BEFORE THE MINNESOTA
BOARD OF MEDICAL PRACTICE

In the Matter of the
Medical License of
Brian R. Molstad, M.D.
Date of Birth: 2/18/45
License Number: 20,366

WHEREAS, Brian Molstad, M.D. (hereinafter "Respondent") has been licensed to practice medicine and surgery in the State of Minnesota during all times material herein and is subject to the jurisdiction of the Minnesota Board of Medical Practice (hereinafter "Board");

WHEREAS, the Board is authorized pursuant to Minn. Stat. §§ 147.01 through 147.33 (1992) to license, regulate, and discipline persons who apply for, petition, or hold licenses to practice medicine and surgery in the State of Minnesota and is further authorized pursuant to Minn. Stat. § 214.10 (1992) to review complaints against physicians, to refer such complaints to the Attorney General’s Office, and to initiate appropriate disciplinary action;

WHEREAS, based upon the hereto attached affidavits of Paula J. Morphew, Richard Irons, M.D. and Ruth Martinez, the Board believes that Respondent has violated statutes or rules which the Board is empowered to enforce and that Respondent’s continued practice would create an imminent risk of harm to others, and that, consequently, a TEMPORARY SUSPENSION of Respondent’s license pursuant to Minnesota Statutes, section 147.091, subdivision 4, is warranted;

WHEREAS, on December 4, 1992, Respondent appeared before a Complaint Review Committee to discuss the following:
1. On March 25, 1987,Respondent’s Illinois medical license was restricted based on Respondent’s high incidence of misdiagnosis while he was an anatomical pathologist at the Chicago Metpath Laboratories, Inc. ("Metpath") during 1984 and 1985. While employed at Metpath, Respondent misdiagnosed at least 106 of the 5000 tissue specimens that he microscopically examined. Respondent’s Illinois Order required him to take remedial education in surgical pathology and to undergo a psychological evaluation to assess the impact of stress on his professional judgment. The Illinois Order remained in effect until February 25, 1988;

2. On July 2, 1991, Respondent applied for hospital privileges at District One Hospital ("District One") in Faribault, Minnesota. By letter dated October 17, 1991, District One denied privileges based on Respondent’s:
   a. Unsatisfactory peer references;
   b. Failure to demonstrate current knowledge, judgment and competency;
   c. Inability to work well with others;
   d. Failure to explain gaps in his employment history; and
   e. Holding a large number of jobs in a relatively short period of time;

   a. During the pre-1992 employment period, Respondent:
      1). Performed an autopsy, but failed to clean up afterwards or to close the body, leaving it for cleaning personnel to discover later in the day; and
      2). Performed an autopsy on patient #21, 50-year old man who crashed his light plane. When the patient’s physician came down during the autopsy, Respondent stated that his patient "had looked like a fly splattered on a windshield."
Respondent also threw a helmet from the accident to an orderly who was not wearing gloves. The helmet had blood and brain tissue on it;

b. During June 1992, Respondent misdiagnosed at least five cases while working at NCRH, including:

1). With respect to patient #1, a 63-year old male, Respondent diagnosed adenocarcinoma following a May 28, 1992, cystoscopy and prostate biopsy. The diagnosis, dated June 2, 1992, resulted in patient #1 and his wife being informed that patient #1 had prostate malignancy. On June 4, 1992, a second opinion was obtained from a Mayo Clinic physician, who diagnosed granulomatous prostatitis. A re-biopsy on June 5, 1992, confirmed the June 4, 1992 diagnosis by the Mayo Clinic physician;

2). With respect to patient #2, a 75-year old male, Respondent’s June 15, 1992, diagnosis as benign following a June 11, 1992, cystoscopy and prostate biopsy, was communicated to patient #2. A second opinion was obtained from the University of Minnesota on July 20, 1992, which indicated adenocarcinoma, Gleason pattern 3-4. Subsequently, patient #2 underwent a Bilateral Intracapsular Orchiectomy;

3). With respect to patient #3, a 58-year old male, Respondent’s June 26, 1992, diagnosis as benign following a June 24, 1992, cystoscopy and prostate biopsy was communicated to patient #3 on June 29, 1992. On July 20, 1992, a University of Minnesota pathologist rendered a diagnosis of adenocarcinoma, Gleason pattern 3-3. Subsequently, patient #3 underwent a radical prostatoseminovesiculectomy, resulting in a diagnosis of grade 3 adenocarcinoma;

4). With respect to patient #4, a 59-year old female, Respondent diagnosed no malignancy following a breast fine needle aspiration on June 1, 1992. On June 3, 1992, patient #4 underwent a right breast biopsy which resulted in a diagnosis of intraductal carcinoma; and
5). With respect to patient #5, an 18-year old female, Respondent's diagnosis indicated "premature membrane rupture-no inflammation" following a full-term, vacuum assisted delivery. Respondent's microscopic description of the placenta indicated "placenta show no chorioamnionitis. There is no increase in the amount of fibrosis nor calcification present." A re-review of the case was requested by the obstetrician because of the high clinical suspicion of chorioamnionitis. Upon re-review, a diagnosis of "prolonged rupture of membranes, chorioamnionitis, post-partum anemia, viable infant" was made.

c. Following Respondent's misdiagnosis of patient #5, a review was conducted of all 11 placentas examined by Respondent while he was employed at NCRH in June of 1992. The review indicated that Respondent had never examined the membranes of any of the 11 placentas.

d. During the period Respondent was employed at NCRH, Respondent engaged in the following practices with respect to his dictation:

1). Respondent used fictitious patient names, such as Winston Churchill, Holly-Holly-Holly and others, in lieu of real patient names;

2). Respondent transposed patient names and/or specimen numbers;

3). Respondent erroneously identified surgical procedures, such as calling a penectomy "a castration";

4). Respondent made concurrent diagnoses of thrombocytopenia and thrombocytosis;

5). Respondent dictated on the second of two consecutive prostate specimens by directing the transcriber to "do the same for" the second specimen as he had dictated on the first;

6). Respondent made inappropriate comments about genital specimens;
7). Respondent repeatedly identified female patients as "bitches" or "whores" and referred to male patients as "bastards"; and

8). A transcription of a portion of one tape dictated by Respondent during the period of employment at NCRH revealed eight (8) errors in patient names dictated by Respondent. This included patient #2483 which Respondent identified as "Dana Molstad." Respondent concluded this dictation with the statement "That's all there is 'cuz there ain't no more. Thank you."

e. Respondent repeatedly "disappeared" from work, sometimes being absent from the hospital for two to three hours. On more than one occasion, Respondent failed to communicate frozen section diagnoses to the hospital surgeons prior to these unexplained mid-day absences from the hospital.

4. Between January 1986 and June 1987, Respondent was employed at Holy Family Memorial Hospital in Manitowoc, Wisconsin. During this period of employment, Respondent periodically disappeared from the hospital for hours.

5. On December 27, 1990, Respondent applied for hospital privileges at Naeve Hospital in Albert Lea, Minnesota. With respect to patient #6, in October 1992, Respondent examined tissue from a prostate biopsy and misdiagnosed it as benign. Subsequently, it was discovered that it was adenocarcinoma;

WHEREAS, on December 4, 1992, the Board requested Respondent to submit to a physical and mental evaluation at Abbott Northwestern Hospital, Minneapolis, Minnesota;

WHEREAS, The following information was brought to the attention of the Complaint Review Committee after Respondent's appearance before the CRC:

1. In October 1992, Respondent entered into a contractual agreement with the Rush City Clinic ("Clinic") and the Rush City Hospital ("Hospital"), as a General Practitioner, to provide medical care at the clinic and be on-call in the Emergency Room at the Hospital;
2. On January 6, 1993, Respondent received a 90-day termination notice from the Clinic and Hospital Administrator;

3. On or about February 4, 1993, Respondent was notified by the Hospital/Clinic that he would be paid for the remainder of the 90-day period, however, he should not continue to come to the Clinic or Hospital to provide patient care during the remainder of that time period;

4. From October, 1992 through January 31, 1993, Respondent provided the following care to patients and/or behaved in the following manner while at the Clinic or Hospital:
   a. In the fall of 1992, Respondent treated patient #7 who had a foot fracture. This patient complained to staff that Respondent's manner was "clipped" and that she "would like a physician to spend more time explaining things" to her;
   b. With respect to the care Respondent provided to patient #8, a 62 year old female, at the clinic, the following was documented in the patient's medical record:

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>10-26-92</td>
<td>S: Nausea. Patient presents in a obvious discomfort with nausea for three days but no vomiting. She has eaten almost nothing she has had moderate diffuse abdominal pain it is not relieved by any activity or by eating. O: Diffuse abdominal tenderness. No fever. No organomegally. Multiple surgery scars. A: Probably gastroenteritis. P: Prochoprizine 25 q 4 h plus serum amalyse. Return pm.</td>
</tr>
<tr>
<td>10-29-92</td>
<td>S: Patient has had dark colored urine for two days and significant amount of itching. O: Urinalysis shows 1+ bilirubin. Hemoglobin equals 14.7. A slight yellow color is noted to the sclera but yellow color to the skin. A: Mild hemolysis possibly to drug reaction or a virus.</td>
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P: Patient reassured the situation explained. Habitrol prescribed to eliminate smoking.

11-1-92 [Emergency Room: Patient #8 was seen by a physician other than Respondent]

S: Itching all over which has gotten worse since Tuesday when seen at R.C. Clinic. Nausea but no emesis. Has also mid-abdominal pain with this. Weakness. Skin color slightly yellow.

O: Deferred.

P: Labs: CBC, Urinalysis, Total Bilirubin, Electrolytes and Blood Sugar. Take upstairs to a room. Lab Results: Urinalysis [not available], Total Bilirubin [5.3], Electrolytes [high CO2] and Blood Sugar [174].

11-5-92 Discharged by a physician other than Respondent and transferred to St. Joseph's Hospital with a diagnosis of acute liver involvement due to obstructive jaundice, Diabetes mellitus, type II and Electrolyte depletion syndrome.

Clinic staff told and an Investigator of the Attorney General's Office that patient #8 later informed her that she, the patient, has Pancreatic cancer;

c. On November 12, 1992, patient #9 was examined by Respondent for symptoms of a "bleeding ulcer, ie., abdominal pain, black tarry stools." Respondent ordered an upper GI and x-ray, but failed to order any lab tests. The patient sought further treatment with another physician;

d. On November 12, 1992, Respondent examined patient #10, a 29 year old female diagnosed with an active miscarriage. During a pelvic examination, staff observed Respondent's examination being performed in such a manner as to cause patient #10 to scream. Respondent documented in patient #10's medical record, "Patient very uncomfortable during remainder of pelvic examination." A physician other than Respondent performed a D & C that evening;

e. On November 18, 1992, Respondent examined patient #11, a 79 year old female, who had fallen backwards and hit her head, was not eating regular
meals and was pale. Respondent documented in the patient's medical record that there were no bruises or cuts to the head; lungs were clear and there were no heart murmurs. Tests included: skull and chest x-ray, CBC, MCV and Hemoglobin. Patient #11 had a MCV of 74 and a hemoglobin of 6.3. Respondent diagnosed the patient with a probable iron deficiency anemia and he discharged her to home.

On November 20, 1992, Respondent performed a sigmoidoscopy on patient #11. Respondent, documented in the patient's medical record that the patient had a, "normal rectosigmoid colon". Respondent ordered blood drawn for a reticulocytes count but failed to order a CBC. Respondent discharged her to home.

On November 23, 1992, patient #11 was admitted to the Hospital and was initially seen by Respondent. While in the Hospital, the patient received three pints of blood. On November 24, 1992, Respondent dictated a discharge summary which included a plan for the patient to schedule her next visit in the outpatient clinic in one to two weeks. However, on November 25, 1992, patient #11's care was assumed by another physician and the patient remained in the hospital. The second physician documented that the patient had developed an "ilius type process with emesis, bile colored," and she exhibited a "change of cognitive status" upon standing. On November 29, 1992 the second physician transferred the patient to United Hospital, St. Paul, because of the ongoing nature of her anemia and GI bleed;

f. On December 23, 1992, Respondent saw pediatric patient #12 who had a foreign body in her left knee. Staff observed that Respondent failed to use sterile gloves and placed "sterile" forceps in the child's knee after he first placed the forceps on the exam table;

g. Staff reported a concern with respect to the care Respondent provided, on December 31, 1992, to patient #13 who had a lacerated hand. Staff
observed Respondent suture a portion of a 2-inch long laceration on the patient's thumb and give him instructions on care of the wound. Respondent then instructed staff to apply a dressing and left the room. Staff went to the doctor's lounge and informed Respondent that there was more of the laceration to be sutured. Twenty minutes later, Respondent returned to the patient and finished the suturing;

h. On January 1, 1993, two Emergency Medical Technicians ("EMTs") had been dispatched to the emergency room "to assist with CPR" as patient #14 was being brought to the Rush City Hospital Emergency Room by the Pine City Ambulance.

At 3:20 A.M., the patient arrived with an Esophageal Oral Airway in place. On more than one occasion, the Pine City EMTs told Respondent that they were unsure of the adequacy of the airway and asked Respondent "to evaluate the airway and do intubation." Respondent ignored their request and failed to evaluate or intubate. While a Pine City EMT performed chest compressions, Respondent instructed him to "slow down the compressions.

Subsequently, Respondent took over doing the chest compressions at a rate of about 50/minute and continued doing them for sometime, but failed to order any medications or perform defibrillation.

At 3:30 A.M., ten minutes after arrival in the Emergency Room, the patient's peripheral IV line was successfully started.

At 3:33 A.M., Respondent ordered that the patient receive Epinephrine.

At 3:39 A.M., one ampule of Bretylium was administered to the patient.

At 3:45 A.M., the patient was pronounced dead, after multiple defibrillations.
During the emergency, Respondent failed to utilize the assistance of another physician who was available in the Emergency Room;

i. On January 2, 1993, Respondent was on-call in the Emergency Room when patient #15 came into ER unresponsive and with agonal respirations. Respondent failed to respond when the staff tried to reach him by pager. Another physician was called, the patient was stabilized and transferred to St. Paul Ramsey Medical Center;

j. On January 7, 1993, patient #16 sustained burns in a fire. When the patient's parents brought him to the Emergency Room, where Respondent was on-call, Respondent stood with his back to the wall, providing no care to the patient. When the parents told Respondent that they had given the patient two Tylenol #3, Respondent replied, "Well, I'm older than he is and I've taken four at a time and it didn't hurt me; maybe we can give him one more." Respondent continued to stand with his back to the wall while the patient tried to get relief by splashing himself with cold water. Nothing was done for the patient until the nurse appeared and took charge.

k. On January 22, 1993, patient #17 wrote a letter of complaint to the Clinic. According to the complaint, the patient had seen Respondent on two occasions; Respondent's attitude was "demeaning, as though [she] was stupid" and, although Respondent treated her symptoms, he failed to look for the underlying cause of her headaches;

l. On January 27, 1993, Respondent saw patient #18, a 60 year old female, who was diagnosed with a vaginal yeast infection. During the pelvic exam, staff observed Respondent hurt the patient so badly that the patient screamed. Respondent inserted a speculum without telling the patient. Respondent later left the speculum hanging in the patient's vagina while he turned his stool away from the
examination table. He then performed a digital examination instead of using a Q-tip for a wet smear. Meanwhile, the patient was "sobbing". Respondent then walked out without saying anything to the patient. After consoling the patient, staff followed Respondent into his office and said: "Why did you do that? You hurt her." Respondent just said, in a high voice, "sorry, sorry."

m. On January 29, 1993, Respondent examined patient #19, an 86 year old male, who complained of abdominal pain and "not feeling good". Respondent documented in the patient's medical record that his lungs were clear, and his abdomen exhibited no tenderness or rebound. Respondent noted the patient's inguinal hernia and enlarged prostate, but failed to specify a diagnosis. Respondent ordered a urinalysis, chemistry profile, sigmoidoscopy, barium enema, upper GI and one other test, documentation which is illegible, to be performed on patient #19.

On February 1, 1993, patient #19 was examined by his primary physician and admitted to the Hospital. The admission diagnosis was gastroenteritis, questionable obstruction. The discharge diagnosis was high grade small bowel obstruction and possible occult tumor. On February 5, 1993, patient #20 was transferred to Cambridge Hospital for possible surgery;

n. Staff documented concern about the care Respondent provided to patient #20 who had a blood pressure of 240/110. Patient #20 was started on antihypertensive medication, but was instructed by Respondent to return in one month when she needed to return in one week;

o. On one occasion, staff observed Respondent care for a female patient who had a cyst in the genital area. Respondent injected a local anesthetic and started lancing the cyst immediately. The patient said, "I feel that," but
Respondent continued the procedure rather than wait for the local anesthetic to take effect;

p. On one or more occasions, staff observed Respondent state, "women like pain";

q. On one or more occasions, staff observed Respondent state, "women like to be treated rough";

r. On one or more occasions, outside of the examination rooms, staff observed Respondent make unkind editorial comments about patients;

s. Staff observed Respondent repeatedly refer to his patients as victims, asking, "Where is the next victim/Are there any more victims?";

t. On one or more occasions, Respondent came to work late and took long lunches, requiring patients to wait for him;

u. On one or more occasions, Respondent "disappeared" from the Emergency Room when on-call, sometimes failing to provide coverage;

v. On one or more occasions, Respondent failed to respond to his pager when staff paged him while he was on-call;

w. On one or more occasions, after Respondent had worked with staff all morning, he asked, "Who is my nurse today?";

x. On one or more occasions, after Respondent worked a half-day in the Clinic, he asked, "which are my examining rooms?";

y. On one occasion, a Staff member who had not met Respondent, observed Respondent outside of the clinic walking back and forth in an agitated manner and behaving in such a manner that assumed he was a psychiatric patient whose behavior would necessitate admission to the Hospital that night;

z. On or about November 13, 1992, Respondent was at the Clinic and had one more patient to see before leaving. Respondent left the Clinic to see a
patient in the Emergency Room and when he was done in the Emergency Room, he went to lunch instead of returning to care for the patient waiting at the Clinic. The Clinic patient had to go home without being seen by Respondent;

6. On one or more occasions, Respondent wrote a prescription for Tylenol #3 for himself;

7. On February 1, 1993, Respondent was admitted to Abbott Northwestern Hospital for a physical and mental evaluation by Richard Irons, M.D. Upon admission to the Professional Assessment Program ("Program"), Respondent submitted to a urine drug screen. The screen was considered to be invalid due to the specimen temperature being below reference range at the time of collection and was sent in with a reported temperature of 88 degrees. This finding leaves open the possibility that the specimen might have been tampered with by either dilution or by substitution. While Respondent was a patient in the Program, Respondent had unexplained absences from the unit. During the Program, there were discrepancies in some of the information that Respondent provided to staff.

Prior to Respondent's discharge from the program, hospital staff informed Respondent of the invalid urine screen and asked Respondent to produce another specimen. Respondent stated that he could do this and, according to protocol, a male staff was obtained to observe the collection. In the bathroom, Respondent threw the cup in the wastebasket and stated that he could not urinate. Staff encouraged Respondent to let them know when he would be able to urinate. Within thirty minutes, when the nursing staff looked for Respondent, staff discovered that Respondent's clothes were gone and he had left the hospital without completing the discharge process or providing the urine specimen;

8. The Board's consultant determined that because of Respondent's level of defensiveness, the assessment team was unable to definitely exclude the possibility of a
significant DSM AXIS I mental illness due to his pathological level of denial and lack of cooperation with the assessment process;

9. The Board's Consultant determined that Respondent's characterologic structure represents a significant handicap in his personal and professional life. It leaves Respondent vulnerable to minor and possibly major lapses in judgment. In Respondent's effort to defend himself, he has the propensity to harm others if he is functioning in a fiduciary capacity;

10. Based on the information available from the assessment, the Board's consultant, has diagnosed Respondent as and AXIS II: Narcissistic Personality Disorder. Board's consultant was unable to rule out an occult chemical dependency with an extremely high level of denial, based upon the inconsistent history, unexplained absences from the unit, as well as allegations of absences from work, allegations of unusual behavior, and Respondent's refusal to provide us with a urine drug screen prior to discharge (which, in the opinion of the Board's consultant, is equivalent to a positive drug screen);

11. On February 5, 1993, Respondent contacted Ramsey County Medical Center ("RCMC") to express an interest in having them train him to perform abortions;

12. From February 5 to February 24, 1993, Respondent repeatedly telephoned the RCMC, attempting to speak to various physicians. Respondent refused to leave a telephone number, as the physicians were unavailable to take the call. Clinic staff felt harassed by Respondent's continuous telephone calls; and

13. Respondent has contacted the Duluth Women's Health Center expressing an interest in having the Center train him in performing abortions if they agreed to hire him as a staff physician.

WHEREAS, on March 13, 1993, the above-entitled matter came on for consideration by the Board;
WHEREAS, Linda F. Close, Assistant Attorney General, was present as counsel to the Complaint Review Committee. Respondent was present and represented by counsel. Robert T. Holley, Special Assistant Attorney General, was present as counsel to the Board;

WHEREAS, based upon its consideration of this matter, the Board makes the following ORDER:

1. IT IS HEREBY ORDERED that the Respondent's license to practice medicine and surgery in the State of Minnesota is temporarily SUSPENDED pursuant to Minn. Stat. § 147.091, subd. 4 (1992). During the period of suspension, Respondent shall not in any manner practice medicine or surgery in this state. The suspension shall take effect immediately and shall remain in effect until the Board issues a final decision in the matter after a hearing;

2. IT IS FURTHER ORDERED that the terms of this suspension are adopted and implemented by the Board this 13th day of March, 1993.

MINNESOTA BOARD OF
MEDICAL PRACTICE

[Signature]
AFFIDAVIT OF PERSONAL SERVICE

RE: IN THE MATTER OF THE MEDICAL LICENSE OF
BRIAN R. MOLSTAD, M.D.
License No. 20,366

STATE OF MINNESOTA )
COUNTY OF RAMSEY ) ss.

[Signature]
being first duly sworn, deposes and says:

That on the 15th day of March, 1993, she served the attached ORDER FOR
TEMPORARY SUSPENSION by handing to and leaving with Linda F. Close, Assistant
Attorney General, at the Office of the Attorney General, Government Services Division,
525 Park Street, Suite 500, St. Paul, MN 55103, a true and correct copy thereof.

Subscribed and sworn to before me this 15th day of March, 1993.

[Signature]
AFFIDAVIT OF SERVICE BY MAIL

RE: IN THE MATTER OF THE MEDICAL LICENSE OF
BRIAN R. MOLSTAD, M.D.
License No. 20,366

STATE OF MINNESOTA } ss.
COUNTY OF RAMSEY } ss.

being first duly sworn, deposes and says:

That at the City of St. Paul, County of Ramsey and State of Minnesota, on the 15th day of March, 1993, she served the attached ORDER FOR TEMPORARY SUSPENSION by depositing in the United States mail at said city and state, a true and correct copy thereof, properly enveloped, with first class postage prepaid, and addressed to:

David P. Bunde, Esq.
Fredrikson & Byron, P.A.
International Center
900 - 2nd Avenue South
Minneapolis, MN 55402

Subscribed and sworn to before me this 15th day of March, 1993.

Kathleen K. Sundstrom
Notary Public