

John P. Flannery, II, Esq.
CAMPBELL FLANNERY PC
1602 Village Market Blvd. Suite 225
Leesburg VA 20176
telephone: 703-771-8344
facsimile: 703-777-1485
JonFlan@aol.com

Attorney for Plaintiff, appearing *pro hac vice* (pending).

Brent Flowers, Esq.
BEEBE FLOWERS
555 Fuller Ave #2
Helena, MT 59601
Tel: 406-302-1946
e-mail: brent@helenalegal.com
Attorney for Plaintiff, Local Counsel

**MONTANA FIRST JUDICIAL DISTRICT COURT
LEWIS AND CLARK COUNTY**

MARK IBSEN, M.D.,	)	Cause No. DDV-2026- _____
	)	
Petitioner,	)	
vs.	)	
	)	
MONTANA STATE BOARD OF	)	PETITION FOR JUDICIAL RELIEF
MEDICAL EXAMINERS,	)	TO VACATE BOME SUSPENSION,
	)	CASE 2026-MED-14282
Respondent.	)	
_____	)	

PETITION FOR JUDICIAL REVIEW OF BOME's SUSPENSION
OF DR. IBSEN's MEDICAL LICENSE ORDERED w/o ANY OPPORTUNITY FOR
DR. IBSEN TO HAVE NOTICE OF AND TO BE HEARD IN OPPOSITION;
DR. IBSEN SEEKS TO VACATE THE UNCONSTITUTIONAL SUSPENSION
OF COMPLAINT 2026-MED-14282 ABSENT ANY ALTERNATIVE REMEDY.

COMES NOW Petitioner, Mark Ibsen, M.D. (hereinafter "Petitioner" or "Dr.
Ibsen"), by undersigned counsel, John P. Flannery, II, Esq., appearing *pro hac*
vice, and by Brent Flowers, Esq., as local counsel, in reliance on

constitutional and statutory authority, to petition this Honorable Court for Judicial Review of Montana State Board of Medical Examiners' (hereinafter "Respondent" or "BOME") suspension of Dr. Ibsen's Medical License ordered without any opportunity for Dr. Ibsen to have notice of and to be heard in opposition to the suspension of his medical license; and, accordingly, by counsel, we seek judicial relief, namely, to vacate BOME's suspension of his medical license in Cause 2026-MED-14282 absent any alternative relief, and;

In support of this petition, Dr. Ibsen states further as follows:

THE PARTIES

1. At all relevant times, Dr. Ibsen has been a resident in Helena, in Lewis & Clark County, Montana.
2. Respondent, the Montana State Board of Medical Examiners, with its principal office in Helena, in Lewis & Clark County, Montana, is an agency of the Montana government charged with the responsibility and duty to regulate physicians including Petitioner.

JURISDICTION

3. The Montana Administrative Procedure Act governs adjudicative procedures of the Board. Section 37-1-310, MCA.
4. This is a case involving a responsible and professional physician who has been hounded because of his criticism of how BOME compromises those chronic pain patients who are ill and that he has treated. See Exhibit 1 (Dr. Ibsen Affidavit).

5. This complaint, now that we have some of the details, what we know, we know only after BOME suspended Dr. Ibsen's medical license, but we can say that BOME charges "technical" matters that Dr. Ibsen seeks to dispute and the suspension does not otherwise cite a single inappropriate script for any chronic pain patient. Exhibit 2 (Notice of Summary Suspension).
6. One thing is certain in the case of this Montana Board and like Boards across the nation, that institutions and the public recoil from the notion that physicians treat chronic pain patients with opioids. *Id.*
7. This Board's bias against any treatment for chronic pain patients has been a changing medical landscape and the ignorance of these Boards on this issue has prompted many chronic and acute pain patients to suffer. *Id.*
8. When we consider some of the arbitrary and capricious acts of this Board in Dr. Ibsen's case, including this recent suspension of his medical license it is because, to repeat a famous quote, that BOME can't handle the truth, the medical truth, that cannot be denied, and, in the bargain, they are causing great harm.
9. What really bothers this Board is that Dr. Ibsen just won't stop speaking about the Board's failure to examine the truth, and that drives this Board – well – somewhat "crazy" – all one has to do is to review all the complaints they've filed that weren't pursued to conclusion or that were dismissed. BOME has been looking for where they could best Dr. Ibsen.

THE PROCEEDINGS – in more detail

10. Mark Ibsen, M.D., licensee No 7378, is the subject of five (5) complaints by the Montana State Board of Medical Examiners (BOME), namely, Complaint Nos 2024-MED-0808, 2024-MED-9656, 2026-MED-00348, 2025-MED-11234, and 2026-MED-14282.
11. No hearings on any of these complaints have been heard since the Board found “reasonable” cause for these five complaints to issue.
12. In complaint No. 2026-MED-14282, on October 14, 2023, BOME issued a “summary suspension” of Dr. Ibsen’s medical license.
13. Dr. Ibsen’s chronic pain patients were thus abandoned by the fiat of BOME claiming they act to protect the public’s health and safety when doing precisely the opposite.
14. Staff counsel, the Board Chair and the Board compromised the chronic pain patients’ health and safety and, on information and belief, in the time since the suspension on October 14, 2026, some of Dr. Ibsen’s patients have, as a last resort, found themselves, abandoned by the order of BOME, seeking medical care wherever they may be treated including emergency rooms.
15. At the public hearings that BOME held on October 14, several patients and concerned citizens spoke, and mentioned that physicians have “tapered” chronic pain patients, not because tapering is the fitting treatment, but because doctors fear lost reputation if they prescribe what’s required by a patient’s condition, but they don’t want to lose their medical license and risk criminal

investigation and prosecution should they treat, bringing their fully honest medical opinion, on the medical condition of these chronic pain patients.

THE CODE

16. The Montana Code, Section 2-4-631, provides that in the ordinary case that “whenever notice is required, no revocation, suspension, annulment, withdrawal, or amendment of any license is lawful unless the agency gave notice by mail to the licensee of facts and conduct which warrant the intended action (underscoring supplied).”
17. This case was the ordinary case and we were given notice by BOME Staff of one complaint, we found it wanting and spelled out how and why in response that it was not “reasonable” or “probable” of any charges, so the Board ducked a careful analysis by going forward with a “screening panel” and, if facts were discussed, they were not made available to Dr. Ibsen or counsel before kicking Dr. Ibsen out of his practice.
18. If we credit BOME, they had different facts and conduct in mind, and did not disclose to Dr. Ibsen or his counsel, not even since issuing the suspension.

IT’S ALL ABOUT THREE PATIENTS BOME SAYS

19. In the summary suspension order, as the basis for suspending Dr. Ibsen’s due process, the Department identified 3 patients, unnamed, no documents, no further details, one alleged patient each from Alabama, California, and Oklahoma, involving telemedicine prescriptions, details unknown, during a

period some time before August 2026, and, it went without mention, that BOME had nothing to complain about any prescription that Dr. Ibsen issued.

20. Accordingly, it is beyond peradventure, that BOME is making a “technical complaint,” hovering close to so vague in utterance, so that we don’t have anything like “notice’ - even now as we wait for any hearings to commence.

21. BOME suspended Dr. Ibsen’s entire practice. Stopping a 70-year-old doctor from his medical practice without giving him a fair chance to know the charges to meet the accusations made, denied his day in court, notice of the facts, his dignity is denied despite certain words found in the Montana Constitution.

BOME AND ITS PARTNER - DEA

22. To make matters more distressing, on information and belief, DEA was cooperating with a grand jury investigation but a request for discovery by DEA by way of an administrative subpoena was denied and, since that time, DEA has stated that it is cooperating with the Montana Board of Medical Examiners. See Exhibit 3 (DEA’s cooperation with BOME).

23. This relationship of law enforcement with an administrative licensing proceeding justifies suspending the civil proceeding until DEA concludes its criminal investigation.

CAN WE AGREE OR HEAR A MOTION TO VACATE

24. In some cases, the rights reserved to a physician are to “request a hearing to determine whether your license should remain suspended ...”

25. We asked staff counsel, Taylor Dugan, to agree to vacate the suspension or have a hearing to consider vacating the suspension.
26. We asked whether Staff Counsel, Mr. Taylor Dugan, would agree with Dr. Ibsen's counsel "to vacate the suspension of Dr. Ibsen's medical license." Barring that consent, we asked, "can the Department grant us an opportunity to be heard, in a separate hearing on vacating the suspension."
27. We have as yet received no response to either request. See Exhibit 4 (Request for agreement or hearing).
28. We suspect any request to agree or hearing before BOME is a futile exercise to obtain relief from this oppressive and unjustified suppression of Dr. Ibsen's medical license.

OUR ONLY POSSIBLE RELIEF IS THIS COURT

29. In Montana, section 4, of the State Constitution provides that the dignity of the human being is inviolable; in section 8, the constitution guarantees the State will "afford such reasonable opportunity for citizen participation in the operation of the agencies prior to the final decision as may be provided by law;" section 16 of the Constitution provides that "Courts of Justice shall be open to every person, and speedy remedy afforded for every injury of person, property, or character ...;" of course, Section 17 provides Montana's version of the US Constitution, of Article 14 and the 5th Amendment that - "No person shall be deprived of life, liberty or property without due process of law."

30. At the core of our complaint is that “due process” mostly equates to “fundamental fairness,” and the procedure here is just not fair.
31. BOME has appeared unconcerned about these fundamental constitutional provisions, about Dr. Ibsen’s dignity, about a “speedy remedy” for courts to consider injuries of person, property, or character, when the BOME suspension is a direct attack on the person, property and character of Dr. Ibsen, and finally BOME foregoes any notice and any fair opportunity for Dr. Ibsen to be heard.
32. After we responded to this complaint, BOME did not disclose anything to refute our objection that the complaint was frivolous.
33. When the suspension of Dr. Ibsen’s license was issued, we learned something more although quite incomplete.
34. MCA Section 2-4-701 provides for an “immediate review of [an] agency action.”
35. It states that “a preliminary, procedural or intermediate agency action is immediately reviewable if review of the final agency decision would not provide an adequate remedy.”
36. The final agency decision is the equivalent of a civil death warrant for Dr. Ibsen’s reputation and his medical practice, and there are chronic pain patients who will die if this goes forward without someone prescribing for them.
37. Waiting until a final decision is a totally inadequate remedy for what BOME has done here.

38. Nor do we have to scale this back from the timing of the final decision to the present. A similar disaster exists in the here and now if the suspension is not redressed sooner. About two weeks have passed and Dr. Ibsen's patients are seeking help in emergency rooms and failing to find any doctors to take the chance they won't be subject to investigation themselves.

39. Plainly, Dr. Ibsen and his chronic pain patients are in dire circumstances now after more than two weeks since the suspension was announced, and we cannot wait upon the suspension in place until there is a "final agency decision" sometime in the future, nor in the passing weeks, months, or more.

40. We are still blind to anything approaching a full disclosure while patients and Dr. Ibsen endure.

41. The rationale for MCA Section 2-4-701 is manifest, if BOME doesn't do justice, if the suspension at issue is not reviewed immediately and there's no other alternative that may provide adequate relief, the Court may consider the question even though the action was a "preliminary, procedural or [an] intermediate agency action,"

WHEREFORE, based on the pleadings herein, the Exhibits hereto attached, we most respectfully request that this Honorable Court vacate the suspension of Dr.

Ibsen's medical license, and to grant such other relief as this Court deems fit and just.

Dated: this 26th day of October, 2026

RESPECTFULLY SUBMITTED

By: 
John P. Flannery, II, Esq,
Attorney for Plaintiff, *pro hac vice*, and

By: /s/ Brent Flowers, Esq.
Brent Flowers, Esq.
Attorney for Plaintiff, local counsel

CERTIFICATE OF SERVICE

I certify that the foregoing petition, has been forwarded to counsel, Taylor Dugan, Esq, Agency Counsel, this day, October 26, 2026, and we have forwarded a copy by e mail, to his personal attention to:

Taylor Dugan, Dept Counsel
Montana Department of Labor & Industry
1327 Lockey Avenue
Helena, MT 59601
Taylor.Dugan@mt.gov

/s/ Brent Flowers, Esq.
Brent Flowers, Esq.
Beebe & Flowers
555 Fuller Ave #2
Helena, MT 59601
406-442-3300
e-mail: brent@helenalegal.com
Attorney for Plaintiff, Local Counsel

Local Counsel, moving the
Admission *pro hac vice* of
John P. Flannery, II, Esq.

EXHIBIT 1

A PHYSICIAN IN PERIL FOR TREATING THOSE WHO ARE ILL

AFFIDAVIT OF MARK S. IBSEN, MD

State of Montana, County of Lewis and Clark, to-wit:

MARK S. IBSEN, MD, does hereby swear or affirm and state under penalty of perjury, as follows:

1. My name is Mark S. Ibsen, M.D.
2. I have prepared this affidavit as I exist in communion with other physicians and patients who treat and/or suffer acute and/or chronic pain to underscore the fact that the rampant and reckless ignorance of pain and pain management has caused physicians to undertreat patients and, in turn, has caused patients to be refugees with pain and many commit suicide to escape the unbearable pain they cannot withstand without pain medication.
3. Cousin to this state of affairs are the reprisals for treating chronic pain patients and, worse, speaking out about this lawful malpractice to under treat patients.
4. The government insists that anyone who takes pain medication is at high risk for addiction. There are corrals of “experts” who see any medical prescription for pain as an act to addict a patient. They often blunt the terrible consequences of their “expert” opinion by suggesting there are worthy alternative therapies. In some cases, that’s certainly true but not generally. What we are truly talking about when considering pain medication is not addiction, rather it is “dependence” until the pain subsides – if and when it does.

5. We look the other way when the pain is in the final days of a patient in the case of cancer patients. Presumably it's because we want to make patients comfortable in their final days. Why won't we make them operational if not comfortable?
6. But what about a patient who has years to live and who may perhaps suffer unnecessarily without treatment?

How I became an accidental pain physician

7. Let me begin by discussing my background.
8. My progression from a young physician to an experienced practitioner parallels the careers of others who sooner or later bump up against the question, how to handle a patient's pain, as it's a correlative aspect of so many ills that trouble our patients. For a physician to fail to treat pain is to fail patients and to undermine the trust of an aging nation for our medical profession.
9. Having taken the proper boards to do so, I began practicing urgent care in Helena, Montana from 2010.
10. I first became aware of the conflict between pain medicine and the intrusion of governmental regulation of the nation's pain crisis, in the period from 2011 to 2013, while practicing in Montana; the government and medical boards failed to apprehend the chaos that was plain to see.
11. In the early days, in 2005, official documents, medical and otherwise, endorsed the treatment of pain. That made sense given that there was no way to separate pain from the many afflictions a patient may endure. There was, for example, no conclusive imaging device to detect and confirm a back pain was real or faked.

12. These documents and directives, on treating pain, were withdrawn, however, without good reason, by arbitrary notice, sometime in 2013.
13. Thus did medical America become a vast wasteland for pain management? T. S. Eliot wrote: ““The awful daring of a moment's surrender which an age of prudence can never retract, by this, and only this, we have existed.” It's a sweet question if our surrender to bad advice, in disregard of medical science, may with prudence be cured.
https://helenair.com/opinion/columnists/montana-has-become-a-wasteland-for-pain-management/article_e567f3fa-a8dc-5f69-aa83-16d37394d496.html
14. Pain patients visited my urgent care clinic in 2011 and some of those appeared because they were dropped by other legacy pain management programs.
15. As an “ER Doc,” one first learned, certainly that’s how I was instructed, to treat pain management aggressively but not recklessly. *See* Julie Baughman, “BIG PAIN IN THE BIG SKY Miscommunication and misinformation: Chronic problems with treating chronic pain” Philadelphia Report (May 18, 2014)
http://b.bsd.dli.mt.gov/license/bsd_boards/pha_board/mpdr/pdf/BigPainInTheBigSkyMay2014.pdf
16. While we physicians are not lawyers, we have learned to pick our way through the Controlled Substances Act (CSA) that makes it unlawful for “any person knowingly or intentionally ... to manufacture, distribute or dispense a controlled substance” except in certain cases. *See* 21 USC Section 841(a)(1).
17. The “exception” for physicians provides any prescription may be made if “issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice.” *See* 21 CFR Section 1306.04(a).

18. Some courts have avoided squirrely worded legal tests that sound in the language of medical malpractice, rather than a criminal prosecution, mistakenly treating civil standards as sufficient to find a criminal violation.
19. The corrective for this current institutional error is to test whether the physician lacks “a good faith basis” for making the prescription.
20. Law enforcement and medical boards targeting physicians who are healing, not dealing, make it a risky challenge for every physician to redress a patient’s pain. I have persisted in treatment – and to talk about it – and I’ve paid a price in my professional and personal life to do so. Unsurprisingly, while there are others, many physicians now refuse to treat pain.
21. How does a fact finder rightly cut the difference? I don’t think they can. That’s why the Supreme Court is being asked to slice and dice the standard of “wrong-doing” going forward.
22. The bias against remedying pain with any opiate is so great that many more patients may suffer this ignorant bias. The fear is that the Supreme Court may prefer a form of criminal Russian roulette for physicians who treat pain and, “oops,” find out afterwards that they got it wrong, and only then, they discover that their “good faith” in their medical practice wasn’t sufficient, if the court allows “good faith” to be relevant when it renders its decision. As a result, a physician’s medical practice, his reputation and freedom may become a memory, gone in this ambiguous changeable law enforcement mist, indifferent to the medical science and the cries of suffering patients.
23. The CSA says a physician must act “knowing or intentionally.” 21 USC Section 841(a)(1). It’s been long established that you must demonstrate “a vicious will” if you

hope “to establish a crime.” See *Staples v. United States*, 511 US 600, 616-617 (1994).

In other words, each element of a crime must be knowing or intentional.

24. So, what have I observed as a physician who has treated pain patients?
25. Patients have come to my practice when other physicians have refused to write a prescription, for their own safety, and not for the patient’s condition.
26. What I found out about the medical profession generally is that patients didn’t care how much I knew until they knew how much I cared.
27. In the current medical pain dragnet, seemingly with little hope for a policy reset, physicians and pain patients have become “opiate refugees,” mostly abandoned, forced by circumstances to fend for themselves, often while they suffer relentless mind-numbing pain.
28. I’m sure I treated some patients that could find no one else to treat their pain.
29. I believe it helped that part of my practice was serving refugees overseas, and necessarily the poor and underserved; I was privileged to serve patients with Mother Teresa in Kolkata, and other patients in the West Indies, Nepal, and Bombay. I have attended upon patients at multiple Indian reservations, inner-city free clinics, and the Dalai Lama’s hospital in Zaskar, India. I believe this wide ranging geographic and social extension of my practice made me a better doctor across the spectrum of the afflicted.
30. Physicians have been well aware, even before the pandemic, that our nation is in the midst of a public health crisis, of dramatic proportions, but if you call public health officials in the state of Montana, or any other state, they have very little to say about what to do to remedy this crisis.

31. It doesn't help that the current fear pain treatment protocol doesn't just involve physicians. Pharmacies have taken it upon themselves to refuse to fill a physician's prescriptions.
32. In addition, physician's themselves, bar the door to pain patients. I've had patients inform our practice that they were not only refused pain management, but were refused to be treated at all by a primary care doctor for other primary care issues; the rule for some physicians has become: "We don't see patients who are on chronic opiate therapy." Some Patients therefore couldn't get medications for blood pressure, diabetes, cholesterol, or any other primary care needs, because they had earlier been prescribed an opiate for their pain.
33. Thus, patients got sicker and went without treatment.
34. Having pain yourself will make you question your assumptions about pain medication.
35. Cytochrome P450 (CYP450) tests help determine how a patient processes (metabolizes) a drug. The human body uses cytochrome P450 enzymes to process medications. Because of inherited (genetic) traits that cause variations in these enzymes, medications may affect each person differently.
36. Chronic Pain Patients may require some multiple of the doses that an average patient may need or endure..
37. This genetic pleomorphism research was done over 20 years ago and is established science is unappreciated and ignored by law enforcement and boards of medical examiners.
38. By the way, as a matter of statistics, there's a 100% chance that 5% of the population will be two standard deviations from the mean (average) of what is, in

fact, an “average dose.” In other words, there is greater variation than may safely be assumed.

39. It can be disastrous when a patient runs out of alternatives.
40. Law enforcement targets physicians, seize medical records, suspend a practice, and often are not charged. They’ve been run out of the profession when we need more pain doctors not fewer. The baby boomers are a group that is living longer and having pain they might not have lived to realize years ago.
41. Perhaps it was truly calculated not to enforce the law but to chill a critical voice – and you can’t look at my history and think my outspoken critique of where we are is unrelated to the focus on my practice and my patients.
42. I can’t help but think this older case before us isn’t a function of the fact that the last complaint was dismissed when screened, and this one will and should be as well – for it is as remote and frivolous as can be.
43. Unfortunately, I have had to experience this hostile regulatory environment in the form of the Montana Board of Medical Examiners (BOME).
44. It has been said that, to a hammer, everything is a nail. That metaphor rings true in my experience with the Montana Board of Medical Examiners – save the last time I “appeared” before a panel of this board and the matter was dismissed.
45. I can’t help but wonder if staff is shopping for a panel that will find this charge has merit – when it has none at all.
46. My path to this day, of charges, and complex litigation and cost and lost business and reputation started in 2013 with the filing of a baseless BOME complaint. The merits of this complaint I could not fully overcome until 2020. I was trying to get my day in court

- on the merits of slander, court fees and the like until 2021. I never got my day in court to attack the delays and expense I suffered because of the BOME's misconduct.
47. In 2015, after extensive discovery and expense in the BOME's one-sided administrative "process," the BOME Hearing Examiner concluded that there was nothing irregular about my pain prescriptions. In other words, the Examiner found I acted in "good faith."
48. Members of the Board did not prefer that outcome, a clean bill of health, and they decided to dictate a different outcome, took into account matters *ex parte* never considered by the hearing examiner, it was a procedural "railroad," concerning information, shared among the BOME, but not provided to my counsel or myself.
49. The Board didn't just add highly questionable and slanderous material to the record, they zeroed out all of the Examiner's favorable findings, the hundreds of factual findings and conclusions about the law. Finally, they suspended my medical license.
50. We appealed the decision to the Court in 2016. We got a stay on my medical license suspension shortly after filing our appeal.
51. Two years later, in 2018, and it took that long, the Court found the Board had violated my constitutional due process rights by their misconduct and sent it back to the Board, remanded it for further more appropriate review, hoping that this time, the Board would render a fair inquiry.
52. Think again!
53. The Board appointed a 2nd Hearing Examiner, rather than return to the 1st Examiner.
54. Nothing happened for the next two years after his appointment. The 2nd Examiner was inert. He did nothing at all.

55. In 2020, I retained John P. Flannery, II, Esq.,¹ as counsel, and he filed in court a mandamus, ordering and demanding that the Board and the 2nd Hearing Examiner perform the legal duty that the Court directed be done by its order in 2018. Simply put, the mandamus charged that the Board and the 2nd Hearing Examiner had done nothing at all, and it was high time that they did what the court ordered.
56. Within a few weeks following the filing of the Mandamus, the 2nd Examiner finally acted. He reinstated the 1st Examiner's finding, that my prescriptions for pain were appropriate, told the Board that they should adopt the 1st Hearing Examiner's findings, rejected the Board's factually unsupported findings that there were any prescription irregularities. The 2nd Hearing Examiner said to forego any suspension of my medical license, but required that I demonstrate that my medical record-keeping was in order.
57. We demanded a hearing on the merits but the trial court refused us one; on appeal two members of the Montana Supreme Court found that we had a right to our day in court on the merits, but the other members of the panel disagreed in a 5-2 decision.
58. Years ago, I stopped prescribing any opiates. You can understand why. My practice suffered because of this lingering case from 2013 to my Montana Supreme Court appeal in 2021. I barely avoided bankruptcy in this period.
59. The worst result of the hostile regulatory environment is that chronic pain patients who can obtain no relief, improvise on a deathly off ramp, by suicide, by gun, by alcohol, by overdosing amitriptyline.

¹ John P. Flannery, II, is the author of a book, "Pain in America – and How Our Government Makes it Worse," and what he originally wrote, about the state of enforcement and its disastrous impact on pain management, now years ago, remains as true today; what I suffered is just one more example of what he earlier found in his research.

60. True, there are clearly folks who really do need palliative opiate treatment. They are easily identified. They need pain relief and do better on pain medication – this despite the self-appointed lay critics who say otherwise.
61. I never treated addicts. They may need treatment. But I have not done so. I have only treated patients who had been treated previously by other physicians.
62. Not everyone appreciates the distinction between acute and chronic pain.
63. The unstated question may be, “how much medication does one need?” It depends on the patient, what he needs to have anything approximating a normal life. We must investigate the condition prompting the acute or chronic pain, and what might work instead of opiates. True, we naturally produce an opiate effect ourselves but that only goes so far.
64. I had coronary artery quadruple bypass surgery several years ago. Among other things, your chest bone, the sternum, is cut wide open. Ribs can be sprained. The surgeon must get at the heart to do what’s required. The good news obviously is that I survived. But then there was the pain. Upon discharge I was given a prescription for oxycodone 5 mg Q6 (every 6) hours, total number of pills, 28.
65. That’s one week’s worth of pain and medication. That was the legal limit in Ohio where I had the procedure.
66. I made the prescription last two weeks. So I had pain.
67. Upon returning to Montana, my cardiologist refused any further oxycodone prescriptions. He said to give Ibuprofen a try. (Suffice it to say it failed.). (Suffice it to say I have thus been the victim of my own physician’s fear to treat for fear of being called out for prescribing what was right and apt in my case.)

68. It's not helpful that DEA Agents won't tell you what is prohibited or permitted. Their rule and that of investigators generally is to pattern enforcement in a kind of "gotcha" scenario.
69. DEA Agents and other law enforcement officers won't say what a physician may do, but are fast to "enforce" if they think that the quantity of opiate prescriptions seem "high" and this is further complicated by the fact that enforcement believes that any prescription leads to addiction, rather than an acceptable dependence that ends when the pain recedes.
70. The Agents will confess, "we are not doctors, we cannot tell you what to do," but in experience that is only a pose.
71. By the nature of what we physicians do, we seek the trust of patients, to believe, while we scrutinize what we're told by a patient. We are by nature curious, healing, empathetic. We are not an arm of the state, serving as an agent, a *de facto* attorney general, charged with finding out wrongdoers. We don't have complete knowledge of who each patient is, what they've done, and the science of imaging, for example, doesn't tell us much about how or where pain may originate and become a patient's misery.
72. We are more sensitive to the consideration that to deny a patient treatment for chronic pain is in fact and truth a restraint on the freedom of being and feeling "well," in control of one's own being, rather than confined in a world of daily unremitting pain. It is nothing less than a "badge of slavery, violating a patient's constitutional rights in this and other ways, especially due process, or fundamental fairness.
73. Going back to "how it was," in 1999 pain was considered a fifth vital sign that had to be treated. There was a righteous concern about how inadequate was our management of

pain. Physicians and the general public were encouraged to treat pain more aggressively, and patients were asked about the results of their pain treatment regularly.

74. As I've suggested, our current governmental regimen recoils from treatment for pain, and has a variety of adverse effects on our patients.

75. In a nation that permits its citizens to abuse their health in so many ways, it is a shame and a disgrace that our government and medical boards effectively bar pain treatment that almost uniformly sustains a person's health.

76. It is not lost on me that so many believe that any pain medication is dangerous because the government at every level, in every election and legislative session, and every press release, has been piping this lie for so long it has become a communal predicate belief that pain medicine hurts and kills, when the government is supposed to promote the general welfare, to tell the truth, rather than compromise the well-being of our citizens suffering in pain.

77. Of course, I am available to respond to any questions as may be required.

78. In this brief affidavit, I have tried to give attention to some few of the salient points that have made pain care in America a nightmare from which we cannot seem to awake.

MARK S. IBSEN, MD

Affiant

Sworn and subscribed before me, a Notary Public, in and for the State of Montana,
County of Lewis and Clark, on the 11th day of July, 2025.

Notary Public

My Commission expires _____

Curriculum Vitae

Mark S. Ibsen, MD, FACEP, FAAFP
6425 Head Lane
Helena, MT 59602
(406) 439-0752
markmusheribsen@Gmail.com

Board Certification

Diplomat, American Board of Emergency Medicine 1988, 1999, 2009
Diplomat, American Board of Family Practice, 1984, Recertified 1992

Postgraduate

Residency: Family Practice
University of Utah Family and Community Medicine
Salt Lake City, UT
7/80-7/83

Chief Resident
1982-1983

Education

Medical School: Washington University School of Medicine, St. Louis, MO
Doctor of Medicine: 1980
Recipient, Cowan Pulmonary Medicine Award 1980

Undergraduate: Williams College
Williamstown, MA
Dean's List 1973-1976

Practice Experience

Alternative Wellness

2458 Hwy 93s,
Suite 301
Kalispell MT 59901
United States
Consultant physician
2015- present (providing consultations for cannabis patients throughout Montana)

Owner/Operator Urgent Care Plus
39 Neill Avenue
Helena, MT
1/1/2010 – January 2016

Locum Coverage

Marias Medical Center
Emergency Room Physician
Shelby, MT
July 7, 2014 – July 14, 2014

Staff Emergency Room Physician
Benefis Hospital
Great Falls, Montana
6/2008 - Present
Staff Emergency Room Physician
St. James Hospital
Butte, MT
4/2008 – 6/2010
Consultant: State of Montana
Department of Disability Services
Helena, MT
6/2007 – 2015
Staff Emergency Room Physician
St. Peter's Hospital
Helena, MT
7/96 – 5/2007
Staff Physician, The Medicine Tree Clinic
St. Ignatius, MT
8/95-7/96

Staff Emergency Room Physician
Kalispell Regional Hospital
Kalispell, MT
8/93-9/95

Interim Medical Director
Emergency Department/A.L.E.R.T. Helicopter
Kalispell Regional Hospital
8/94-8/95

Staff Emergency Room Physician
Mercy Medical Center
Redding, CA
6/92-7/93

Assistant Director Emergency Department
Director AIR MED TEAM Helicopter Program
Director EMS programs
Redding Medical Center
Redding, CA
11/91-7/92

Staff Emergency Physician
St. John's Hospital
Jackson, WY
5/91-12/91

Staff Emergency Physician
Mercy Medical Center
Redding, CA 6/88-8/91

Staff Emergency Physician
Pioneer Valley Hospital
West Valley City, UT
9/87-4/88

Staff Emergency Physician
Wasatch Emergency Physicians
Salt Lake City, UT
1/87-9/87

Director, Emergency Department
Tooele Valley Hospital
Tooele, UT
7/83-1/87

Public Service

Mother Teresa's Missionaries of Charity
Calcutta, India
1/90-2/90

SYDA Foundation PRASAD Project
Ganeshpuri, India
11/89-2/90

St. Jude's Hospital, Sisters of the Sorrowful Mother
St. Lucia, West Indies
11/87-2/88
Mescalero Apache Reservation
10/82-12/82

National Health Service Corps
Health Manpower Shortage Area Service Payback
Tooele, UT
7/83-7/85

Utah State Medical Association Pre-trial Arbitration Board

1987-1988

Board of Trustees, Lewis and Clark county Cooperative Clinic, 2004 - 2007

Board of Trustees, Helena Center of Creative Living, 1998-2003, 2004-2006, 2009 – 2014

Mentor, Landmark Education Wisdom Course 2008 - 2012.

Volunteer and medical Director Hands on Global 2015-present.

Trips to Zanskar 2015,2017.

Lesbos Greece 2018

Standing Rock 2017.

Medical Director R.I.V.E.R. , a service and teaching organization for veterans with PTSD. 2016-present

Certifications

ACLS Instructor Trainer

Utah Heart Association

1986 -1988

ACLS Certified, ACLS Instructor

1985 -1988

1995 - Present

PALS Certified

1988 - 3/95

ATLS Certified

1983 - Present (Recertification 1/95)

Licensure

Montana 1991 - Present

North Dakota 2020

Awards and Honors

Fellow, American College of Emergency Physicians

Fellow, American Academy of Family Physicians

Physician of the Year, 1985, Utah EMT Association

Cowan Pulmonary Medicine Award, Washington U. 1980

National Merit Scholarship Finalist, 1973

MVP and Special Mention All-State Football, 1973

Faculty Appointments

University of Utah Clinical Faculty 1986-88

U.C. Davis Clinical Faculty 1990-93

Committees

Chairman, Emergency Medicine Section 8/94-8/95
Quality Assurance 12/93-9/94
Ethics 2/94-9/95
Ethics and Pharmacy/Therapeutics at Mercy 1988-91 and 1992-93
Secretary-Treasurer Flathead County Medical Society 1995
Trauma Committee 12/94-9/95
Ethics Committee – St. Peter's Hospital 1998-2003; 2006-2007

EMS Experience

Utah Governor's EMS Committee
1986-1988

Tooele County EMS Director
1983-1987

EMS and Air Medical Director
Redding Medical Center
11/91-7/92

Instructor, Bigfork QRU EMT Course, Glacier Park EMT Course
Medical Director, Bigfork quick Response Unit
Medical Director, Kalispell Fire Department Ambulance
Representative, MT Regional Trauma Advisory Committee
Medical Director, Flathead Valley Community College Paramedic Course

Wilderness Medicine

Member, Wilderness Medical Society 1983-1995

Member Flathead Nordic Ski Patrol
Instructor Wilderness Emergency Care Course 1993-1996

Wasatch Mountain Club 1983-1988
Medical director Great Divide Ski Patrol

Professional Societies

ACEP, AAFP, WMS, Montana Medical Society
Flathead Medical Society
American Academy of Emergency Physicians
Board of Trustees, Great Basin Nature Conservancy
Institute of Noetic Sciences
Lewis and Clark County Medical society(president 2003-2005)

**Personal Growth and
Development**

7/13/07 &
09/16/11

Landmark WorldWideParticipation

Landmark Forum

Advanced Course 8/24/07	Self Expression and Leadership Program
10/6/2007 Communication Access to Power 1/14/14	Communication Power to Create
5/10/14 Wisdom Unlimited 3/298/08	Landmark Assisting Program 2008 -
Present Partnership Unlimited 6/26/09	Power and Contribution
3/24/10 Discourse Program 1/1/10 - Present	Conference for Global
Transformation: Conference Presenter May 2014 and Poster Presenter May 2013 and 2015	

Professional Conferences: PainWeek 2015 9/7/15 - 9/13/15

Personal

Born: May 12, 1955, Grand Rapids, Michigan

Raised: Geneva, Illinois (1960-1973)

Interests: Kayaking, Skiing (alpine, telemark), Biking, Hiking

Transformational personal growth work

Ski-joring, Public Speaking, running

Dog mushing (2005 2006 Beargrease race-380 miles, Race to the Sky finisher 2008, 2010,-2014)

Bicycle racing, marathon running (St. Louis marathon, Deseret news marathon, St. George marathon, montana Governors cup)

Ski marathons (Yellowstone Rendezvous)

Mission Statement

In my practice of medicine, I provide top-notch patient-centered medical care. I strive to serve my patients in an efficient, cost-effective and compassionate manner. I aim to be present to whatever is needed. My values include: quality, teamwork, and service to patients, community, medical staff, and hospital.

EXHIBIT 2

Taylor Dugan
Agency Counsel
Department of Labor & Industry
Office of Legal Services
P.O. Box 1728
Helena, MT 59624-1728
Telephone: (406) 444-5466
E-mail: laborlegal@mt.gov

**BEFORE THE BOARD OF MEDICAL EXAMINERS
STATE OF MONTANA**

In the Matter of Mark Ibsen, Physician, License No. 7378.	Case No. 2026-MED-14282 NOTICE OF PROPOSED BOARD ACTION, SUMMARY SUSPENSION, AND OPPORTUNITY FOR HEARING
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On October 14, 2026, the Screening Panel of the Montana Board of Medical Examiners (the Screening Panel) considered information presented by the Montana Department of Labor & Industry (Department) and directed this *Notice of Proposed Board Action, Summary Suspension, and Opportunity for Hearing* (Summary Suspension Notice) be served upon you.

SUMMARY SUSPENSION ORDER

Summary suspension of a license is authorized by **Mont. Code Ann. § 2-4-631**, which provides:

- (1) When the grant, denial, renewal, revocation, suspension, annulment, withdrawal, limitation, transfer, or amendment of a license is required by law to be preceded by notice and opportunity for hearing, the provisions of this chapter concerning contested cases apply.
- (3) Whenever notice is required, no revocation, suspension, annulment, withdrawal, or amendment of any license is lawful unless the agency gave notice by mail to the licensee of facts or conduct which warrant the intended action. If the agency finds that public health, safety, or welfare

imperatively requires emergency action and incorporates a finding to that effect in its order, summary suspension of a license may be ordered pending proceedings for revocation or other action. These proceedings shall be promptly instituted and determined.

Due to the nature and circumstances of the factual assertions set forth below, the Screening Panel finds that public health, safety, or welfare imperatively requires emergency action.

IT IS ORDERED that the physician license of Mark Ibsen, MD (Respondent) to practice in the State of Montana be **IMMEDIATELY AND SUMMARILY SUSPENDED** for an indefinite period pending further investigative and disciplinary proceedings or other resolution of this matter.

Respondent shall return all documentation of licensure in person or by mail to the Board office within 24 hours of receiving this Summary Suspension Notice.

DATED 10 / 15 / 2026



Presiding Officer, Screening Panel
Montana Board of Medical Examiners

A. FACT ASSERTIONS

1. On or about July 17, 1993, the Montana Board of Medical Examiners (Board) issued Respondent a physician license, number 7378. Respondent's license is active through March 31, 2028.

2. On or about September 21, 2026, the Department received a complaint from Prime Therapeutics, LLC (Prime) that Respondent prescribed medications, including controlled substances, in Alabama, California, and Oklahoma without an active Alabama, California, or Oklahoma license.

ALABAMA

3. Alabama prohibits the unlicensed practice of medicine and requires every person who practices medicine in the state to be licensed under its laws. Ala. Code § 34-24-51.

4. Respondent is not licensed to practice medicine in Alabama.

5. Respondent does not have a DEA registration number in the State of Alabama to allow him to prescribe medications, including controlled substances, in the State of Alabama. See 21 U.S.C. § 822(e)(1) (separate registration required); 21 C.F.R. § 1301.12 (separate registration required).

6. From May 2025 through July 2026, Respondent prescribed a Schedule II controlled substance to a patient residing in Alabama.

CALIFORNIA

7. California prohibits the unlicensed practice of medicine and requires every person who practices medicine in the state to be licensed under its laws. Cal. Bus. & Prof. Code § 2052.

8. Respondent is not licensed to practice medicine in California.

9. Respondent does not have a DEA registration number in the State of California to allow him to prescribe medications, including controlled substances, in the State of California. See 21 U.S.C. § 822(e)(1) (separate registration required); 21 C.F.R. § 1301.12 (separate registration required).

10. From March 2025 through July 2026, Respondent prescribed a Schedule II controlled substance to a patient residing in California.

OKLAHOMA

11. Oklahoma prohibits the unlicensed practice of medicine and requires every person who practices medicine in the state to be licensed under its laws. Okla. Stat. Tit. 59, § 491.

12. Respondent is not licensed to practice medicine in Oklahoma.

13. Respondent does not have a DEA registration number in the State of Oklahoma to allow him to prescribe medications, including controlled substances, in the State of Alabama. See 21 U.S.C. § 822(e)(1) (separate registration required); 21 C.F.R. § 1301.12 (separate registration required).

14. From June 2025 through August 2026, Respondent prescribed Schedule II controlled substances to a patient residing in Oklahoma.

B. ASSERTIONS OF LAW

1. The Board has subject matter jurisdiction and legal authority to bring this action under Mont. Code Ann. Title 37, chs. 1 and 3, and Admin. R. Mont. Title 24, chs. 101 and 156. For disciplinary purposes, the Board retains jurisdiction over the license for two years after lapse. Mont. Code Ann. § 37-1-141.

2. The Department provides all administrative, legal, and clerical services needed by the Board, including those related to processing and issuing licenses, renewing licenses, and disciplining licensees. Mont. Code Ann. § 37-1-101.

3. The Board established a Screening Panel to determine whether there is reasonable cause to believe a licensee violated a particular statute, rule, or standard justifying disciplinary proceedings. Mont. Code Ann. § 37-1-307(1)(d).

4. Based on the foregoing factual assertions, the Screening Panel found reasonable cause to believe Respondent violated each of the following statutes, rules, or standards, justifying disciplinary proceedings:

Montana Code Annotated:

§ 37-1-316 (2023). Unprofessional Conduct. (1) The following is unprofessional conduct for a licensee or license applicant governed by this part:

(b) permitting, aiding, abetting, or conspiring with a person to violate or circumvent a law relating to licensure or certification;

(o) assisting in the unlicensed practice of a profession or occupation or allowing another person or organization to practice or offer to practice by use of the licensee's license;

§ 37-1-316 (2025). Unprofessional Conduct. (1) The following is unprofessional conduct for a licensee or license applicant governed by this part:

. . . .
(d) permitting, aiding, abetting, or conspiring with a person to violate or circumvent a law relating to licensure or certification;

. . . .
(q) assisting in the unlicensed practice of a profession or occupation or allowing another person or organization to practice or offer to practice by use of the licensee's license, or practicing while the licensee's license is in an inactive status;

. . . .

- (v) violating a federal, state, or local law or rule relating to the conduct of the profession or occupation.

Administrative Rules of Montana:

24.156.405. Unprofessional Conduct.

- (1) It is unprofessional conduct for a licensee or applicant to violate any statute, rule, or standard of care governing their scope of practice.

24.156.813. Practice Requirements For Physicians and Physician Assistants Using Telemedicine.

- (1) Treatment of a patient who is physically located in Montana by a licensee using telemedicine occurs where the patient is physically located.

C. STATEMENT OF RIGHTS AND PROCEDURES

1. You may request a hearing to determine whether your license should remain suspended pending further proceedings to contest these charges and present evidence and arguments on whether the suspension or revocation should be made permanent. To exercise your right to a hearing, you must send a written request within 20 days of your receipt of this Summary Suspension Notice, addressed as follows:

Department of Labor & Industry
Office of Legal Services
P.O. Box 1728
Helena, MT 59624-1728

2. Failure to request a hearing within 21 days of the receipt of this Notice constitutes a default and allows the Board to enter a Final Order of discipline against you on the basis of the facts available to it.

3. If you request a hearing within 21 days, the Commissioner of Labor & Industry will appoint an impartial hearings examiner to conduct the hearing. The

hearings examiner will notify you and the Department of the time and place of the hearing. You have the right to appear in person or by or with counsel.

4. Procedural and substantive requirements governing this matter may be found at Mont. Code Ann. Title 2, ch. 4, pt. 6 (Montana Administrative Procedure Act); Title 37, ch. 1, pts. 1 and 3; and Title 37, ch. 3, including the right to a hearing before an impartial hearings examiner, the right to present evidence and testify and confront and cross-examine witnesses at the hearing, the right to be represented by legal counsel, the right to subpoena witnesses, and the right to request judicial review and appeal.

5. After a proposed decision of a hearing examiner, a default, or a stipulated agreement, the Board will issue a Final Order imposing one or any combination of the following sanctions:

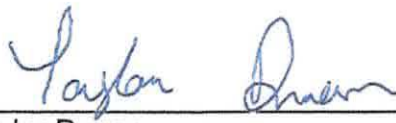
- a. revocation of the license;
- b. suspension of the license for a fixed or indefinite term;
- c. compliance with the conditions of probation for a period not to exceed 3 years;
- d. restriction or limitation of the practice;
- e. monitoring of the practice by a supervisor approved by the disciplining authority;
- f. satisfactory completion of a specific program of remedial education or treatment;
- g. payment of a fine not to exceed \$5,000 for each violation. Fines must be deposited in the state general fund.
- h. denial of a license application or issuance of the license for a probationary period not to exceed 3 years;
- i. censure or reprimand;
- j. refund of costs and fees billed to and collected from a consumer; or
- k. other appropriate action.

Mont. Code Ann. § 37-1-312(1).

6. You may request judicial review of a Final Order of the Board entered after consideration of a proposed decision of a hearings examiner by filing a petition in district court within 30 days of the issuance of a Final Order.

7. In lieu of a hearing, you may enter into a stipulated agreement resolving potential or pending charges that include one or more sanctions authorized by law.

DATED this 15th day of October 2026.



Taylor Dugan
Agency Counsel

CERTIFICATE OF SERVICE

I certify I served a true and accurate copy of this document by placing it in the United States Postal Service mail, certified with return receipt requested and postage prepaid, addressed to the following:

John P. Flannery
1602 Village Market Blvd
Leesburg, VA 20176

Mark Ibsen
6425 Head Lane
Helena, MT 59602

Dated this 15th day of October 2026.



Department of Labor & Industry

EXHIBIT 3

Complaint - Mark Ibsen, DR.0074164

Name Drug Enforcement Administration - Diversion Invest

Respondent

Name
Mark Ibsen

Address
27 Neil Ave
Helena, Montana 59601
United States

E-mail
markmusheribsen@gmail.com

Work Phone
(408) 594-7166

License Number
DR.0074164

Complainant

Name
Drug Enforcement Administration - Diversion Invest

Address
2970 King Ave W
Billings, Montana 59102

Home Phone
(571) 362-3313

E-mail
heidi.s.crater@dea.gov

10. Were there any witnesses to the event(s) that occurred to you? This would include other professionals, family members, other clients, etc.
Yes

11.

- If you said "Yes" above, please enter the name(s) and contact information (phone number and email address as available) of the witness(es) below:

Special Agent Anne Frankenberger, 406-855-9332 anne.m.frankenberger@dea.gov

12. Have you filed any of the below regarding the event(s)?

- A police report or law enforcement
- A complaint with another office/agency
- An Expert Review or third party investigator

Yes

13.

- If you said "Yes" above, please enter the name(s) and contact information (phone number and email address as available) of the investigator(s)/expert(s) AND any case number(s) you may have related to the investigation:

Montana Board of Medical Examiners

EXHIBIT 4

From: JOHN FLANNERY jonflan@aol.com
Subject: On going forward thanks for your note. John P. Flannery, II, Esq.
Date: Oct 25, 2026 at 1:53:23 PM
To: Taylor Dugan taylor.dugan2@mt.gov

Dear Taylor,

I quite appreciate the fact that you have other matters that keep you busy. No problem.

That said, I do consider it a fair question you pose about how we consider discovery and related matters.

I'm working on several other matters today, so I'm distracted. But I will conduct my due diligence on your requests. Maybe later this afternoon.

On the other hand, I do have one question, as staff counsel, representing the Department, can you and I agree to vacate the suspension of Dr. Ibsen's medical license?

It not, can the Department grant us an opportunity to be heard, in a separate hearing on vacating the suspension?

Please advise.

Talk to you about your requests that I will review as soon as I can.

All the best,

John

JOHN P. FLANNERY, II, Esq.
202-365-5060
Jonflan@aol.com
www.lawyerflannery.com