BEFORE THE MINNESOTA

BOARD OF MEDICAL PRACTICE

COMPLAINT REVIEW COMMITTEE

In the Matter of
the Medical License of
John Simon, M.D.
Birth Date: 1-21-51
License Number: 23,781

AGREEMENT FOR CORRECTIVE ACTION

This agreement is entered into by and between John Simon, M.D. ("Respondent") and the Complaint Review Committee of the Minnesota Board of Medical Practice ("Committee") pursuant to the authority of Minn. Stat. § 214.103, subd. 6(a) (Supp. 1993). Respondent and the Committee hereby agree as follows:

FACTS

1. The Committee has received information alleging the following:

a. Respondent provided care to patient #1 (DOB: 12-28-38), a woman who had diagnoses of major depression, recurrent, and obsessive compulsive illness, as follows:

1) From May 9, 1990 through January 28, 1992, Respondent inappropriately prescribed Chlordiazepoxide 25 mg., Klonopin, Diazepam and Lorazepam 2 mg. to patient #1;

2) Respondent prescribed Klonopin at 16 mg. per day. The Board's consultant stated that he has not encountered such high doses even in seriously ill psychiatric patients;

3) Respondent prescribed Lorazepam at 16 mg. per day. The 1990 PDR recommends a maximum daily dose of 10 mg. per day. Respondent failed to document any justification for exceeding the maximum recommended dose;

4) Respondent failed to require the patient to engage in cognitive/behavioral psychotherapy as a condition of her treatment with medication;

5) Respondent failed to respond adequately when he observed that patient #1 was developing serious and dangerous central nervous system side effects while on high doses of Klonopin and Ativan. Specific examples of side effects include, but are not limited to, the following:

Date	Documentation
1-6-91	Discharge summary from Riverside Medical Center: " . . . she had been highly anxious . . . unsure whether she had bathed, taken her medicine or other tasks of living."
5-6-91	"She is having urinary hesitancy and is waking up at night and not returning to sleep."
9-10-91	" . . . difficulty in distinguishing her pills. . . ."
12-2-91	"Continue Ativan at the dosage that does not leave her oversedated, 2 mg. twice a day and two pills at bedtime."
3-4-92	Patient was admitted to Riverside Medical Center where she was treated for dehydration, inability to function and confusion as well as other medical conditions.

6) On July 23, 1991, patient #1 reported feeling "worse than [she'd] ever been before." By this time, Respondent had been seeing her for two and a half years; patient #1's symptoms had been very poorly controlled for the most recent 22 months. Respondent's treatment was to re-institute Librium and Prozac, two medications he gave patient #1 previously without success. Hospitalization and/or review of diagnosis would have been the accepted treatment options for this patient with a poor treatment outcome and significant side effects from current treatment;

7) Despite the patient's deterioration and continuous high-dose treatment, Respondent failed to obtain a second psychiatric opinion or refer the patient for chemical dependency evaluation.

b. Respondent provided care to patient #2 (DOB: 10-16-41), a man with a history of chemical dependency and diagnoses including anxiety and tension headaches, as follows:

BEFORE THE MINNESOTA

BOARD OF MEDICAL PRACTICE

In the Matter of
the Medical License
James C. Harvanko, M.D.
Date of Birth: 3/30/1963
License Number: 37,637

COMMITTEE ORDER AMENDING THE BOARD'S AMENDED STIPULATION AND ORDER

FACTS

1. During all times herein, James C. Harvanko, M.D. ("Respondent"), has been and now is subject to the jurisdiction of the Minnesota Board of Medical Practice ("Board") from which he holds a license to practice medicine and surgery in the State of Minnesota.

2. By Amended Stipulation and Order dated July 10, 2004 ("Amended 2004 Order"), the Board conditioned and restricted Respondent's license to practice medicine and surgery in the State of Minnesota based upon Respondent's inability to practice with reasonable skill and safety to patients by reason of chemical dependency and inappropriate sexual behavior. Paragraph 5.d of the Amended 2004 Order required that Respondent submit to at least 12 unannounced biological fluid screens per quarter. Paragraph 5.e required that Respondent attend self-help meetings, such as AA/NA, at least two times per week. Paragraph 5.f required that Respondent attend Sex Addicts Anonymous at least four times per month. Paragraph 5.l limited Respondent's practice to no more than forty (40) hours per week.

3. On September 19, 2005, the Board received Respondent's written petition in which he requested a reduction in the minimum number of required biological fluid screens, a reduction in the number of self-help meetings and an increase in his work hours pursuant to the Amended 2004 Order.

1) From January 29, 1992 to January 21, 1993, Respondent inappropriately prescribed Diazepam 10 mg. continuously to patient #3;

2) Respondent ignored multiple signs of current chemical dependency by patient #3 and continued to prescribe benzodiazepines to the patient. Specific documentation from the patient's medical records includes, but is not limited to, the following:

Date	Documentation
12-13-91	"Has been drinking ethanol."
1-14-92	"Telephone call to office. Person calling: Hennepin County Jail. Valium D/C, secondary over use."
1-30-92	"He states that he attended a wedding on November 24 and had alcohol at that time."
3-19-92	"Robbed and needs Valium refilled. . . ."
4-23-92	"He notes memory problems. . . ."

3) On February 5, 1992, Respondent documented in patient #3's medical record that the patient "Helped ex-wife move furniture last week. Has had back pain since in thoracic spine in area of previously fractured vertebrae . . . Given Darvon N-100 #15 (fifteen) 3-day supply for back pain." Respondent failed to refer the patient to his primary care physician or to an orthopedist for evaluation and treatment of back pain;

4) Respondent failed to refer patient #3 for chemical dependency evaluation or co-management.

d. Respondent provided care to patient #4 (DOB: 5-15-54), a woman with a history of alcohol abuse with blackouts and other drug use but no previous chemical dependency treatment. Her diagnoses included major depression, recurrent, and post traumatic stress disorder secondary to abuse:

1) From May 10, 1990 to December 18, 1992, Respondent inappropriately prescribed benzodiazepines continuously to patient #4;

2) Respondent prescribed inappropriately high doses of benzodiazepines with frequent and erratic changes in dosage for patient #4. The 1990 PDR

recommends a maximum dosage of 10 mg. Ativan per day. Respondent prescribed Ativan in doses as follows:

a) In July 1990, he prescribed Ativan 6 mg. hs.;

b) On September 18, 1990, Respondent increased the dose to 10 mg. per day;

c) On October 3, 1990, Respondent increased the dose to 12 mg. per day;

d) On February 26, 1992, Respondent's Riverside Medical Center discharge summary increased the patient's Ativan to 14 mg. per day, along with Robaxin 750 mg. tid., Ludiomil 300 mg. hs., Lithium carbonate 300 mg. tid., Synthroid, Reglan, Motrin and Micronase.

3) Respondent's prescribing to patient #4 resulted in dangerous central nervous system side effects. Specific examples from the patient's medical records include but are not limited to the following:

Date	Documentation
5-27-92	"She is having more concentration problems, and she is also sleepwalking more at night . . . we discussed this as possible side effects of Ativan, Ludiomil, and possibly Flexeril."
6-30-92	"Overall she is doing poorly with continuing memory problems and some more tremors."
7-24-92	"Overall [patient #4] has been doing a bit worse. Concentration is still low and energy quite low during day . . . Lithium will be further reduced to 2 at bedtime only, Ludiomil further decreased to 4 at bedtime only. Ativan will be tapered further to 3 of the 2 mg. pills at bedtime."

4) On August 26, 1992, Respondent reduced the Ativan to 6 mg. at bedtime only. On December 12, 1992, Respondent increased patient #4's Ativan dose to 12 mg. per day;

5) On June 19, 1992, Respondent documented in patient #4's medical records that, "[Patient #4] notes memory is poor and we discussed this again as an Ativan side effect but at this point she would much rather have the anxiety relief and look at tapering the Ativan slowly as her mood lifts." Respondent inappropriately permitted patient #4 to make the

decision to continue high risk benzodiazepine treatment in the face of significant CNS side effects and strong evidence of untreated chemical dependency. Respondent failed to refer the patient for chemical dependency consultation or co-management, or for a second psychiatric opinion.

e. Respondent provided care to patient #5 (DOB: 11-4-55), a woman with a history of substance abuse and diagnoses of recurrent major depression, borderline personality disorder, bulimia, hypothyroidism, and post traumatic stress disorder secondary to sexual abuse, as follows:

1) From May 8, 1990 to December 10, 1992, Respondent inappropriately prescribed benzodiazepines continuously to patient #5;

2) Respondent prescribed benzodiazepines for patient #5 for questionable or inappropriate indications as follows:

a) A hospital discharge summary dated February 2, 1987, notes patient #5 was intoxicated on a pass from the hospital and at the time of hospital discharge. She also had a history of medication overuse. Nevertheless, Respondent discharged her on Desipramine and Xanax;

b) On September 22, 1989, Respondent prescribed Ativan 0.5 mg. tid "due to great anxiety she feels around people." Psychotherapy is usually the preferred treatment for such anxiety;

c) On October 23, 1989, patient #5 reported her use of alcohol while on prescribed Ativan. Respondent asked her to use no alcohol, noting she may use one extra Ativan prior to intimacy;

d) A note dated February 9, 1990, reports that patient #5 was still using alcohol. Respondent continued Ativan.

3) Respondent's inappropriate prescribing of Ativan and Xanax to patient #5 resulted in dangerous central nervous system side effects. Specific documentation from the patient's medical record includes, but is not limited to, the following:

Date	Documentation
7-10-90	"She has side effects of spaciness, memory disturbance, and more mood lability. These spaciness and memory disturbance are probably due to the Ativan and we discussed this."
8-13-90	"Memory problems are still a factor. . . ."
5-21-91	"She had a seizure last night and went to the Emergency Room. She had skipped two doses of Xanax. . . ."
2-13-93	"The Xanax at 2 mg. four times a day is not that helpful for the anxiety, and may be adding some to her cognitive mild difficulties."

4) Respondent failed to regulate patient #5's use of benzodiazepine medications when she was noncompliant with his prescribed doses and schedule, as follows:

Date	Documentation
8-28-90	"She stopped the Klonopin two days ago when she realized it affected her mood, but did not restart Ativan."
9-16-91	"Patient has "self tapered" Xanax to 0.5 mg. one at bedtime."
9-1-92	"She has reduced Xanax on her own. . . ."

5) Respondent failed to refer patient #5 for chemical dependency evaluation or co-management, or for a second psychiatric opinion.

f. Respondent provided care to patient #7 (DOB: 11-21-55), a woman who had diagnoses of continuous polysubstance dependence, recurrent major depression, seizure disorder and migraine headaches, and whom Respondent knew through his employment prior to the time she became his patient, as follows:

1) Respondent prescribed controlled substances for patient #7 even though the patient exhibited numerous signs of chemical dependency and drug-seeking. Specific examples from the patient's medical records include, but are not limited to, the following:

Date	Documentation
7-30-84	"She states that she took 600 mg. of Elavil a day for the past two days to try to sleep through the weekend. She states that she has also taken larger amounts than prescribed of her Valium."

8-17-84	"The decrease in Valium from 15 to 10 mg. a day did not go well. Initially on two 5 mg. tablets she felt distressed and irritable. When I recommended a change to four of the 2.5 mg. pill fragments, she states she was able to do this but irritability was there as well as anger toward me." "Shift the Valium to Tranxene 7.5 mg. three times a day, which with its smoother action may be easier to taper. She also asks for Fiorinal for headaches. . . ."
8-24-84	"She asked to increase the Tranxene or add Halcion. . . ."
8-2-85	"She is experiencing headache pain and has sought narcotics [from another physician] for this. She was not fully revealing to her doctor the extent of her chemical dependency and psychiatric history, and she indicates he is somewhat perturbed by this."
11-11-86	"She has had a very difficult time recently, following her prescription of Klonopin she was over-sedated at work and spent most of the weekend sleeping."
11-15-86	"She has continued better after the disastrous use of Klonopin . . . If she uses Xanax her speech slurs. . . ."
3-9-87	"Note of phone call. Patient called stating she has been vomiting all weekend and has used up Tylenol #3 and diazepam. Patient called back and I said [Respondent] refused refill, she said she wasn't asking for a refill. Then pharmacy called and I told him no refill. He said [patient #7] said [Respondent] okayed refill."
4-14-87	"Note of phone call. [Patient #7] called from [another physician's] office stating [patient #7] called them asking for a refill of #30 Tylenol #3. Apparently [patient #7] called them one month ago asking for the same and they were told by the pharmacist that she is only to get it from us. But on 4/2/87 she had an appointment with [the other physician] and told him that per <u>you</u> she was to get it from him, so he did give a prescription for #30 Tylenol #3 which she filled on 4/4/87."
8-1-87	"Patient called on Saturday night close to midnight from United Hospital, St. Paul, stating she is completely out of chlordiazepoxide 25 mg."
8-7-87	"I noted again a second week of 'prescription problems.' She states the pharmacy was closed due to power outage and she was not able to refill her medications on time."
9-3-87	"Plan will be to decrease the Librium, Tylenol #3, and Vistaril to three a day instead of four a day. She has no explanation for running out four days early when she asked me to release two weeks supply at once."
9-9-86[sic]	"She states that due to a lung infection she could not decrease to three times a day. She later notes that three times a day she is not 'numbed' sufficiently by the medications."
11-30-87	"She states that because of hand injuries this time she has used up much of the months worth of Tylenol."

3-16-88	"She inquired about a prn of Valium and I again reiterated my overall plan to taper and stop this hence I am not comfortable with any increased beyond 2 a day."

2) Respondent's notes between July 1984 and February 1991 frequently state an intent to limit patient #7's controlled substances, but Respondent nevertheless continued to prescribe large amounts;

3) Respondent's documentation in patient #7's medical records reflected her medication abuse, as follows:

Date	Event
10-28-88	Patient #7 quit her job at a nursing home, drugs were found missing. Respondent notes patient #7 "feels untrusted there and this is difficult for her."
1-10-89	Patient #7's counselors notify Respondent that she presents herself unable to drive a car and they feel this is due to oversedation. Respondent states, "I believe it's also due to the patient simply overworking herself."
2-3-89	After numerous previous chart notes about patient #7's irresponsible use of medications and application of a chemical dependency diagnosis to her problems, Respondent writes to patient #7's work supervisor: "[patient #7] understands her limits . . . and is a . . . responsible individual and I believe she will adhere to her limits to minimize any recurring difficulties . . . In reviewing the narcotic improprieties you noted, I have no personal knowledge of current chemical problems with [patient #7]."
5-8-89	Respondent notes, "[Patient #7] notes she has a bottle of Halcion at home and I have asked her to take no extra or unprescribed meds." Simply asking this patient to refrain from self-medication is ineffective.
6-5-89	Hospital discharge diagnoses per Respondent: major depression, headaches, chemical dependency, seizure disorder. In a post-script, Respondent shows understanding of patient #7's behavior: "[patient #7] overused minor tranquilizers to the point of memory loss; . . . also claims to need narcotics on intermittent basis for headache pain but when has these available ends up using these on a regular basis. For the above reasons, I have not been comfortable prescribing these classes of medication to her . . . narcotics, which I think affect her moods and thinking . . . with access to Librax . . . I worry about her use of these."
7-14-89	In spite of the above expressed concerns, Respondent's response to patient #7's later failure to follow his prescribed medication regime is as follows: "I have recommended she throw away all of her own meds, stick to this regimen, and I will see her next week."
3-14-90	Patient #7 discharged from hospital after treatment for major depression and Dilantin toxicity. She had been fired from her job as an RN after a narcotic irregularity was traced to her. She had been using Percocet for headache pain, but "ran through an amount rather quickly."

4-19-90 Respondent recommends chemical dependency treatment to the patient.

5-16-90 Patient #7 expresses opposition to Respondent's recommendation for chemical dependency treatment. His response to her opposition focuses attention on Respondent's needs rather than correcting patient #7's behavior: " . . . I have indicated that if she wants to show me she appreciates my care she can follow my recommendations."

4) With respect to the care Respondent provided to patient #7:

a) Evidence showed Respondent had difficulty recognizing and limiting patient #7's abuse of the prescriptions;

b) Respondent showed poor follow through of his stated objectives to taper and/or discontinue benzodiazepine medications;

c) Respondent employed a high dose benzodiazepine treatment resulting in significant CNS side effects dangerous to patient #7;

d) Respondent delayed or failed to obtain chemical dependency consultations and/or second psychiatric opinions in the face of patient deterioration and clear symptoms of chemical dependency problems;

e) Respondent's case management and medication prescribing were naive and enabling.

g. Overall, Respondent frequently makes abrupt and drastic changes in type and dosage of medication which seem erratic, not well considered and poorly integrated with non-medication management strategies. The degree of these changes is unusual compared to most practicing psychiatrists in this community.

2. On May 13, 1994, Respondent met with the Committee to discuss the allegations set forth in paragraph 1, above. The Committee views Respondent's practices as inappropriate under Minn. Stat. § 147.091, subd. 1 (g), (k) and (o) (1992) and Respondent agrees that the conduct cited above constitutes a reasonable basis in law and fact to justify this corrective action agreement. Based on the discussion, Respondent and the Complaint Review Committee agreed to enter into an Agreement for Corrective Action to address the concerns reflected therein.

CORRECTIVE ACTION

3. Respondent agrees to address the concerns reflected in paragraph 1 by taking the following corrective actions:

a. Respondent shall complete a clinical training program designed specifically for Respondent. The curriculum shall address use of referrals and team management in treating dual diagnosis psychiatric patients. The program shall be created by a medical facility that regularly offers visiting clinician programs and Respondent shall successfully complete the program at the same medical facility. The nature, scope and duration of the program shall be specified by the facility after review of this Agreement and shall be approved in advance by the Committee. Successful completion of the program shall be determined by the Committee and must be accomplished within nine months from the date of the Agreement. Respondent shall bear the cost of the program.

4. Upon Respondent's satisfactory completion of the corrective action referred to in paragraph 3, the Committee agrees to dismiss the complaint(s) resulting in the allegations set out in paragraph 1. Respondent agrees that the Committee shall be the sole judge of satisfactory completion. Respondent understands and further agrees that if, after dismissal, the Committee receives additional complaints similar to the allegations in paragraph 1, the Committee may reopen the dismissed complaints.

5. If Respondent fails to complete the corrective action satisfactorily, or if the Committee receives additional complaints similar to the allegations described in paragraph 1, the Committee may, in its discretion, reopen the investigation and proceed according to Minnesota Statutes chapters 147, 214 and 14. Failure to complete corrective action satisfactorily constitutes failure to cooperate under chapter 147. In any subsequent proceeding, the statements contained in paragraphs 1a-1g shall be deemed admitted by Respondent.

6. Respondent has been advised by Committee representatives that Respondent may choose to be represented by legal counsel in this matter and he has so chosen Mary Sherman.

7. This agreement shall become effective upon execution by the Committee and shall remain in effect until the Committee dismisses the complaint, unless the Committee

receives additional information that renders corrective action inappropriate. Upon receipt of such information, the Committee may, in its discretion, proceed according to Minnesota Statutes chapters 147, 214 and 14.

8. Respondent understands that this agreement does not constitute disciplinary action. Respondent further understands and acknowledges that this agreement is classified as public data. Respondent also understands that any dismissal letter issued pursuant to paragraph 4 shall be classified as public data.

9. Respondent hereby acknowledges having read and understood this agreement and having voluntarily entered into it. This agreement contains the entire agreement between the Committee and Respondent, there being no other agreement of any kind, verbal or otherwise, which varies the terms of this agreement.

Date: 7/2/94

JOHN SIMON, M.D.
Licensee

MARY SHERMAN
Attorney at Law

701 - 25th Avenue S, Suite 303
Minneapolis MN 55545
(612) 339-4841

Date: 8-12-94

For the Complaint Review Committee

SARAH G. MULLIGAN
Assistant Attorney General

525 Park Street, Suite 500
St. Paul MN 55103
(612) 296-9695

AFFIDAVIT OF SERVICE BY MAIL

Re: In the Matter of the Medical License of John Simon, M.D.
License No. 23,781

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

Cynthia Ransom, being first duly sworn, deposes and says:

That at the City of St. Paul, County of Ramsey and State of Minnesota, on August 15, 1994, she served the attached AGREEMENT FOR CORRECTIVE ACTION 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:

Mary Sherman, Esq.
701 - 25th Avenue S, Suite 303
Minneapolis MN 55545

Cynthia O. Ransom
Cynthia Ransom

Subscribed and sworn to before me
this 15th day of August, 1994.

Cheryl J. Geiselhart
Notary Public

CHERYL J. GEISELHART
NOTARY PUBLIC-MINNESOTA
WASHINGTON COUNTY
MY COMMISSION EXPIRES SEPTEMBER 27, 1994

MINNESOTA BOARD OF MEDICAL PRACTICE
2700 University Avenue West, #106 St. Paul, MN 55114-1080 (612) 642-0538

PUBLIC DOCUMENT

August 25, 1995

John E. Simon, M.D.
Riverside Park Plaza
701 25th Avenue South, #303
Minneapolis, MN 55454

RE: Agreement for Corrective Action, Dated August 12, 1994

Dear Dr. Simon:

This is to notify you that, following review of information that you have satisfied the terms of your Agreement for Corrective Action, the Complaint Review Committee has decided to dismiss the case, as allowed by the terms of your Agreement. The above matter is now closed.

Thank you for your cooperation.

Sincerely,

H. Leonard Boche

H. Leonard Boche
Executive Director