
25 **kind of went on and on.**

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1 **And then she had the pulmonary embolism,**
2 **and once that was resolved and she was off the**
3 **Warfarin, I never saw her for pain after that.**
4 Q. Well, according to Exhibit M, which is
5 your copies of the PDR, you last prescribed
6 Hydrocodone 10 on 3-11-13 and there isn't another
7 prescription for Hydrocodone until 10-29-13, so a
8 period of seven months.
9 A. **Okay.**
10 Q. And you don't know why she was on
11 Hydrocodone after she was off of it in the spring
12 of --
13 A. **Did I prescribe it the seven months later?**
14 Q. No. A different doctor. So as far as you
15 were concerned, you were able to successfully wean
16 her from the pain medication?
17 A. **Oh, yeah.**
18 Q. And this is a patient who obtained in many
19 instances early refills on her Hydrocodone?
20 A. **Oh, yeah. I wouldn't call an early refill**
21 **on someone who is having acute pain. Unless if I**
22 **come back to your room while you're having a kidney**
23 **stone and I give you more morphine, that's an early**
24 **refill. Essentially we have to give enough pain**
25 **medication to get the pain relieved. There is no**

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1 **early refill when you're dealing with acute pain.**
2 Q. So by that you mean the prescription
3 wasn't enough to do the job?
4 **A. Yeah. The pain is not being relieved.**
5 **She had a period of time where she took -- I think**
6 **the month she actually had the pulmonary embolism --**
7 **it was a month's worth of prescription. I think it**
8 **was January. But, at any rate, during that month**
9 **she was recovering from your pelvic surgery, she had**
10 **her pulmonary embolism, and she used up maybe 120**
11 **Hydrocodone and she was not getting pain relief and**
12 **she got Percocet. So she got Percocet and**
13 **Hydrocodone in the same month. But it wasn't some**
14 **tragic event, it was attempting to get her pain**
15 **under control. It was all acute pain.**
16 Q. Would you talk to the patient when she
17 asked for an early refill?
18 **A. Yeah.**
19 Q. Would you make a recordation in the
20 records about that sort of thing?
21 **A. Uh-huh.**
22 Q. Did you record why it was she got an early
23 refill?
24 **A. This would be different stuff, different**
25 **day.**

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1 Q. What do you mean?
2 **A. Well, it's not the same as SSDD. This is**
3 **an acute workup here. So she's got pain in her**
4 **pelvic, pain in her abdomen, pain in her chest, and**
5 **crying and upset and worried and having several**
6 **life-threatening events such as hemorrhages in her**
7 **abdomen and blood clots in her lungs. So a very**
8 **anxious lady who's having a lot of pain.**
9 Q. So by the volume of her records, you knew
10 what was going on and causing the pain?
11 **A. I think so, but I also knew that I'd**
12 **better listen to her because every time she has**
13 **something, she has something. She was sick every**
14 **time she said she was sick.**
15 Q. Including PE?
16 **A. Right.**
17 Q. Which is life-threatening.
18 **A. Yes.**
19 Q. The next patient is L-3.
20 **A. Got it.**
21 **MR. FANNING:** Mr. Doubek, is that number
22 6?
23 **MR. DOUBEK:** It is. Wait a minute. L-3
24 is Patient Number 6. Right, Mike.
25 Q. (By Mr. Doubek) This patient presented to

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1 you with what kind of problem?
2 **A. It looks like he needed help with his**
3 **pain.**
4 Q. And according to the records of the PDR,
5 it looks like the last prescription of Hydrocodone
6 was 4-16-13, so --
7 **A. And he only saw me a few times, yeah.**
8 Q. Yes, he had been under the care of
9 Dr. Weinert, who prescribed him as much or more than
10 you, and then he was under the care of Dr. Ellis,
11 who prescribed Suboxone?
12 **A. Uh-huh.**
13 Q. And also under the care of Dr. Will
14 Schneider, who prescribed more Hydrocodone.
15 **A. (Nods head.)**
16 Q. Did he present to you with a chronic pain
17 or acute pain?
18 **A. He said he had pain in his low back and**
19 **also, what Susan wrote was the main reason he was**
20 **here was for medication refill. He was lifting and**
21 **pushing on heavy objects. So it was multifactorial.**
22 **He had low back pain, shoulder pain, neuropathy,**
23 **high blood pressure, hypothyroidism, anxiety, five**
24 **previous knee surgeries on the right, two previous**
25 **knee surgeries on the left, two previous shoulder**

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1 **surgeries and recurrent shoulder pain requiring --**
2 **he was looking forward to a third one -- a hernia**
3 **and sinus surgery. So a lot of meds, Gabapentin,**
4 **Cymbalta, et cetera, et cetera.**
5 Q. And then I'm just going to cover the next
6 three patients pretty quickly. Number 7 is in L-8.
7 For what reason was this patient given narcotic pain
8 medication?
9 **A. Oh, this patient had a surgical procedure**
10 **on his back. Well, the first time he saw us was for**
11 **pneumonia or something like that. But he had a**
12 **surgical procedure at the spinal, Laser Spinal**
13 **Institute in Pittsburgh, had a microdiscectomy,**
14 **really was pleased with it, did really well, until**
15 **pretty soon, like maybe six weeks after surgery, he**
16 **herniated a disc above it. He was in a lot of**
17 **financial difficulty. It turned out that that**
18 **surgery, though it had been promised to be paid for**
19 **and it wasn't. He went bankrupt over it and he was**
20 **in a lot of trouble.**
21 Q. So you prescribed pain medication for that
22 condition?
23 **A. Yes, for his back pain.**
24 Q. And then at some point in time this past
25 summer he was receiving no further pain medication

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1 from you; is that true?
2 A. **I think December of 2013 was his last**
3 **prescription from me.**
4 Q. I see one in the PDR for 7-17-14 for 60
5 Hydrocodone and then nothing from you after that.
6 A. **Yeah. He must have come in because of an**
7 **acute flare.**
8 Q. And he got seven from somebody else that
9 next week but none after that according to the PDR
10 as of this month?
11 A. **Yeah.**
12 Q. Success story in terms of --
13 A. **I would say success. You'd have to ask**
14 **him.**
15 Q. Patient Number 8 is L-9. For what reason
16 did this patient present to you for pain care?
17 A. **She initially had a urinary tract**
18 **infection. But it turns out that she ultimately**
19 **started coming to see us because her**
20 **gastroenterologist would refuse to treat her pain.**
21 **She had, I think, ulcerative colitis, and she went**
22 **from a Helena gastroenterologist -- sorry, Crohn's**
23 **disease -- a Helena gastroenterologist to a series**
24 **of gastroenterologists in Missoula. And then the**
25 **note here says, "Dr. Lee refuses to see her." She**

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1 **was going to Dr. Morris in Missoula, he retired and**
2 **moved on. She ended up seeing Dr. Cortese in Butte.**
3 **None of these gastroenterologists were comfortable**
4 **giving her ongoing opioids for her pain. She was a**
5 **tough case.**
6 Q. And it looks like after you -- your last
7 prescription was on 5-12 of this year?
8 A. **Yeah. I told her that -- essentially that**
9 **was when my hearing was scheduled for June. I said,**
10 **"Here comes June 23rd. You better wean slow or wean**
11 **fast. If I lose my prescription privileges, it's**
12 **going to be uncomfortable to you and then she**
13 **decided to move on.**
14 Q. And this other practitioner, according to
15 the records, has prescribed the same amount of
16 Hydrocodone that you did?
17 A. **Right. So is she a failure? Is that what**
18 **you're asking me?**
19 Q. Sure.
20 A. **Okay. No. She's been maintained somewhat**
21 **functional. She's pretty much disabled by her**
22 **Crohn's disease. I was not able to get her off any**
23 **opiates. She's also not increased her opiates.**
24 **She's had specialists from out of town to manage her**
25 **therapy. She's on Humira now for her Crohn's**

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1 **disease and I think she's stable.**
2 Q. At some point in time you stopped giving
3 her fentanyl. Was she intolerant to that?
4 A. **Correct.**
5 Q. How do you know that?
6 A. **She didn't like it. It didn't relieve her**
7 **pain and she felt that it was not lasting the three**
8 **days, and I was not comfortable giving her higher**
9 **doses of fentanyl in order to have her last longer.**
10 Q. The last patient, Number 9, is --
11 A. **Got it.**
12 Q. This is a lady who had an implantable pain
13 pump a couple of times actually, the last time it
14 was removed for bad wiring. Why did she present to
15 you for pain management, or attention for her pain?
16 A. **It looks like it was 11-12 of 2010. Her**
17 **provider is no longer available and I no longer**
18 **recall who that was.**
19 Q. John Stevens, died in a plane wreck.
20 A. **So reflex sympathetic dystrophy, spinal**
21 **cord stimulator, depression, ulcers. She was on**
22 **Percocet four a day, Cymbalta, the spinal cord**
23 **stimulator that had stopped functioning, Clonazepam,**
24 **Ambien, Flexeril. Complicated.**
25 Q. And this patient remains on pain

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1 medication?
2 A. **She does. She's been off very briefly,**
3 **but never more than a month free of pain meds.**
4 Q. But she's been on for a number of
5 maladies?
6 A. **Right.**
7 Q. Doctor, do you occasionally have patients
8 who are going to be on pain medications of some type
9 or another indefinitely?
10 A. **Well, I never said that to them. Only**
11 **time will tell about that. But what I do**
12 **distinguish with patients is that pain is a -- pain**
13 **will take you out of the present and put you either**
14 **in your past worrying about it or into your future**
15 **worrying about what your future is going to have.**
16 **So what I say repeatedly to patients is don't think**
17 **that you're going to always have that pain, you're**
18 **just looking through the filter of pain right now.**
19 **And it wouldn't let you consider the option of not**
20 **having pain. So I never say to somebody, yeah,**
21 **you're not going to be on them indefinitely.**
22 **I inherited a lot of these patients. I**
23 **don't start people on pain medications. I consider**
24 **my job to be to get people off medications. As an**
25 **ER doc for 30 years, I couldn't deal with any of**

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1 **these patients. I had to say, you know, "If you're**
2 **in chronic pain, go see your doctor. An emergency**
3 **on your part is not necessarily an emergency on my**
4 **part." And, yet, now I don't know where these**
5 **patients could go. When they come to me and if I**
6 **don't take care of them, who will?**
7 Q. Do you feel that with respect to any of
8 these patients, any of these 21 or 22 or these 9
9 patients or anybody else that you have you've ever
10 overprescribed narcotics?
11 **A. No.**
12 Q. What about your recordkeeping, do you feel
13 that it satisfies standard of care?
14 **A. Yes.**
15 Q. Why is that?
16 **A. Every patient comes in, every patient gets**
17 **an exam, every patient gets a story to tell, every**
18 **patient has an assessment made and every patient**
19 **that gets a prescription, their prescription is**
20 **recorded. There is a lot of notes that I take that**
21 **I hand to the patients to go home with. I spend a**
22 **great deal of time with certain patients at certain**
23 **times.**
24 **I used to do this in the ER but I could**
25 **only do it at 3:00 in the morning. So I kind of**

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1 **enjoy taking on a challenging patient from time to**
2 **time, particularly a patient who can't get care**
3 **anywhere else. I served in India, I served in the**
4 **West Indies. I'm interested in serving the**
5 **underserved, and this is a patient population that's**
6 **highly underserved all of a sudden.**
7 Q. Do you know why that is?
8 **A. It's completely mysterious to me. My**
9 **theory is that -- and this is going to sound really**
10 **cynical -- pain is the fifth vital sign was**
11 **supported by an organization called the American**
12 **Pain Society. The American Pain Society was**
13 **supported 85 percent of their finances by Perrigo**
14 **Pharma, and they've produced some of those**
15 **medications that have been used for the last 14**
16 **years. So a lot of pressure on doctors. And as an**
17 **emergency physician, I was assessed by a survey**
18 **called Press Ganey on how well did I treat patients'**
19 **pain. And I was very serious about treating acute**
20 **pain when I was in the ER. In fact, I would have**
21 **nurses balk from time to time about how much pain**
22 **medication I wanted to give. And I think the**
23 **definition of how much pain medicine you need to**
24 **give is give it until it's enough. And in the ER**
25 **you can give it until they stop breathing and nobody**

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1 **ever did. So I'm not particularly overwhelmed by**
2 **the process of giving high doses of pain medications**
3 **to people who might need them. I've seen people**
4 **have pain generators that are very, very powerful.**
5 **I also give other patients other medications in the**
6 **ER that are life-threatening if I couldn't control**
7 **their airway such as Succinylcholine or Etomidate,**
8 **all kinds of heavy-duty medications. So I'm not**
9 **afraid of the medication profile themselves.**
10 Q. Doctor, are you aware of any standard of
11 care applicable to your practice that requires you
12 have a written pain contract with patients such as
13 these?
14 **A. No. In fact, these patients, a lot of**
15 **these patients were negatively affected by a pain**
16 **contract.**
17 Q. And have you reviewed the medical
18 literature to determine whether there is any
19 difference between the management of a pain patient
20 who has a written contract versus one who does not
21 have a written contract?
22 **A. Well, I think there is lots of**
23 **recommendations about having written contracts. My**
24 **goal is never to be carrying a patient long term.**
25 **My goal has always been weaning them. So a pain**

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1 **contract never made any sense to me from the**
2 **standpoint of the Patients 3, 4, 7, 8, that have**
3 **been successfully weaned, therefore, making a pain**
4 **contract made no sense to me.**
5 **As far as the ones that stayed, on -- it**
6 **was always my goal to get Patient Number 8 off of**
7 **those medications for her Crohn's disease. So --**
8 **MR. FANNING:** Objection. I believe the
9 question was is there any standard of care
10 about a written pain contract and now we've got
11 a series of narratives that are unbridled.
12 **MR. DOUBEK:** He's describing the basis for
13 that.
14 **MR. FANNING:** That's a yes or no.
15 **MR. DOUBEK:** No, it isn't.
16 **THE WITNESS:** So bridled --
17 **HEARING EXAMINER SCRIMM:** Hold on. Will
18 you read the question?
19 (Previous question read.)
20 **HEARING EXAMINER SCRIMM:** I think the
21 question has been answered. Thank you.
22 **MR. DOUBEK:** Thank you.
23 Q. (By Mr. Doubek) What do you do in lieu of
24 having a written pain contract with your patients?
25 **A. When I'm finished with my patient, at the**

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1 **end of my examination with them I say, "I will stand**
2 **by you until this problem is resolved."**
3 Q. Is trust an important thing, do you, in
4 your belief, as to caring for these kinds of
5 patients?
6 A. **Yes.**
7 **MR. DOUBEK:** I have no other questions.
8 **HEARING EXAMINER SCRIMM:** Why don't we
9 take a break for ten minutes.
10 (Break taken.)
11 **HEARING EXAMINER SCRIMM:** We're back on
12 the record after a short afternoon recess. I
13 believe Mr. Fanning has some questions for
14 Dr. Ibsen.
15 **MR. DOUBEK:** One loose end. Did I offer
16 and did you admit Exhibit D?
17 **HEARING EXAMINER SCRIMM:** That does not
18 sound familiar to me.
19 **MR. DOUBEK:** This was a packet of
20 documents that I had sent to the Board which
21 included the affidavit of FR. I thought I did.
22 **MR. FANNING:** If you did, it would have
23 been over my objection. But I don't recall
24 that being offered because we had that
25 gentleman here and he testified and there is no

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1 objection for hearsay.
2 **MR. DOUBEK:** My question was did I offer
3 Exhibit D.
4 **HEARING EXAMINER SCRIMM:** I believe you
5 did and I believe it was admitted. That was
6 the letter, your response to the Board?
7 **MR. DOUBEK:** Yes. A was.
8 **MR. FANNING:** Actually, I thought that was
9 Exhibit A and that's the one I objected to and
10 you said that it could be admitted provided
11 that it wasn't offered for the truth of the
12 matter asserted.
13 **MR. DOUBEK:** For the --
14 **HEARING EXAMINER SCRIMM:** That's correct.
15 So D was not offered.
16 **MR. DOUBEK:** So I would offer it for the
17 same purpose.
18 **MR. FANNING:** And I object because it's
19 nothing but hearsay. That witness was here,
20 did testify, and there is no reason to
21 substitute hearsay for live testimony.
22 **HEARING EXAMINER SCRIMM:** We have FR's
23 testimony, so D is not admitted.
24 **MR. DOUBEK:** All right. That's fine. I'd
25 offer it.

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1 **HEARING EXAMINER SCRIMM:** Anything else,
2 Mr. Doubek?
3 **MR. DOUBEK:** No. Thanks. I apologize. I
4 should have asked you that.
5 **HEARING EXAMINER SCRIMM:** Mr. Fanning, are
6 you going to use your Exhibits 1 through 9 or
7 are you going to use --
8 **MR. FANNING:** If anything, it will be my 1
9 through 9.
10
11 CROSS-EXAMINATION OF DR. MARK IBSEN
12 **BY MR. FANNING:**
13 Q. Good afternoon, Dr. Ibsen.
14 A. **Good afternoon.**
15 Q. In your direct examination with Mr.
16 Doubek, you talked about the discussion that you had
17 last June with the pharmacist, Mr. Gardipee, and you
18 referenced boundaries that he set. Do you recall
19 that?
20 A. **Yes.**
21 Q. But, in fact, it was not boundaries he
22 set, it was boundaries that you had crowed about in
23 the newspaper, correct?
24 A. **Crowed about?**
25 Q. You had been interviewed extensively in

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1 the newspaper about your success in weaning,
2 correct?
3 A. **I don't recall everything in that article.**
4 Q. Did you contact the newspaper and invite
5 them to interview you?
6 A. **Yes.**
7 Q. And you don't recall the gist of it?
8 A. **Yeah, the gist of it is that pain is a big**
9 **challenge.**
10 Q. Do you recall Mr. Gardipee's testimony
11 that he read the paper, you claimed to be weaning
12 and he was holding you to account?
13 A. **Yeah, he may have said that.**
14 Q. So it was actually your boundaries that he
15 was holding you to; isn't that right?
16 A. **No.**
17 Q. You indicated in that meeting that the DEA
18 just refused to tell you how to treat your patients;
19 is that right?
20 A. **No, that's not what I said.**
21 Q. Okay, what did you say?
22 A. **I said the DEA said we're not physicians**
23 **and we can't give you direction about how to care**
24 **for your patients.**
25 Q. Was there ever an instance where the DEA

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1 said this individual is diverting, don't prescribe
2 to him?
3 A. **Not the DEA.**
4 Q. Who? What would be the Missouri River
5 Drug Task Force?
6 A. **Yes.**
7 Q. That would be Shane Hiett?
8 A. **Yes.**
9 Q. That would be the individual you said you
10 worked cooperatively with?
11 A. **Yes.**
12 Q. And did you follow his advice?
13 A. **Yes.**
14 Q. Are you still prescribing to the patient
15 that we're calling Exhibit 29-21?
16 A. **I don't know.**
17 Q. And I know that's a bit of an oblique
18 question. So do you recognize that individual?
19 A. **Oh, I do.**
20 Q. And were you ever counseled by Shane Hiett
21 to discontinue because he was suspected of being a
22 drug seeker?
23 A. **Shane and I had some conversations and at**
24 **one point he did say I should not prescribe for that**
25 **patient.**

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1 Q. So he did give you specifics about real
2 threats, didn't he?
3 A. **Yes.**
4 Q. But --
5 A. **Do you know about the rest of my**
6 **conversation with Shane Hiett?**
7 Q. Did you continue to prescribe to that
8 individual?
9 A. **No, actually what I did is I had a**
10 **continued conversation with Shane Hiett and I told**
11 **Shane about the circumstances of the individual, the**
12 **additional confounding circumstances that he has,**
13 **and Shane and I came to an agreement that I would**
14 **continue to prescribe to him.**
15 Q. In other words, you did? That's a yes?
16 **MR. DOUBEK:** Objection, it's responsive to
17 your question.
18 Q. (By Mr. Fanning) My question specifically
19 was, did you continue to prescribe to that
20 individual? And that would be easily answered --
21 A. **Yes.**
22 Q. Very good.
23 **HEARING EXAMINER SCRIMM:** Okay.
24 Gentlemen, I know that this a tense situation,
25 but I can see tension rising and I would ask

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1 you both to kind of scale back a little bit now
2 before it gets further down the road. Thank
3 you.
4 **THE WITNESS:** What kind of guidance would
5 you give me?
6 **HEARING EXAMINER SCRIMM:** Well...
7 **MR. DOUBEK:** Be cool.
8 **HEARING EXAMINER SCRIMM:** Be cool.
9 **THE WITNESS:** All right. Will do.
10 **HEARING EXAMINER SCRIMM:** And Mr. Fanning
11 as well.
12 **THE WITNESS:** Great.
13 Q. (By Mr. Fanning) Regarding the
14 Dr. Christensen patients that you said came to you
15 on 30 milligram oxycodone, you made a remark that I
16 noted, "It was enough of a drug to put a city to
17 sleep." Do you recall that?
18 A. **I did say that.**
19 Q. And you suggested that it was probably
20 because they were habituated, that they could
21 tolerate that level of pain, is that correct, or
22 that level of dosage?
23 A. **Yes.**
24 Q. But --
25 A. **I was able to review them in the**

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1 **Prescription Drug Registry, which is a great tool.**
2 Q. But there is also another possibility that
3 would account for those large quantities and that
4 was that they were diverting them. That's possible,
5 isn't it?
6 A. **Yes.**
7 Q. Regarding the discussion that you had with
8 Jeremy Otteson that led to the complaint that you
9 filed. You know what I'm talking about, right?
10 A. **Yes.**
11 Q. Did you say that you could admit now that
12 maybe the communication wasn't ideal?
13 A. **Correct.**
14 Q. And did you also say that part of it was
15 because you were possibly defensive because it
16 seemed as though that was an attack on your skill as
17 a physician?
18 A. **Yes.**
19 Q. But had you just told Jeremy Otteson that
20 this person was a regular patient and this was not
21 for a toothache but for fibromyalgia, much of this
22 could have been avoided, couldn't it?
23 A. **No. He was told that.**
24 Q. Is it in your judgment a weaning success
25 if that patient goes to another provider and

Page 888

1 continues opioid medication through that person?
2 **A. I don't judge my successes with patients**
3 **on what they do with another provider.**
4 Q. Okay. Is it fair to say, Dr. Ibsen, that
5 you kind of get your back up a little bit when
6 you're challenged?
7 **MR. DOUBEK:** Objection, irrelevant,
8 immaterial.
9 **HEARING EXAMINER SCRIMM:** Overruled.
10 Q. (By Mr. Fanning) Do you know what I mean?
11 **A. No.**
12 Q. Do you get defensive when you're
13 challenged?
14 **MR. DOUBEK:** Objection, vague.
15 **HEARING EXAMINER SCRIMM:** Can you
16 rephrase, Mr. Fanning?
17 **MR. FANNING:** Okay.
18 Q. (By Mr. Fanning) Do you feel as though
19 when you're confronted with the sort of conflicts
20 that we all have to deal with as grownups and
21 professionals that you manage those professionally
22 and appropriately --
23 **A. Yep.**
24 Q. Okay. But isn't it true that everybody
25 who has testified here in this proceeding that

Page 889

1 challenged you suffered some form of counterattack
2 or retaliation?
3 **A. No.**
4 Q. All right. Let's go through them.
5 **A. Okay.**
6 Q. Sarah Damm. She was the one person at
7 your office with the courage to challenge you about
8 your prescribing practice.
9 **MR. DOUBEK:** Objection to the testimony by
10 counsel characterizing her as having the
11 courage. She was fired.
12 Q. (By Mr. Fanning) Did Sarah Damm challenge
13 you about your prescribing practices?
14 **A. Yes.**
15 Q. And since that she's been maligned at this
16 hearing, hasn't she?
17 **A. Did I malign her?**
18 Q. I didn't ask you that. Has she been
19 maligned at this hearing?
20 **A. I don't know.**
21 Q. Did you hear your counsel give his opening
22 saying that she was a poor employee?
23 **A. Well, that was a fact.**
24 Q. Did you look at her records that suggested
25 that she had no disciplinary write-ups of any kind

Page 890

1 until she was fired?
2 **A. That's not true.**
3 Q. The women from the Western Montana Mental
4 Health Center testified. You recall that, right?
5 **A. Yes.**
6 Q. And that all had to do with that patient
7 who went to Hays-Morris House in crisis and you
8 offered her your narcotic, correct?
9 **A. No.**
10 Q. What happened?
11 **A. I offered her my Percocet.**
12 Q. Thank you. But they refused to give that
13 to the patient as you directed?
14 **A. There was an initial agreement that they**
15 **would and, yes, then they didn't.**
16 Q. And you were very unhappy about that,
17 weren't you?
18 **A. I don't recall how unhappy I was. I was**
19 **unhappy. I'm not sure about very.**
20 Q. But did you call one of those women on her
21 private time and tell her to bring your fucking meds
22 back?
23 **A. No.**
24 Q. Do you recall the testimony that they
25 alerted you that if you continued to harass the

Page 891

1 staff that they would have you arrested should you
2 appear?
3 **A. No.**
4 Q. Did you threaten to --
5 **A. They were going to arrest me in some**
6 **future?**
7 Q. If you appeared at their clinic, they
8 advised you you would be arrested?
9 **A. Fair enough. They can say anything they**
10 **want.**
11 Q. Did you threaten to file a complaint
12 against Western Montana Mental Health and Ms. Dunks
13 for refusing to give those medications as you
14 thought they should be given?
15 **A. No.**
16 Q. So all of that testimony that they offered
17 was false?
18 **A. No. I was going to file a complaint**
19 **against the Western Montana clinic and the**
20 **Hays-Morris House for admitting a patient who was**
21 **suicidal because of their pain and refusing to give**
22 **them pain medication, admitting a patient to a**
23 **facility where they had no capability of taking care**
24 **of the medical needs of that patient and essentially**
25 **fraudulently projecting that they could actually**

Page 892

1 **care for that patient.**
2 Q. Jeremy Otteson refused to give or issue
3 the prescription that you provided for one of those
4 patients, right?
5 A. **I'm sorry. I'm confused.**
6 Q. Okay. Jeremy Otteson is the Walgreens
7 pharmacist who testified.
8 A. **Yes.**
9 Q. And he declined to give the full
10 prescription for a certain patient that you wrote?
11 A. **Correct.**
12 Q. And that made you very unhappy, didn't it?
13 A. **Well, it actually made the patient very**
14 **unhappy. She was the one in tears.**
15 Q. But then you retaliated against
16 Mr. Otteson by filing a complaint with the Board of
17 Pharmacy.
18 A. **So do you think that filing a complaint**
19 **against a board is a retaliation?**
20 **HEARING EXAMINER SCRIMM:** I'm sorry, sir.
21 Mr. Fanning is asking you questions at this
22 time. If your counsel wants to ask you
23 questions in response to his, he certainly will
24 be able to do that.
25 A. **Well, I'm not going to characterize it as**

Page 893

1 **retaliation.**
2 Q. (By Mr. Fanning) But you did file a
3 complaint against Mr. Otteson?
4 A. **I reported him to the Board of Pharmacy**
5 **for refusing to fill a legitimate prescription for a**
6 **patient.**
7 Q. Agent Tuss tried to work with you for a
8 number of months, didn't she?
9 A. **I don't know what Agent Tuss tried to do.**
10 Q. Well, we know that she stopped by your
11 clinic on a number of occasions.
12 A. **Yeah. You sent her.**
13 Q. We know that you met with her and
14 Mr. Gardipee.
15 A. **Yes.**
16 Q. And we know that there were a number of
17 telephone calls between her office and yours and her
18 and your office manager.
19 A. **Yes.**
20 Q. Then this past summer when you became
21 frustrated with her, you threatened her as well,
22 didn't you?
23 A. **No.**
24 Q. So her testimony that you were no longer
25 welcome to call and discuss issues with her, that's

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1 false?
2 A. **Agent Addis talked to me about not talking**
3 **to the DEA agents any further without my attorney**
4 **present. He did call me about that.**
5 Q. Your attorney or their attorney?
6 A. **My attorney.**
7 Q. All right.
8 A. **They said there was an active**
9 **investigation with the Deputy U.S. Attorney of the**
10 **State of Montana and that there was no longer, no**
11 **longer could they talk to me without my attorney**
12 **present.**
13 Q. In fact, it's probably fair to say that
14 you were unhappy with the fact that you were being
15 prosecuted by the Board of Medical Examiners?
16 A. **No.**
17 Q. Do you think that me as an individual is
18 treating you unfairly?
19 A. **Yes.**
20 Q. In fact, you've written extensively about
21 that in your Facebook posts, haven't you?
22 A. **I would say that's probably 1 percent of**
23 **what's on my Facebook.**
24 Q. Well, it's the 1 percent though let's talk
25 about now. Do you feel as though there is some sort

Page 895

1 of conspiracy against you?
2 A. **No.**
3 Q. Did you write that, "I smell a rat. Get
4 ready for conflict"?
5 A. **I don't know.**
6 Q. If it was in the Facebook, would you agree
7 that that was so?
8 A. **I don't know. If I saw my Facebook page**
9 **and could confirm it, I probably would.**
10 Q. Did you say that you won't stand for
11 bullying?
12 A. **I think I might have.**
13 Q. More than once?
14 A. **Okay.**
15 Q. That's not an answer. Please, did you say
16 that more than once in your Facebook?
17 A. **Okay.**
18 Q. One more time. On more than one occasion
19 did you allege that the Board of Medical Examiners
20 or me as an individual was bullying you?
21 A. **I'm not sure if it's more than one**
22 **occasion. I'd have to look and see. If you could**
23 **show me the actual Facebook entries, I would**
24 **actually affirm that. But not looking at them**
25 **currently, I can't say one way or the other. I'd**

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1 **say it's pretty likely I might have done it once.**
2 **If it's more than once, I would have to actually**
3 **look at the facts and then attest to whether it was**
4 **three or five or more than one.**
5 Q. It could be though? It could be?
6 A. **It could be.**
7 **MR. DOUBEK:** Objection, it's been asked
8 and answered.
9 **HEARING EXAMINER SCRIMM:** Sustained.
10 Q. (By Mr. Fanning) Did you indicate that
11 you were going to do something to make this process
12 ugly?
13 A. **No.**
14 Q. You never said that?
15 A. **No. The process is pretty ugly already**
16 **so, no.**
17 Q. Let me quote something to you and see if
18 you remember writing this.
19 **MR. DOUBEK:** Your Honor, this has nothing
20 to do with any of the issues in this case, and
21 I would object to this line of questioning.
22 **MR. FANNING:** It has everything to do with
23 credibility and has everything to do with
24 whether or not the facts that are recorded in
25 Exhibits 22 and 23 have resurfaced and we need

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1 to address them.
2 **MR. DOUBEK:** No. There has been no link
3 by any witness at this point, and I would
4 object to further questions in this regard.
5 Mr. Ramirez did not testify about this sort of
6 thing in any way, shape, or form.
7 **MR. FANNING:** And the reason for that was
8 to protect your client, but it is in the
9 record.
10 **HEARING EXAMINER SCRIMM:** Can you read the
11 question back?
12 (Previous question read.)
13 **HEARING EXAMINER SCRIMM:** The objection is
14 overruled.
15 Q. (By Mr. Fanning) In your Facebook posts,
16 I'm going to quote something --
17 A. **Do you mind if I actually take a look at**
18 **my Facebook posts, or can I actually look at what**
19 **you're reading?**
20 Q. You know what, I think that's a capital
21 idea. I believe it's Exhibit 21. It is.
22 **MR. DOUBEK:** Your Honor, we have objected
23 to this and I believe you sustained our
24 objection and, thus, questions about this
25 irrelevant document should be sustained.

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1 **HEARING EXAMINER SCRIMM:** At this point
2 the question is not about the document, it's
3 about the Facebook page. And the doctor has
4 that and can see it, so I think your client
5 opened the door on this.
6 **MR. DOUBEK:** Well, he was asked the
7 question though and he's trying to answer the
8 question.
9 Q. (By Mr. Fanning) Dr. Ibsen, I think it
10 might be to your right. Is that it? You can keep
11 it, sir. Turn to page or, excuse me, Exhibit 21,
12 please. Now, turn to page 869 within that.
13 **MR. DOUBEK:** May I have a continuing
14 objection about Facebook -- it is certainly
15 likely that the doctor is upset that he's being
16 hauled into a procedure like this. I don't
17 think that's abnormal for anyone and, thus,
18 asking him about his level of upsetness is
19 irrelevant and immaterial.
20 **HEARING EXAMINER SCRIMM:** You can have a
21 continuing objection.
22 **MR. DOUBEK:** That's what I want. Thank
23 you.
24 Q. (By Mr. Fanning) Are you on page 689?
25 A. **Yeah. It says BOME.**

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1 Q. Right. Below that.
2 A. **"Met with attorney. Told him to tell BOME**
3 **to F off. He listened. Told him we have gone over**
4 **all this crap months ago. 17 months ago. Then they**
5 **told us get expert testimony and we will close the**
6 **case. Vacated, vamoose, et cetera. Don't worry has**
7 **been repeated more than what, me worry now that the**
8 **Montana Board of Medical Examiners and their**
9 **attorneys have lied, stalled and otherwise bullied**
10 **me, they are now changing course to pursue a full**
11 **hearing. Well, okay. They will not get me to**
12 **repeat answers to ridiculous, repetitive questions**
13 **designed only to have me trip up. If told to show**
14 **up, I will. Then they will hear me. I took an**
15 **oath. I swore by Asciepius, not by the BOME and**
16 **their tactics."**
17 Q. Dr. Ibsen, that's all I want. But if you
18 want to keep reading, you're welcome to.
19 A. **Okay.**
20 **MR. DOUBEK:** Doctor, just -- this is
21 garbage. Just answer the questions.
22 Q. (By Mr. Fanning) So you didn't think
23 anything of the discovery, right? You thought that
24 was something that was frivolous or just an
25 imposition that was designed to impose upon you for

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1 no reason?
2 **MR. DOUBEK:** Objection, argumentative.
3 **MR. FANNING:** That's a question.
4 **MR. DOUBEK:** It's argumentative.
5 **HEARING EXAMINER SCRIMM:** Overruled.
6 Q. (By Mr. Fanning) You said that you
7 weren't going to answer ridiculous questions
8 designed to trip you up, right? You read that?
9 **A. Let me refer back to that page. "They**
10 **will not get me to repeat answers to ridiculous**
11 **repetitive questions designed only to have me trip**
12 **up."**
13 Q. So you didn't think much of the discovery
14 process, did you?
15 **A. What does discovery process mean?**
16 Q. Well, if you turn the page on 870, you've
17 got photographs of the discovery that I sent to you.
18 Does that refresh your recollection?
19 **A. I can't read those photographs.**
20 Q. No. But that's what I'm talking about.
21 Those were questions that I offered you designed to
22 elicit what this case was about.
23 **A. Right.**
24 Q. And it was your determination that that
25 wasn't something you were willing to participate in?

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1 **A. These were the same questions that were**
2 **presented to me in the original complaint from Sarah**
3 **Damm of 17 months prior to this. And it seemed to**
4 **me to repeat the questions without any historical**
5 **precedent of how I answered the previous question,**
6 **that it was designed to get me to answer a question**
7 **differently than I answered 17 months prior. That**
8 **seems like to me it was designed to make me make a**
9 **mistake.**
10 Q. So was that the reason --
11 **A. Why would I have to answer all those**
12 **questions all over again?**
13 Q. Was that the reason why there was 2,000
14 pages of medical records that we didn't get
15 initially?
16 **MR. DOUBEK:** Objection --
17 **A. You got those initially, my friend.**
18 Q. (By Mr. Fanning) All right. Now on
19 page 870, the last two lines of text. Did you
20 author that where it says, "I am sharing this"?
21 **A. "Because bullying only responds to**
22 **transparency."**
23 Q. Keep going.
24 **A. "I won't stand by while someone is**
25 **bullied, that includes me."**

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1 Q. So do you think the Board of Medical
2 Examiners is acting outside of its bounds or that I
3 am individually?
4 **A. Yes.**
5 Q. All right. So what did you resolve to do
6 about that?
7 **A. What did I resolve to do about that?**
8 Q. Right. You said that you weren't going to
9 stand by and be bullied. What were you going to do?
10 **A. It seemed to me that the process was quite**
11 **secretive and that having discussed the situation**
12 **with my attorney on numerous occasions, having**
13 **responded to requests by the Board of Medicine**
14 **attorney numerous times to both open up my clinic,**
15 **bring in the SAMHSA document, take different**
16 **courses, jump through several hoops, it seems to me**
17 **like there were several agreements that were in**
18 **place that if we just get these things done, we can**
19 **get this thing resolved. And the more we did, the**
20 **more it didn't get resolved.**
21 **So it became clear to me that this process**
22 **was going somewhere with no interest in any**
23 **resolution based on the behavior of the attorney for**
24 **the Board of Medicine. I don't have anything**
25 **against the Board, I don't think they've heard about**

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1 **any of this. My problem is with you. And you've**
2 **talked to my attorney numerous times and we've had**
3 **settlement conversations numerous times and you've**
4 **reneged on each one of them and here we are.**
5 **So it seemed clear to me that this process**
6 **was going to go on and on, maybe in order to build**
7 **your career. I have no idea what you're up to. All**
8 **I know is what I'm up to.**
9 Q. Okay. What you were up to is you revealed
10 on page 872. So page forward a little bit where the
11 post with your name on it begins. Can you read that
12 first line?
13 **A. 872. "Edie Cartwright says GDSF."**
14 Q. I'm talking about your post, the first
15 line.
16 **MR. DOUBEK:** Just read it to yourself.
17 Q. (By Mr. Fanning) Read it out loud,
18 please.
19 **HEARING EXAMINER SCRIMM:** Go ahead.
20 **MR. DOUBEK:** Go ahead.
21 **A. "It's going to get public and ugly.**
22 **Ariela Cohen and Marshall" -- (phonetic)**
23 Q. (By Mr. Fanning) That's all I need, sir.
24 So what do you mean by it's going to get ugly? What
25 are going to do?

Page 904

1 **A. Is this pretty right now?**
2 Q. Were you threatening me?
3 **MR. DOUBEK:** This is just argument.
4 **MR. FANNING:** What we're doing is
5 establishing the foundation for the documents
6 that the Hearing Officer excluded before
7 because of the relevance.
8 **A. Well, I don't know. Is this ugly or not?**
9 Q. (By Mr. Fanning) Let's turn to page 877,
10 and we're almost done with this material. Now,
11 there are a number of posts that are attributed to
12 you, but there is one in the middle that begins
13 clearly. Read that out loud, please.
14 **A. "Bringing ER in helped. Had me thinking**
15 **of rabbit mostly. But like the Shrek story, there**
16 **is some of each character in each of us. Aye?"**
17 Q. Actually, what I said was the one that
18 begins with the word clearly.
19 **A. I don't see one that begins with the word**
20 **clearly.**
21 Q. Just below that.
22 **A. "Poo sticks" is the one that's right below**
23 **that.**
24 Q. Keep going.
25 **A. Okay. "See what floats by."**

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1 Q. Keep going.
2 **A. "Clearly, my lawyerly nemesis at BOME has**
3 **upped the ante. Now his career is on the line,**
4 **which means it's going to get real nasty real**
5 **quick."**
6 Q. So what did you intend to do to make it
7 nasty?
8 **A. I didn't intend to do anything to make it**
9 **nasty. It's obviously gotten nasty. It was pretty**
10 **much an excellent foreshadowing, I think. My**
11 **crystal ball is working pretty good.**
12 Q. Do you prefer it nasty?
13 **MR. DOUBEK:** Objection, that's
14 argumentative.
15 **HEARING EXAMINER SCRIMM:** Sustained.
16 Q. (By Mr. Fanning) Who is Dave Edmiston?
17 **A. He is a friend of mine who is a physician,**
18 **retired ophthalmologist who is currently working as**
19 **an evaluator for Medicare patients, doing in-home**
20 **evaluations of patients in Montana, Kentucky, and**
21 **other states. He is available if you want to call**
22 **him.**
23 Q. He is a friend of yours you say?
24 **A. Yeah.**
25 Q. And you trust his opinion? You think he's

Page 906

1 got good judgment?
2 **A. Well, he is a person who is a friend of**
3 **mine.**
4 Q. Do you know if he's ever met me?
5 **MR. DOUBEK:** Objection, this is irrelevant
6 and immaterial.
7 **MR. FANNING:** We're looking at the
8 underpinning on Exhibit 24.
9 **HEARING EXAMINER SCRIMM:** Where are we
10 going?
11 **MR. FANNING:** It's pretty clear that
12 Dr. Ibsen set about a program to attack anybody
13 who's threatened him, that includes me, and 24
14 is that attack.
15 **MR. DOUBEK:** Objection, it's irrelevant to
16 any issue in this case.
17 **HEARING EXAMINER SCRIMM:** I don't see
18 that -- I don't see the connection.
19 **MR. FANNING:** Well, the connection is that
20 Dr. Ibsen has tried to undermine anybody who
21 has ever threatened him and somehow he
22 perceives me as the object of a threat. So he
23 contacted the Board of Medical Examiners and
24 called me a vicious dog and that this was a
25 witch hunt and that he was going to assure that

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1 I was silenced. I apparently am a wildly out
2 of control attorney with my own agenda.
3 **HEARING EXAMINER SCRIMM:** I think you made
4 your point. Let's move on.
5 **MR. FANNING:** Okay.
6 Q. (By Mr. Fanning) Did you have anything to
7 do with Dr. Edmiston submitting that to the Board of
8 Medical Examiners?
9 **A. I'm not sure what you mean by the**
10 **question.**
11 Q. Did you talk to Dr. Edmiston about this
12 disciplinary action?
13 **A. Yes.**
14 Q. Did you indicate to Dr. Edmiston that you
15 were frustrated with the action?
16 **A. Yes.**
17 Q. Was it you who indicated to him the nature
18 of the attorney's conduct?
19 **A. No.**
20 Q. So you don't have any idea how this
21 stranger -- where does he live?
22 **A. Well, right now he is in Kentucky.**
23 Q. So he has nothing to do with Montana or
24 me. How was it that he became aware of this and
25 that I was behaving like a vicious dog?

Page 908

1 **A. I don't know.**
2 Q. Okay. You had nothing to do with that?
3 **A. No, I didn't say I didn't have anything to**
4 **do with it.**
5 **MR. FANNING:** Now, I want to advise
6 Counsel and the Hearing Officer that I want to
7 explore some specifics in Exhibits 22 and 23
8 and it may be that you don't want that done
9 publicly.
10 **MR. DOUBEK:** I don't think it ought to be
11 done, period. It's got nothing to do with the
12 issues of charting or prescribing or care
13 rendered to these. In fact, you offered it and
14 said this is just backup information if that's
15 what we get to at the conclusion of this
16 matter.
17 **MR. FANNING:** Well, I don't want to
18 quibble, but what I indicated is that that is
19 information that would be instructive both to
20 the Hearing Examiner and to the Board of
21 Medical Examiners adjudication panel in the
22 event that the Hearing Examiner finds that
23 there has been unprofessional conduct and some
24 discipline is appropriate. That discipline I'm
25 suggesting is a lot of behavioral and

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1 psychological work.
2 **MR. DOUBEK:** Well, that wasn't the
3 testimony presented by Mr. Ramirez.
4 Mr. Ramirez didn't connect any dots to this
5 proceeding versus what happened years and years
6 ago. All he indicated is that the doctor was
7 cooperative and was cleared by folks,
8 professionals that he saw and he released him
9 early from an MPAP agreement.
10 **MR. FANNING:** I don't believe that's what
11 happened. He was under a doctor's care and he
12 no longer is.
13 **MR. DOUBEK:** He was ordered to receive
14 some care. He didn't seek it voluntarily and
15 the doctor said he didn't need care.
16 **MR. FANNING:** I don't believe you'll find
17 that in Exhibit 22 or 23, Mr. Doubek.
18 **HEARING EXAMINER SCRIMM:** I think we have
19 the testimony. I don't find the issue to be
20 relevant.
21 Q. (By Mr. Fanning) Were some of your
22 patients addicted?
23 **A. No.**
24 Q. So if the chart indicated that they
25 believed themselves to be addicted, that would be

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1 inaccurate?
2 **A. Well, you know, addiction is a complex**
3 **issue. I don't treat addiction patients, so I said**
4 **no based on the fact that my patients aren't being**
5 **seen for their addictions. I apologize for my**
6 **confusion that might have come from my short answer.**
7 Q. Well, but addiction patients deserve an
8 entirely different medical approach than a chronic
9 pain patient; would they not?
10 **A. So you're saying --**
11 Q. That's a question. I'm not saying
12 anything. Do addiction patients require a different
13 medical approach than somebody with more of a
14 run-of-the-mill chronic pain presentation?
15 **A. I think there is a -- to use a term you**
16 **used -- venn diagrams with some overlap.**
17 Q. But some of these by admission had
18 addiction issues, didn't they?
19 **A. Perhaps, yes. They all had pain issues.**
20 Q. But Patient Number 2 --
21 **A. Excuse me. Let me refer to that.**
22 Q. It will be here, Doctor. If you're using
23 your numbers, that's not going to work. You need to
24 use this one. Turn to page 96 of that document,
25 will you, please?

Page 911

1 **A. Yes. 96.**
2 Q. In the second block of text in the middle,
3 that patient is charted as saying that she admits
4 she is addicted and she was going to sign on for a
5 Suboxone program with Dr. Ellis, right?
6 **A. According to the note from the nurse that**
7 **typed this, yes.**
8 Q. And that nurse is one of your staff
9 members?
10 **A. Correct.**
11 Q. But Suboxone treatment is restricted,
12 isn't it?
13 **A. Correct.**
14 Q. Only DATA waived specifically authorized
15 physicians can offer maintenance treatment to
16 addicted patients, right?
17 **A. Well, actually, Dr. Ellis --**
18 Q. Is that a yes or a no?
19 **A. It's not a yes-or-no answer.**
20 Q. So was it possible for you to treat
21 addiction on an outpatient basis?
22 **A. No.**
23 Q. Right. Okay.
24 **A. So are you saying by this --**
25 **HEARING EXAMINER SCRIMM:** Doctor,

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1 Mr. Fanning is asking the questions at this
2 point.
3 **MR. DOUBEK:** What page number is that?
4 **THE WITNESS:** This is page 96.
5 **MR. DOUBEK:** Okay. Excuse me.
6 Q. (By Mr. Fanning) And then Patient
7 Number 4 --
8 **A. Hang on. I want my attorney to catch up.**
9 **MR. DOUBEK:** It may take a while. No,
10 that's fine.
11 Q. (By Mr. Fanning) I'm going to try to
12 hasten this along a little bit. Patient Number 4 at
13 page 300 reported to you that --
14 **A. Hang on. I'm not quite caught up to you**
15 **yet. Okay. Thanks.**
16 Q. -- that he was on Suboxone and now he
17 wanted off; is that correct?
18 **A. It says here, "Wants to wean Suboxone.**
19 **When he stops, he get symptoms of withdrawal."**
20 Q. But, in fact, if you look at page 295,
21 what actually occurred was Dr. Ellis cut him off for
22 breach of the understanding that they had; isn't
23 that right?
24 **A. It says, "Patient upset. Dr. Ellis saw**
25 **him only once. There was a problem. Now cut off**

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1 **and XXXX's trouble weaning from Suboxone.""**
2 Q. Now, if I could get Mr. Doubek's
3 indulgence. In your Exhibit L-2 at page 857.
4 **A. Okay.**
5 Q. What actually happened, according to in
6 Nurse Ryder's note?
7 **A. "Lindy from Dr. Ellis's office called UCP**
8 **with concerns about XXXX" -- Sorry.**
9 Q. Okay. Continue.
10 **A. -- "under investigation for fraudulently**
11 **obtaining controlled substances. He called**
12 **Dr. Ellis to do a pill count. He refused."**
13 Q. That's enough.
14 **A. "States he has sold his business and is**
15 **moving to Florida."**
16 Q. Let's return to the other smaller stack of
17 documents, Patient Number 6. At page 537 you
18 discussed weaning with Patient 6.
19 **A. Yep.**
20 Q. What was the date of that?
21 **A. 3-29 of '13.**
22 Q. It was shortly after that that you last
23 saw that individual, wasn't it?
24 **A. I don't know.**
25 Q. And to help you out, Doctor. If you'd

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1 turn to the tab there at 6, you'll find the MPDR for
2 that patient. And you can turn to the second page
3 and see your last prescribing. Your last
4 prescription was issued on April 16th of '13, right?
5 **A. Hang on. Correct.**
6 Q. So, in other words, within a month after
7 you suggested he wean, he left your practice and
8 then ultimately ended up with Dr. Ellis?
9 **A. Right.**
10 Q. And --
11 **A. I guess he didn't want to wean.**
12 Q. Yeah, that's my point. Then he ended up
13 on a long-term Suboxone program with Dr. Ellis?
14 **A. I don't know what happened to him after he**
15 **saw me.**
16 Q. Well, you look at the front page of
17 Exhibit 28-6 and see that he's regularly prescribed
18 Suboxone by Dr. Ellis.
19 **A. Correct.**
20 Q. In other words, he also was in an
21 addiction recovery program.
22 **A. You'd have to ask the patient or Dr. Ellis**
23 **about that.**
24 Q. So, in other words, of the nine patients,
25 three of them ended up in addiction care, didn't

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1 they?
2 **A. No. Dr. Ellis is a pain doctor. He's a**
3 **psychiatrist. He puts himself out as someone who**
4 **treats patients with chronic pain.**
5 Q. But not with Suboxone?
6 **A. He doesn't treat them with Suboxone? I**
7 **think that's the only thing he uses.**
8 Q. You know that the law forbids you from
9 using narcotics as a maintenance therapy for
10 addicted patients, right?
11 **A. Yes.**
12 Q. And that's not what you were doing with
13 these patients?
14 **A. No. These patients had pain.**
15 Q. There were a number of firsts that we
16 heard about your practice and Urgent Care Plus. Do
17 you recall some of the testimony from the other
18 witnesses?
19 **MR. DOUBEK:** I don't understand the
20 question. It's vague.
21 **MR. FANNING:** I hadn't really got to a
22 question yet.
23 **A. Oh, I thought that was a question.**
24 Q. (By Mr. Fanning) No. I just said do you
25 recall the other witnesses who testified. The

1 witnesses from Western Montana Mental Health Clinic,
2 there were three of them, remember?
3 **A. No. There were more than three from that**
4 **incident.**
5 Q. They indicated that your clinic was the
6 first time they had seen a physician divert his own
7 medication to a patient. Do you recall that
8 testimony?
9 **A. You might be right.**
10 Q. They testified that your incident was the
11 first time that they ever had to threaten to call
12 the police on a physician. Do you recall that?
13 **MR. DOUBEK:** Objection, it's been asked
14 and answered.
15 **HEARING EXAMINER SCRIMM:** Sustained.
16 Q. (By Mr. Fanning) Your former physician
17 assistant and your personal caregiver, Lisa
18 Weinreich testified, correct?
19 **A. (Nods head.)**
20 Q. She testified that yours was the first
21 instance where she had to call the Board of Medical
22 Examiners for consultation on a patient's conduct.
23 That was you, wasn't it?
24 **A. Actually, I trained Lisa so she's only**
25 **been practicing for maybe three years. So whatever**

1 **firsts she has, she had a lot of them with me.**
2 Q. And she testified that was the first time
3 that she had to call a lawyer for consultation about
4 what to do with a prescription?
5 **A. Did she have to call a lawyer? I'm not**
6 **sure she did have to call a lawyer. Clearly the**
7 **fact that she won't talk to me now because she is in**
8 **communication with a lawyer because of all the FUBAR**
9 **about this ugly incident that continued to get ugly.**
10 **So, yeah, my relationship with Lisa is uncertain**
11 **right now because she has retained a lawyer and I'm**
12 **chagrined about it.**
13 Q. In fact, she quit her job because of her
14 supervising physician's conduct, your conduct?
15 **MR. DOUBEK:** Objection --
16 **A. Well, thank you very much for saying so.**
17 **But she told me she moved to Missoula, which is**
18 **where she lives, and didn't quit her job and she was**
19 **working part time with us anyway.**
20 Q. (By Mr. Fanning) Do you recall her
21 testimony that she had lost faith in you and quit
22 taking shifts?
23 **A. No.**
24 Q. Your office manager said --
25 **A. She, in fact, said I was a phenomenal**

1 **clinician, it seems to me.**
2 Q. She did. Your office manager testified
3 that this was her first experience with having the
4 DEA have a role in office practices. Do you recall
5 that?
6 **A. Yeah. Thanks to you.**
7 Q. Pharmacist Jeremy Otteson said your
8 practice was the first time that he ever refused to
9 fill a prescription for a physician.
10 **A. Okay.**
11 Q. You have to answer yes or no. Do you
12 recall that testimony?
13 **A. Do I recall that testimony?**
14 Q. Yeah.
15 **A. Yes.**
16 Q. He also testified that your clinic was the
17 first time that he ever had seen that many
18 out-of-town patients flood to an urgent care
19 practice. Do you recall that?
20 **A. No.**
21 Q. Pharmacist Bob Gardipee testified your
22 clinic was the first instance where he had a sitdown
23 meeting with a doctor and the DEA to sort out the
24 doctor's prescribing practices.
25 **A. Well, there is a lot of firsts here.**

1 Q. Yeah, there are. DEA Agent Tuss said that
2 yours was the first incident where she had to have a
3 conversation of that same sort.
4 **A. What sort? I'm not sure what you're**
5 **saying.**
6 Q. Going back to my previous question. There
7 was a triumvirate between you, the DEA, and the
8 pharmacist?
9 **A. A triumvirate?**
10 Q. Would you like another term?
11 **A. I just don't know what you mean.**
12 Q. There was a three-way meeting between you,
13 the DEA, and the pharmacist to figure out how to --
14 **A. And the office manager was there too, so I**
15 **guess it was a...**
16 Q. -- to how to figure out how to improve
17 your prescribing practices. That was a first for
18 the DEA as well.
19 **A. It was about improving my prescribing**
20 **practices?**
21 Q. What was it about?
22 **A. It was about resolving the conflict**
23 **between myself and Mr. Gardipee and getting**
24 **prescriptions for my patients who needed them.**
25 Q. Isn't it just true that you don't believe

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1 the laws apply to you?
2 A. **No.**
3 Q. No, they don't apply, or no, you don't
4 believe that?
5 A. **It's not true. You asked me is it true.**
6 **I said no.**
7 Q. But the law requires you to prescribe in
8 the ordinary course of a legitimate medical
9 practice, doesn't it?
10 A. **The law requires me to prescribe in the**
11 **legitimate...**
12 Q. In the course of a legitimate medical
13 practice.
14 A. **Yeah. I think I have a legitimate medical**
15 **practice, yes.**
16 Q. But, yet, all of those people are trying
17 to intervene to redirect your practice.
18 **MR. DOUBEK:** Objection,
19 mischaracterization of the testimony of several
20 witnesses.
21 **THE WITNESS:** I called the --
22 **HEARING EXAMINER SCRIMM:** Sustained.
23 A. **I called the meeting.**
24 **MR. DOUBEK:** Mark, wait. He sustained
25 that objection.

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1 Q. (By Mr. Fanning) So do you recall that
2 Montana's medical marijuana law applies to you?
3 A. **Are you asking me am I a medical marijuana**
4 **patient?**
5 Q. No. I'm asking whether or not you believe
6 the restrictions on offering medical marijuana to
7 Montana patients applies to you and your practice.
8 A. **I've actually prescribed many medical**
9 **marijuana prescriptions and they've all been**
10 **approved by the State.**
11 Q. So is that a yes or no? Do you --
12 A. **You have a complex question and I'm trying**
13 **to answer it the best I can.**
14 Q. Do you feel as though your medical
15 marijuana recommendations are consistent with
16 Montana law?
17 A. **Yes.**
18 Q. All right. And Montana law requires
19 objective evidence of some source of chronic pain
20 before you can offer that medical marijuana, right?
21 A. **No.**
22 Q. You don't think that that's true?
23 A. **No.**
24 Q. So Montana law does not require MRI, CT,
25 x-ray or some other similar objective --

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1 A. **It requires previous records.**
2 Q. Okay. And we could find those in the
3 charts of the nine?
4 A. **Yes.**
5 Q. And in the event that there is not
6 objective evidence, two physicians have to sign;
7 isn't that correct?
8 A. **No.**
9 Q. Okay. Now, isn't it also the case that
10 Montana law disallows any medical marijuana
11 recommendation for greater than one year?
12 A. **There is a question on the medical**
13 **marijuana form, "For what period of time is the**
14 **patient going to need medical marijuana (not to**
15 **exceed one year)?"**
16 Q. That's exactly it. And do your
17 prescriptions exceed one year?
18 A. **No.**
19 Q. Isn't it true that every single one of
20 them says lifetime?
21 A. **That's how long they're going to need it.**
22 **But they're going to, they get a prescription card**
23 **every year.**
24 Q. But it says "not to exceed one year" and
25 in the face of that you write lifetime every single

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1 time, don't you?
2 A. **Yes.**
3 Q. And so there is no point in me even
4 bothering to go through it because --
5 A. **You don't have to.**
6 Q. -- it says one year, you say lifetime?
7 A. **No. It says not to exceed one year. What**
8 **period of time does this patient perhaps need**
9 **medical marijuana (not to exceed one year). That's**
10 **a difficult question to answer, so I put lifetime**
11 **down.**
12 Q. Always?
13 A. **Every one.**
14 Q. Regardless of their hope for weaning,
15 regardless of their hope for --
16 A. **I'm not trying to wean them from medical**
17 **marijuana.**
18 Q. No.
19 A. **No. They only have it for a year and then**
20 **they can re-up if they want to. There is no need to**
21 **worry about that.**
22 Q. Do you recall writing a letter to the
23 editor to some publication called Emergency Medicine
24 News?
25 A. **Nope.**

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1 Q. Did you in September of 2014?
2 **A. I don't recall that.**
3 Q. I'll hand you this. I'm going to mark it
4 as department's exhibit, I think we're at 30.
5 **HEARING EXAMINER SCRIMM:** Thirty.
6 **MR. FANNING:** Thank you.
7 Q. (By Mr. Fanning) This is just one page of
8 it.
9 **A. Okay.**
10 Q. Do you subscribe to Emergency Medicine
11 News?
12 **A. It says Life In Emergistan.**
13 Q. Yes, it does. Read the letters to the
14 editor, please. Does your name appear anywhere in
15 there?
16 **A. Yes.**
17 Q. Did you write that letter?
18 **A. Let me see. I think I did.**
19 Q. So now you remember it?
20 **A. I do.**
21 Q. Can I have that back, please?
22 **A. I would like to read it the rest of the**
23 **way.**
24 Q. Certainly.
25 **A. In fact it might just make it easier so I**

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1 **can refer to it. Do you mind if I take a picture of**
2 **it?**
3 Q. No. Go ahead. I wish I had another copy
4 of it but I don't.
5 **MR. DOUBEK:** That's fine.
6 **A. Somehow I feel I'm going to need this.**
7 Q. (By Mr. Fanning) Okay. Now, this letter
8 to the editor in the September 14 issue of Emergency
9 Medicine News was from you. That is your --
10 **A. I think so.**
11 **MR. FANNING:** I'm going to move the
12 admission of Exhibit 30, and I can show Counsel
13 if you want.
14 **MR. DOUBEK:** That's fine. If he said he
15 wrote it, that's fine.
16 **HEARING EXAMINER SCRIMM:** Admitted.
17 Q. (By Mr. Fanning) And can you -- I don't
18 know about phones like that, Doctor, but can you
19 read the part that's in the second column that
20 begins, "The patient must titrate"?
21 **A. Yes.**
22 Q. Go ahead and read it out loud, please.
23 **A. "The patient must titrate his intake,**
24 **which he does without guidance from or dependence on**
25 **any physician. No visits, pill counts, groveling**

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1 **for more, being discharged, abandoned if he uses too**
2 **much. These patients are empowered and independent,**
3 **which is exactly what we say we want for our**
4 **patients. They do not come in begging for more or**
5 **they don't come in at all."**
6 Q. So does that accurately reflect your
7 philosophy about pill counts? Is that a form of
8 groveling?
9 **A. No. What that refers to is the fact that**
10 **patients on medical marijuana only have to come in**
11 **once a year. They don't have to have a pill count**
12 **because they're not on any pills. It's more**
13 **convenient for the patient to come in once a year**
14 **for their medical marijuana card than it is to have**
15 **to go through the various things that happen when**
16 **you do the pharmacy crawl, you have to pee in a cup,**
17 **you have to beg for pills, you have to possibly get**
18 **abandoned, or your doctor has the risk of losing his**
19 **prescribing privileges and move on to someone else.**
20 **All of those things are at risk for someone who is**
21 **on an opioid and they're not at risk for someone who**
22 **is on a medical marijuana card.**
23 Q. But isn't it true that you have an
24 obligation as a physician to continue to monitor
25 those patients for whom you offer medical marijuana?

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1 You can't just cut them loose and let them go on
2 their own, can you?
3 **A. Well, they come back next year for another**
4 **card.**
5 Q. So for one year they are on their own to
6 use as much marijuana in whatever setting, whatever
7 frequency that they choose?
8 **A. That's right.**
9 Q. But under the law you're required to
10 monitor the person's response to the use of
11 marijuana and evaluate the efficacy, but here you
12 suggest that they can use as much as they want
13 independently, correct?
14 **A. Well, every patient I write a medical**
15 **marijuana card for I invite them to come back if**
16 **they have a problem and they don't seem to do that.**
17 Q. And you believe that that satisfies the
18 laws' demand that you monitor the patient?
19 **A. I do.**
20 Q. Were any of your patients suspected of
21 fraudulently obtaining dangerous drugs?
22 **A. Yes.**
23 Q. A number of them, weren't they?
24 **A. Suspected, yes.**
25 Q. And that could have been discerned had you

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1 looked at the MPDR records and seen multiple
2 providers, true?
3 **A. False.**
4 Q. Okay. You don't believe the fact that
5 there are multiple providers is indicative of doctor
6 shopping?
7 **A. Do you want to talk about the specifics of**
8 **all these patients?**
9 Q. Not especially. I'm just talking about a
10 generality. The MPDR --
11 **A. I use the MPDR.**
12 Q. And if there are multiple prescribers
13 simultaneously with you, would that make you
14 hesitant and say hey, I cannot prescribe any more
15 because you are violating our oral contract?
16 **A. It depends on if they've told me about**
17 **that person or if I referred them to that person.**
18 **It depends on a lot of different scenarios. If the**
19 **scenario you're providing is I'm seeing another**
20 **doctor hoping to, you not notice I'm seeing this**
21 **other doctor and obtaining these other medications**
22 **then yes, the answer would be that would be a red**
23 **flag for me.**
24 Q. And sometimes did you redirect the course
25 of your care based on that analysis of the MPDR?

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1 **A. I don't know what you're referring to so I**
2 **can't answer your vague question specifically.**
3 Q. Well, if someone came in early for pills,
4 would you say it's too early, you cannot have any
5 more pills. I see by the MPDR it's only been five
6 days and you had a 20-day supply. Would you then
7 say you cannot have those?
8 **A. Only after having a conversation for why**
9 **did you use all those pills up in five days? Did**
10 **you fall down the stairs? Did you have an increase**
11 **in pain? Did acute pain come in on top of chronic**
12 **pain? This a complex issue so I can't really answer**
13 **it hypothetically for you. I apologize for that.**
14 Q. All right. But it's fair to say that
15 there were many, many early refills with almost all
16 of these patients? I think Dr. Kneeland said
17 universally there were early refills.
18 **A. Dr. Kneeland also said there is plenty of**
19 **reasons to have an early refill.**
20 Q. But did you ever on any instance see that
21 there was an early refill and say I'm not going to
22 prescribe for you now?
23 **A. Yes.**
24 Q. And what percentage do you suppose that
25 happened?

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1 **A. I don't know.**
2 Q. Less than 1 percent?
3 **A. There is only nine patients we're talking**
4 **about. Less than 1 percent would be like somebody's**
5 **toe.**
6 Q. But we're talking about hundreds of
7 prescriptions, right?
8 **A. Yes.**
9 Q. Now, did you ever refuse to continue to
10 care for a patient or refuse to prescribe for a
11 patient --
12 **A. I would never refuse to care for a**
13 **patient.**
14 Q. Even if they're obviously doctor shopping?
15 **A. Yes.**
16 Q. Now, I want to make sure I understand
17 that. Even if they're obviously doctor shopping,
18 you are still going to prescribe for them?
19 **A. No. You asked me if I would care for**
20 **them.**
21 Q. Are you still going to prescribe for them?
22 **A. No.**
23 Q. Now, it's a fact that one of your patients
24 ended up being prosecuted recently for fraudulently
25 obtaining, right?

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1 **A. I don't know that.**
2 Q. Okay. I'm going to hand you what I'm
3 going to mark as Department's Exhibit 31.
4 **MR. DOUBEK:** What patient number is that?
5 **MR. FANNING:** Can I have a sidebar?
6 (Sidebar discussion.)
7 **MR. FANNING:** I would have brought this up
8 yesterday but I didn't want to because it would
9 give away the name. So I'm not going to say
10 that it's a patient that was here yesterday
11 because we've disclosed their name.
12 **MR. DOUBEK:** She testified yesterday it
13 was all dismissed.
14 **MR. FANNING:** It was deferred. So what
15 I'm saying is I could have brought this up then
16 but I didn't want to because it would give it
17 away. And I'm going to say it's a generic
18 patient and not necessarily one of these
19 people, and that's the only thing I want to do.
20 **MR. DOUBEK:** He hasn't seen that or
21 anything of the kind, so I don't know how you
22 can ask him about it.
23 **HEARING EXAMINER SCRIMM:** Well, he may not
24 know.
25 **MR. DOUBEK:** Okay.

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1 (Sidebar discussion ended.)
2 Q. (By Mr. Fanning) Dr. Ibsen, I'm going to
3 give you this document that we've marked as
4 Exhibit 31. And you don't have to announce the
5 individual's name. But in the top of the first page
6 there there is a patient, there is a name, State of
7 Montana versus, right?
8 **A. Okay. Yeah.**
9 Q. Is that individual who is the defendant in
10 that criminal case a patient, or former patient of
11 yours?
12 **A. Yes.**
13 Q. And what was that person charged with?
14 **A. Let's see what it says here. Fraudulently**
15 **obtaining dangerous drugs (common scheme) a felony.**
16 Q. Now flip to the next page and there is
17 typically a list of witnesses on an information.
18 Are you listed as a witness in that?
19 **A. I am.**
20 Q. In fact, there is a whole bunch of doctors
21 listed as witnesses, aren't there?
22 **A. There is, and there is some midlevels**
23 **there too that are called doctor.**
24 Q. Yeah, and probably mislabeled. But,
25 nevertheless, a number of prescribers and you're one

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1 of them, correct?
2 **A. Yes.**
3 Q. Thank you.
4 **A. That's it for this?**
5 Q. Well, no. In fairness, flip one more
6 page.
7 **A. Thank you.**
8 Q. One more page. I just want to indicate
9 the outcome of that case, and I don't want to
10 misrepresent it. There was a deferred prosecution
11 agreement that at least for the time being has
12 resolved that, right?
13 **A. I don't know. This the first I've seen**
14 **this.**
15 **MR. DOUBEK:** It's a legal document and so
16 forth.
17 Q. (By Mr. Fanning) That's fine. I don't
18 want to put you on the spot, but I didn't want to
19 suggest that this had a different outcome than it
20 actually did.
21 **A. So was it a good outcome? I don't know**
22 **what that actually means.**
23 **MR. DOUBEK:** Mark, it doesn't matter.
24 **MR. FANNING:** And I'm going to move the
25 admission of Exhibit 31 and cite Rule 202

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1 because the Hearing Examiner can take judicial
2 notice of this pleading.
3 **MR. DOUBEK:** Objection, no link to any
4 issue in this proceeding.
5 **HEARING EXAMINER SCRIMM:** I'm going to let
6 it in. I don't know what weight it has, but
7 we'll let it in.
8 **MR. DOUBEK:** That's fine.
9 Q. (By Mr. Fanning) You testified, or rather
10 I should say Alicia Tuss testified that in her
11 discussion with you you announced that there were a
12 number of red flags that would alert you to a
13 patient that deserved attention to make sure that
14 they didn't divert or overuse, right?
15 **A. Yes.**
16 Q. Would we ever find any of those red flags
17 noted in your charts?
18 **A. Maybe.**
19 Q. That's not something you thought was worth
20 documenting?
21 **A. It was pretty clear where people who were**
22 **from Great Falls or Florence came to see me because**
23 **of their inability to obtain their pain medication**
24 **from Dr. Christensen's office. I made it very clear**
25 **about each one of those in the documents. So I'm**

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1 **not quite sure what you're talking about. In fact,**
2 **I called the DEA as soon as I noticed there were a**
3 **couple family members that were coming to me and I**
4 **said, "Here is a couple that are actually following**
5 **the red flag warnings that you've given me." And I**
6 **told them about them in April, that there is a**
7 **family coming to see me, they all were seeing**
8 **Dr. Christensen and now they're seeing me. This**
9 **sort of concerns me for the possibility that these**
10 **people could be diverting, you might want to look**
11 **into it and that's what I said to them.**
12 Q. Was there more than one family?
13 **A. There was some intertwining going on, so I**
14 **don't know if it's one family or two.**
15 Q. But that's certainly unusual in your
16 experience to have a whole family with that kind of
17 intractable pain?
18 **A. We've already documented there is a lot of**
19 **firsts.**
20 Q. So did you think it was a red flag or
21 didn't you?
22 **A. Yeah. I talked to the DEA about it**
23 **immediately.**
24 Q. And what about the original nine? Were
25 there any red flags among the nine that you would

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1 have charted?
2 A. **Well, the fact that they come through my**
3 **door is a red flag. The fact that they're doctor**
4 **shopping when they see me is a red flag, so they're**
5 **all red flags. They've been cut loose by some other**
6 **physician, they're on high doses of opiates for**
7 **chronic pain issues, and they're coming to an urgent**
8 **care. That's a red flag.**
9 Q. Are you willing to work with Michael
10 Ramirez and the Montana Professional Assistance
11 Program, or do you just have such a dislike or
12 distaste or distrust for them that that could never
13 be effective?
14 **MR. DOUBEK:** Objection, irrelevant and
15 beyond the scope of any question he ought to be
16 posing to this witness at this time. It's a
17 have you stopped beating your wife kind of
18 question.
19 **HEARING EXAMINER SCRIMM:** Mr. Fanning, why
20 don't you take that one step at a time.
21 Q. (By Mr. Fanning) You worked with
22 Mr. Ramirez for a year or maybe a little bit over a
23 year if everything was added up?
24 A. **I worked with Mr. Ramirez would be**
25 **probably -- there probably would be other ways to**

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1 **characterize it more effectively than that.**
2 Q. But you did have an MPAP contract for a
3 year?
4 **MR. DOUBEK:** Objection. Objection, again,
5 a continuing objection to all questions about
6 this.
7 **HEARING EXAMINER SCRIMM:** Well, you have a
8 continuing objection.
9 **MR. DOUBEK:** Thanks.
10 Q. (By Mr. Fanning) You did have an MPAP
11 contract for a year, is that correct, or roughly?
12 I'm not sure how long.
13 A. **Sure.**
14 Q. And when you went to a particular clinic
15 for an evaluation, that you didn't approve of it and
16 Mr. Ramirez testified that with some negotiation he
17 agreed to allow you to have a second evaluation at a
18 different clinic, right?
19 A. **No.**
20 Q. But you did, in fact, get a second
21 evaluation at a different clinic?
22 A. **Well, you asked several things in that**
23 **sentence. You said I didn't approve of it.**
24 Q. Okay. Why didn't you follow the
25 recommendations of the first clinic?

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1 A. **I went to the Menninger Clinic at the**
2 **behest of my partners at the emergency department at**
3 **St. Peter's Hospital. They got the idea that I was**
4 **abusing a substance. They got an idea that I was**
5 **impaired. In order to save my job, I had to go to**
6 **the Menninger Clinic. They evaluated me there after**
7 **five days and I think it was a $10,000 fee.**
8 **They came up with a diagnosis of**
9 **narcissistic personality disorder. I said, "Okay,**
10 **great. Send me back to work with all the other**
11 **narcissists." I asked them to document any harm to**
12 **any patient and there wasn't any. And they said,**
13 **"Okay. Wait just one second. We have a ten-week**
14 **inpatient treatment program for you at a thousand**
15 **dollars a day." At that point I balked.**
16 Q. A thousand dollars a day?
17 A. **(Nods head.)**
18 Q. Okay.
19 A. **So it was $70,000 for me to do an**
20 **inpatient treatment program at a facility like**
21 **theirs. It seemed like I could hear cha-ching,**
22 **cha-ching going on in the background.**
23 Q. So you thought that their professional
24 opinion was just driven by money?
25 A. **No. I thought it was driven by malice.**

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1 Q. All right.
2 A. **They were being used by the people that**
3 **were trying to get rid of me from the emergency**
4 **department.**
5 Q. All right. So --
6 A. **So I thought it was malicious. I thought**
7 **it was a legal escapade masquerading as a medical**
8 **one and I later settled with that group.**
9 Q. But then for one reason or another you got
10 a second evaluation within a couple of months?
11 A. **For one reason or another?**
12 Q. I don't know why. You're trying to tell
13 me why.
14 A. **(Nods head.)**
15 Q. Let me rephrase the question. You did get
16 a second evaluation within a couple months, didn't
17 you?
18 A. **Right.**
19 Q. That was about May of 2007?
20 A. **Yep. It was actually before the ten weeks**
21 **would have gone by.**
22 Q. So was that second evaluation adopted in
23 and applied as part of your MPAP contract with
24 Mr. Ramirez?
25 A. **Yes.**

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1 Q. Did you follow the expectations of the
2 MPAP contract?
3 A. **Yes. It called for me to do things that I**
4 **didn't think were applicable to me. My counsel**
5 **counseled me to sign the agreement anyway. I**
6 **thought it was a parallel to sending me to the gulag**
7 **and I didn't like it, and I wanted to keep my job.**
8 **It turns out that the job was gone anyway.**
9 Q. But at the end of one year, Mr. Ramirez
10 agreed to release you from that contract and you're
11 free to practice without any restrictions either
12 from the Board or from MPAP, right?
13 A. **Correct.**
14 Q. So did you have the ability now to work
15 cooperatively and protectively with MPAP or is that
16 something that's a bridge that you burned, and you
17 just can't find it within yourself to do it again?
18 A. **Well, it's -- fortunately I live in the**
19 **now and now I'm not being offered an MPAP agreement**
20 **or contract, and I really can't predict how I might**
21 **feel in the future. I can't care for Mr. Ramirez**
22 **one bit, but I don't know what I'll do if that's**
23 **offered to me.**
24 **MR. FANNING:** I have no further questions,
25 Mr. Scrimm.

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1 **HEARING EXAMINER SCRIMM:** Redirect?
2 **MR. DOUBEK:** No. No questions.
3 **HEARING EXAMINER SCRIMM:** I have none.
4 Thank you, Doctor.
5 **THE WITNESS:** Thank you.
6 **HEARING EXAMINER SCRIMM:** Any other
7 witnesses?
8 **MR. DOUBEK:** I have no other witnesses at
9 this time, or I guess any other time.
10 **HEARING EXAMINER SCRIMM:** This is the
11 time.
12 **MR. DOUBEK:** Thanks.
13 **HEARING EXAMINER SCRIMM:** With that, we'll
14 close the record.
15 **MR. FANNING:** Rebuttal?
16 **HEARING EXAMINER SCRIMM:** I'm sorry, sir.
17 I didn't see that expression on your face so I
18 thought we were done.
19 **MR. FANNING:** I didn't know where Mr.
20 Doubek was. Probably ten minutes at the most.
21 **HEARING EXAMINER SCRIMM:** Okay.
22 (Off the record briefly.)
23 (Witness sworn.)
24
25

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1 DIRECT EXAMINATION OF DR. JEAN-PIERRE PUJOL
2 **BY MR. FANNING:**
3 Q. Would you state your name and spell it for
4 the assistance of the court reporter, please?
5 A. **Jean-Pierre Pujol. J-e-a-n-P-i-e-r-r-e**
6 **P-u-j-o-l. J.P. works.**
7 Q. You are a physician?
8 A. **I am.**
9 Q. Licensed in good standing in Montana?
10 A. **Yes.**
11 Q. Formerly affiliated with Urgent Care Plus?
12 A. **Yes.**
13 Q. When was that?
14 A. **I'm not certain when I first started**
15 **working with Mark. It's been a while. Three years**
16 **maybe, four, somewhere around there. Up until this**
17 **summer, July.**
18 Q. July of '14?
19 A. **Yes. Somewhere in that ballpark.**
20 Q. What was the nature of your work at Urgent
21 Care Plus? What do you view an urgent care clinic
22 to offer?
23 A. **I did just what it says, urgent care. I**
24 **took care of acute illnesses, injuries, that was**
25 **what I did. If you had a cold, pneumonia, or chest**

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1 **pain, whatever, that's what I did.**
2 Q. Was it common for you at that facility to
3 have a long-term physician-patient relationship or
4 primary care relationship?
5 A. **When -- no. When I -- especially when I**
6 **started working part time with Mark, definitely not.**
7 **When I was urgent care, when I actually owned what**
8 **was called Helena Urgent Care, there were people who**
9 **tried to use me as a primary care but I avoided it.**
10 **That's not what I liked to do, I want to do urgent**
11 **care. That's what I do.**
12 Q. Is it in any way improper or illegal to
13 have a primary care relationship?
14 A. **No.**
15 Q. It's just not something that you preferred
16 to do?
17 A. **It's personally -- I did not prefer to do**
18 **that, right. That's why I went into urgent care. I**
19 **didn't really want to do primary care. That was a**
20 **personal choice.**
21 Q. Did you have any chronic pain patients at
22 Urgent Care Plus?
23 A. **Me personally?**
24 Q. Yes.
25 A. **No.**

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1 Q. Were you like a contract employee or
2 contractor or an employee?
3 A. **I don't really know the true business. I**
4 **worked there, you know, I was paid. And I don't**
5 **know that I was officially a contract employee. I**
6 **was I think for a while because the way I was paid**
7 **is more of a check without the taxes taken out.**
8 **Then I became an employee where I actually was paid**
9 **that way.**
10 Q. Was Dr. Ibsen then your supervisor or some
11 sort of superior in the hierarchy?
12 A. **I don't know if he looked at it that way**
13 **but I guess technically, yes.**
14 Q. Did you have patients in common with
15 Dr. Ibsen?
16 A. **Well, yes.**
17 Q. How about pain patients?
18 A. **Well, there were pain patients who would**
19 **come to -- sometimes when Dr. Ibsen was not there**
20 **that I was asked to manage. Mark and I had an**
21 **understanding that that was not my job and I would**
22 **generally not take care of those patients. But I**
23 **can't say that they didn't come in. They did come**
24 **in on occasions.**
25 Q. On occasions did someone come in in

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1 distress and say I absolutely need to be seen?
2 A. **That -- I'm not sure how to answer that.**
3 **One person's perception of reasons being seen versus**
4 **maybe what my perception of them may not make sense.**
5 Q. Let's talk about the patients stated.
6 A. **I think they'd come in sometimes and**
7 **state -- are we talking about the pain patients?**
8 Q. Yes.
9 A. **There were times when pain patients would**
10 **come in expecting their medication because they were**
11 **out and for whatever reason they didn't remember**
12 **that they were supposed to come and see Mark or Mark**
13 **was unavailable because, you know, he had his time**
14 **off and they came on my day.**
15 Q. Did the pain patients typically come in on
16 a particular day?
17 A. **Usually if Mark was there because -- and I**
18 **don't know about the other days, I can only speak**
19 **about when I was there. Because it was pretty clear**
20 **to the staff and most of the patients that if I was**
21 **working, then I wasn't going to be managing the pain**
22 **patients. It was not something I felt comfortable**
23 **doing or wanted to do.**
24 Q. If you were going to see a patient and
25 prescribe an opioid, were you able to take any

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1 precautions to assure that it was legitimate?
2 A. **To the best of my knowledge, I tried to,**
3 **yes. I would check the Prescription Drug Registry,**
4 **look at the old chart, try to get a feel for the**
5 **person. And after doing this for 30-some years, you**
6 **kind of get a little bit of a radar sensation or**
7 **Gestalt.**
8 Q. Would you calculate when a prescription
9 should be due?
10 A. **If you mean did I go to the Prescription**
11 **Drug Registry and see how many they had taken or**
12 **been given before.**
13 Q. Exactly.
14 A. **I did that with any patient, almost any**
15 **patient that I was giving narcotics to. Even if it**
16 **was somebody that came in for their broken bone or a**
17 **laceration, that was just kind of my routine.**
18 Q. If it appeared as though they were coming
19 in early and they should have medications remaining,
20 what would you do?
21 A. **I'd usually calculate how many I thought**
22 **they should have, how many they should have left and**
23 **then say, "Hey," point to what I see, "this is how**
24 **many of this drug you should have left and if you**
25 **don't, you know, I'm sorry, but I'm not going to**

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1 **give them to you."**
2 Q. In other words, you'd refuse early
3 refills?
4 A. **90 -- you know, nothing is 100 percent**
5 **absolutely. But the vast majority, 90-plus percent**
6 **of the time I would do that.**
7 Q. Was there a uniform approach in the clinic
8 among the providers with respect to treatment of
9 pain patients?
10 A. **That's a little harder for me to answer,**
11 **because I don't know what everyone did. Because**
12 **when I was there, I was there. And I can't tell you**
13 **100 percent if everybody did. I know it was what I**
14 **expected me, you know, that's what my self**
15 **expectations were, that's what I chose to do. But I**
16 **don't know. I can't speak to everyone else.**
17 Q. At periodic office meetings did you
18 discuss the clinic's philosophy on pain medication?
19 A. **You know, I was actually reading that**
20 **in -- I don't know if it was in the subpoena to me**
21 **or in one of the notes I was reading about that --**
22 **and I honestly -- I didn't attend all of those**
23 **meetings. I've attended, you know, maybe half a**
24 **dozen, I don't know, and I know it came up**
25 **occasionally. It wasn't -- in my opinion I don't**

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1 **know that I would say it was all the time. I**
2 **wouldn't say it was every meeting. But it**
3 **definitely did come up.**
4 Q. Did you have occasion from time to time to
5 visit with Dr. Ibsen about this disciplinary action?
6 **A. Yes.**
7 Q. Once or twice or many times?
8 **A. I don't know. More than a few, let's put**
9 **it that way. I'd say, yeah, a thousand plus, you**
10 **know.**
11 Q. Did Dr. Ibsen indicate to you that he was
12 being mistreated by the Board of Medical Examiners
13 or me as an individual?
14 **A. Boy, I don't know that he viewed you as an**
15 **individual. I do think he thought the Board of**
16 **Medical Examiners was being unfair, yes.**
17 Q. Did he express why that was?
18 **A. I think it was because he -- well, I hate**
19 **to say he when he's sitting right here. It's really**
20 **hard for me not to address Mark. Mark believes, you**
21 **know, he's providing a service that very few in the**
22 **medical community are willing to provide, and so he**
23 **thinks that what the Board was coming after him for**
24 **was unfair, yes.**
25 **I don't know if that answers your**

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1 **questions. But I think that was the crux of the**
2 **situation is that he felt he was practicing**
3 **appropriate medicine doing a service for people who,**
4 **yeah, hard to find doctors. Because there is many**
5 **doctors, if I can add, I know I'm not supposed to**
6 **talk more than yes-or-no questions. But I'm going**
7 **to say that there is many doctors, myself included,**
8 **I don't want to deal with that group of patients,**
9 **and for a variety of reasons.**
10 Q. Did you counsel Dr. Ibsen as a colleague
11 and I suppose a friend about reaction to this
12 disciplinary action?
13 **A. Yes. Yeah.**
14 Q. What did you indicate?
15 **A. Well, I suggested that Mark -- and he**
16 **knows this -- that in order to continue to take care**
17 **of his patients, my personal philosophy, because I**
18 **know Mark cares, Mark more than cares for his**
19 **patients, that if he wanted to continue to do this,**
20 **sometimes you just have to pull back and, you know,**
21 **go through the hoops. That was my take on it.**
22 Q. As his colleague and friend, did you come
23 to know him and his personality?
24 **A. You know, we were friends in the sense**
25 **that we've known each other since Kalispell. He and**

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1 **I both worked in Kalispell. I worked in the urgent**
2 **care there; he worked in the emergency room. So**
3 **we've had congenial discussions about many unusual**
4 **patients over the years. I don't know when that**
5 **was, mid '90s, something like that. And then he**
6 **moved over -- I guess you moved before I did and**
7 **then I did, and so that carried on.**
8 **So do we go and hang together and do**
9 **things like that? No. I'm kind of a, not**
10 **antisocial, I'm just a little asocial, I tend to**
11 **keep to myself.**
12 Q. Do you have some insights about his
13 personality over these many years?
14 **A. I don't know. I guess --**
15 Q. Let me give you an example.
16 **A. That's a hard...**
17 Q. Is Dr. Ibsen one to be willful or
18 headstrong when he believes in something?
19 **A. In this particular case, yes. Other**
20 **cases, I don't know that we've had that kind of --**
21 **I'm trying to be fair here.**
22 Q. And I appreciate that. So when you
23 counseled him about how to get through this, was he
24 willing to accept any counsel?
25 **A. He listened, you know, he did. I do**

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1 **believe -- we had this discussion more than once and**
2 **he heard but he, you know, just like all of us, he's**
3 **going to do what he thinks is right.**
4 Q. You departed Helena Urgent Care Plus last
5 summer?
6 **A. I did.**
7 Q. Did this board action have anything to do
8 with that?
9 **A. It made me nervous, yes, it did. I didn't**
10 **want -- yeah. I was nervous about it. Also, I**
11 **wasn't sure what kind of things would overflow into**
12 **my personal life. At the same time I was also**
13 **working full time elsewhere and, so...**
14 Q. Were you aware that the DEA was paying --
15 **A. Yes.**
16 Q. -- visits?
17 **A. Yes.**
18 Q. And how did that affect you?
19 **A. Again, it made me nervous. I don't like**
20 **being scrutinized. I like my license, I like**
21 **practicing, or I did like practicing. And having**
22 **the DEA in the door, yeah, it put the fear in me.**
23 **Fear of God. Fear of the DEA, not for God.**
24 Q. So were you fearful of your standing in
25 the community, in the licensed medical community?

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1 **A. I was -- yeah, I was a little afraid of**
2 **what, you know, what -- yeah, you know, what the**
3 **rest of the community might think.**
4 Q. Were you afraid that an association with
5 that clinic may result in some sort of spillover to
6 your license?
7 **A. That's a good word. I was looking for a**
8 **word to find and spillover is a good word. Yes, I**
9 **was a little concerned about that.**
10 Q. So did that drive your decision to leave?
11 **A. It definitely influenced it greatly. It**
12 **wasn't the only factor but it was a factor.**
13 Q. Now, just the last series of questions.
14 You didn't have a lot of common patients but did you
15 have occasion to review Dr. Ibsen's charting?
16 **A. I did.**
17 Q. And are you familiar with his attention to
18 detail and his completeness?
19 **A. Yes.**
20 Q. Describe your observations about
21 Dr. Ibsen's charting.
22 **A. Before or after the electronic medical**
23 **records?**
24 Q. Let's say before.
25 **A. Before, I don't think they were -- in some**

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1 **cases there wasn't always as much as I would have**
2 **liked to have seen for me to review to make a**
3 **decision.**
4 Q. Well, is that another way of saying that
5 you did not believe it met the standard of care?
6 **A. Oh, that -- I don't know how to phrase**
7 **this. I want to be very careful on how I phrase**
8 **that, because standard of care, 20 years ago, 30**
9 **years ago, notes that I saw were very common. As we**
10 **become more and more litigious, we're trying to be**
11 **less, you know, more detail is probably a little**
12 **better. And so is there truly -- I don't know the**
13 **standard of care. I think it's not what most people**
14 **like to see, you know. I think they like to see a**
15 **little more.**
16 Q. Was your charting more complete than
17 Dr. Ibsen's?
18 **A. I would like to think so most time. But**
19 **on the -- I know you probably don't want to hear**
20 **this, but I am going to put the but in there because**
21 **I think this is important. I used to work with a**
22 **gentleman, Dr. Book, and his notes were incredible.**
23 **You knew exactly what he was thinking and where he**
24 **was going and, literally, it would sometimes be two**
25 **pages long. Compared to his notes, my notes weren't**

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1 **there. I was lucky to get a page. My page compared**
2 **to Mark's, yeah, I think I have more documentation**
3 **than Mark did.**
4 **So when you ask me standard of care, I**
5 **don't know. Dr. Book's I think would be the, I**
6 **don't want to say the gold standard but what people**
7 **should aspire to and mine may be more adequate.**
8 Q. Should people aspire to the level of
9 documentation that Dr. Ibsen used?
10 **A. Aspire to it, no. I would have to say no.**
11 Q. Would you be here had I not subpoenaed
12 you?
13 **A. Probably not.**
14 **MR. FANNING:** No further questions.
15
16 CROSS-EXAMINATION OF DR. JEAN-PIERRE PUJOL, M.D.
17 **BY MR. DOUBEK:**
18 Q. Let me ask you, do you consider Mark a
19 good doctor?
20 **A. I think he's a good doctor, yeah.**
21 Q. Do you think he is a caring doctor?
22 **A. I think he is a caring doctor.**
23 Q. Hard-working?
24 **A. Hard-working.**
25 Q. And honest?

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1 **A. Yes, honest, yeah.**
2 Q. And you and he have a good relationship?
3 **A. I think so.**
4 Q. He likes you a lot.
5 **A. Well, I think we have a mutual like.**
6 **MR. DOUBEK:** No other questions.
7 **HEARING EXAMINER SCRIMM:** Anyone else?
8 **MR. FANNING:** No, Mr. Scrimm.
9 **HEARING EXAMINER SCRIMM:** Thank you,
10 Doctor. Anything else, gentlemen?
11 **MR. DOUBEK:** No.
12 **MR. FANNING:** I don't believe so,
13 Mr. Scrimm.
14 **HEARING EXAMINER SCRIMM:** I would like to
15 suggest that -- I would like to talk about some
16 scheduling, or not scheduling but a briefing
17 schedule sometime next week.
18 **MR. FANNING:** That's wonderful. I should
19 be available. I just wondered if we needed to
20 consider recalling Dr. Kneeland before we
21 commit to a briefing schedule.
22 **HEARING EXAMINER SCRIMM:** No.
23 **MR. DOUBEK:** Okay. Let's try to shoot for
24 Monday or whatever.
25 **HEARING EXAMINER SCRIMM:** Monday is

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1 terrible next week. But I'll have Sandy Duncan
2 get ahold of you and we'll work something out
3 to figure out briefing schedule and details of
4 that briefing.
5 Are you each satisfied that you have moved
6 the exhibits that you wanted to move? And I'm
7 sorry, I have a list from our last in October
8 and unfortunately I have misplaced it -- it's
9 probably buried on my desk upstairs -- of the
10 exhibits that appear to have been discussed but
11 not moved.
12 **MR. FANNING:** And I'm grateful for the
13 opportunity. I moved Exhibit 21 and I'd like
14 to renew that. I moved Exhibit 24 and I'd like
15 to renew that. I'm going to withdraw 25. And
16 what else was left? And renew 26.
17 **MR. DOUBEK:** We would object for the same
18 reasons.
19 **HEARING EXAMINER SCRIMM:** I thought we
20 dealt with 26. 21 and 24 are admitted. 24 is
21 not admitted. Let me correct that. I was
22 looking at 25 when I said that. What was the
23 other one, Mr. Fanning?
24 **MR. FANNING:** I withdrew 25 and renewed
25 26.

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1 **MR. DOUBEK:** Which one was 26?
2 **HEARING EXAMINER SCRIMM:** I believe 26 was
3 admitted.
4 **MR. DOUBEK:** Which one was that, Mike?
5 **HEARING EXAMINER SCRIMM:** It's the notice
6 posted in the doctor's office about --
7 **MR. DOUBEK:** I think it was admitted.
8 **MR. FANNING:** Thank you, gentleman.
9 **MR. DOUBEK:** And I wouldn't object to it
10 anyhow.
11 **HEARING EXAMINER SCRIMM:** Well, I will
12 have Sandy Duncan get ahold of you about a
13 briefing schedule conference.
14 **MR. DOUBEK:** Thank you very much.
15 **HEARING EXAMINER SCRIMM:** Thank you all.
16 We're done. And safe travels.
17 (The hearing was concluded at
18 4:55 p.m.)
19 * * * * * * * *
20
21
22
23
24
25

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1 C E R T I F I C A T E
2
3 I, LISA R. LESOFSKI, Registered
4 Professional Reporter do hereby certify:
5 That the proceedings were taken before me
6 at the time and place herein named, that the
7 proceedings were reported by me and that the
8 foregoing pages contain a true record of the
9 proceedings to the best of my ability.
10 Dated this 22nd day of December, 2014.
11
12
13 ______________________________
Lisa R. Lesofski
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