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MEDICAL BOARD OF CALIFORNIA
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**BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

In the Matter of the Accusation Against: **EDWARD CHARLES OLSGARD, M.D. 2675 Harris Street Eureka, CA 95503** Physician's and Surgeon's Certificate No. G 25166 Respondent.	Case No. 12-2012-226067 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about July 24, 1973, the Medical Board of California issued Physician's and Surgeon's Certificate Number G 25166 to Edward Charles Olsgard, M.D. (Respondent). The certificate is renewed and current with an expiration date of April 30, 2016.

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JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board),[1] Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2004 of the Code states, in pertinent part:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board."

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division deems proper.

6. Section 2234 of the Code, states, in pertinent part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

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[1] The term "board" means the Medical Board of California. "Division of Medical Quality" shall also be deemed to refer to the Medical Board. (Bus. & Prof. Code, § 2002.)

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence."

7. Section 2242, subdivision (a), of the Code provides that prescribing, dispensing, or furnishing dangerous drugs without an appropriate prior examination and a medical indication constitutes unprofessional conduct.

8. Section 2266 of the Code states: AThe failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.@

9. Section 725 of the Code provides, in part, that repeated acts of clearly excessive prescribing or administering of drugs or treatment as determined by the standard of the community of licensees is unprofessional conduct.

PERTINENT DRUGS

10. The following controlled substances and/or dangerous drugs are involved in this proceeding:

A. **Adderall** is a trade name for **amphetamine** and **dextroamphetamine**, a central nervous system stimulant. Amphetamine is a dangerous drug as defined in section 4022 of the Code, a Schedule II controlled substance as defined by section 11055, subdivision (d) (1) of the Health and Safety Code, and a Schedule II controlled substance as defined by section 1308.12 (d)

of Title 21 of the Code of Federal Regulations. Adderall is used in the treatment of Attention Deficit Hyperactivity Disorder (ADHD). Like all amphetamines, it has a high potential for abuse.

B. **Flurazepam** is a benzodiazepine used to treat sleep disorders. It is a dangerous drug as defined in section 4022 of the Code and a Schedule IV controlled substance as defined in Health and Safety Code section 11057, subdivision (d)(5).

C. **Gabapentin (Neurontin)**, is an anticonvulsant indicated as adjunctive therapy in the treatment of partial seizures with and without secondary generalization in adults with epilepsy. It is also used in adults to treat nerve pain caused by the herpes virus or shingles and to treat restless leg syndrome (RLS). It is a dangerous drug as defined in section 4022 of the Code.

D. **Methadone** is a synthetic narcotic analgesic with multiple actions quantitatively similar to those of morphine. It is a dangerous drug as defined in section 4022 of the Code, a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (c) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (c) of Title 21 of the Code of Federal Regulations. Methadone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of Methadone, and it should be prescribed and administered with the same degree of caution appropriate to the use of morphine. Methadone should be used with caution and in reduced dosage in patients who are concurrently receiving other narcotic analgesics. The usual adult dosage is 2.5 mg. to 10 mg. every three to four hours as necessary for severe acute pain.

E. **MS Contin (morphine sulfate)** is for use in patients who require a potent opioid analgesic for relief of moderate to severe pain. Morphine is a dangerous drug as defined in section 4022 of the Code, a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations. Morphine can produce drug dependence and has a potential for being abused. Tolerance and psychological and physical dependence may develop upon repeated administration. Abrupt cessation or a

sudden reduction in dose after prolonged use may result in withdrawal symptoms. After prolonged exposure to morphine, if withdrawal is necessary, it must be undertaken gradually.

F. **Norco, Vicodin, and Vicodin ES** are trade names for **hydrocodone bitartrate**, a semisynthetic narcotic analgesic. Hydrocodone bitartrate is a dangerous drug as defined in section 4022 of the Code, a Schedule III controlled substance and narcotic as defined by section 11056, subdivision (e) of the Health and Safety Code, and a Schedule III controlled substance as defined by section 1308.13 (e) of Title 21 of the Code of Federal Regulations. Repeated administration of hydrocodone over a course of several weeks may result in psychic and physical dependence. The usual adult dosage is one tablet every four to six hours as needed for pain. The total 24 hour dose should not exceed 6 tablets.

G. **Nortriptyline** is a tricyclic antidepressant used to treat symptoms of depression. It is a dangerous drug as defined in section 4022 of the Code.

H. **Oxycodone hydrochloride** is a white odorless crystalline powder derived from an opium alkaloid. It is a pure agonist opioid whose principal therapeutic action is analgesia. Other therapeutic effects of oxycodone include anxiolysis, euphoria, and feelings of relaxation. Oxycodone is a dangerous drug as defined in section 4022 of the Code, and a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations. Respiratory depression is the chief hazard from all opioid agonist preparations. Oxycodone should be used with caution and started in a reduced dosage (1/3 to 1/2 of the usual dosage) in patients who are concurrently receiving other central nervous system depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers, and alcohol.

I. **Prednisone** is a **glucocorticoid (hydrocortisone and cortisone)**, indicated for the treatment of certain endocrine disorders, rheumatic disorders, collagen diseases, dermatologic diseases, allergic states, ophthalmic diseases, respiratory diseases, hematologic disorders, neoplastic diseases, edematous states, gastrointestinal diseases (ulcerative colitis and regional enteritis), and acute exacerbations of multiple sclerosis, tuberculous meningitis, and trichinosis. It

is a dangerous drug as defined in 4022 of the Code. Glucocorticoids cause profound and varied metabolic effects. In addition, they modify the body's immune responses to diverse stimuli. Psychic derangements may appear when corticosteroids are used, ranging from euphoria, insomnia, mood swings, personality changes, and severe depression to frank psychotic manifestations. Also, existing emotional instability or psychotic tendencies may be aggravated by corticosteroids. A great many adverse reactions are associated with the use of prednisone including fluid retention, congestive heart failure in susceptible patients, hypertension, muscle weakness, loss of muscle mass, tendon rupture, pancreatitis, abdominal distension, facial erythema, convulsions, vertigo, headache, development of Cushingoid state, manifestations of latent diabetes mellitus, posterior subcapsular cataracts, glaucoma, urticaria and other allergic, anaphylactic or hypersensitivity reactions.

J. **Temazepam** is a hypnotic agent, sold under the trade name **Restoril**. It is a dangerous drug as defined in section 4022 of the Code, a Schedule IV controlled substance and narcotic as defined by section 11057, subdivision (d) of the Health and Safety Code, and a Schedule IV controlled substance as defined by Section 1308.14 of Title 21 of the Code of Federal Regulations. Temazepam is indicated for the short-term treatment of insomnia (generally 7-10 days). Patients using temazepam should be warned about the possible combined effects with alcohol and other central nervous system depressants. As with any hypnotic, caution must be exercised in administering temazepam to individuals known to be addiction prone. The recommended usual adult dosage is one 15 mg. tablet before retiring.

K. **Valium** is a trade name for **diazepam**, a psychotropic drug used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022 of the Code, and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code, and a Schedule IV controlled substance as defined by Section 1308.14 of Title 21 of the Code of Federal Regulations. Diazepam can produce psychological and physical dependence and it should be prescribed with caution particularly to addiction-prone individuals (such as drug addicts and alcoholics) because of the predisposition of such patients to habituation and dependence.

L. **Wellbutrin** is a trade name for **bupropion hydrochloride**, an antidepressant of the aminoketone class. It is a dangerous drug as defined in section 4022 of the Code. Wellbutrin is an antidepressant agent chemically unrelated to tricyclic, tetracyclic, or other known antidepressant agents. The incidence of seizures associated with Wellbutrin may exceed that of other marketed antidepressants by as much as fourfold.

M. **Xanax** is a trade name for **alprazolam** tablets. Alprazolam is a psychotropic triazolo analogue of the benzodiazepine class of central nervous system-active compounds. Xanax is used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a schedule IV controlled substance and narcotic as defined by section 11057, subdivision (d) of the Health and Safety Code, and a schedule IV controlled substance as defined by Section 1308.14 (c) of Title 21 of the Code of Federal Regulations, and a dangerous drug as defined in Business and Professions Code section 4022. Xanax has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol and other CNS depressant drugs during treatment with Xanax.

FIRST CAUSE FOR DISCIPLINE

(Re: Patient ES)

(Unprofessional Conduct/Gross Negligence/Negligence/Incompetence/Excessive Prescribing/Inadequate Records)

11. Respondent first saw Patient ES,[2] a 32-year-old woman, on June 29, 2007 for a nursing school pre-entrance physical examination. Respondent's care and treatment of Patient ES was reviewed through December 2012. At the first visit, ES completed a Medical Questionnaire, noting that her medical history included interstitial cystitis[3] and bladder surgery (date and details not noted). ES reported that she was currently taking Norco and that she had been given Xanax for "test taking/speeches for school," but that she did not use it regularly. Vital signs were

[2] Patient names are kept confidential to protect their right to privacy but will be identified to Respondent in discovery.

[3] Interstitial cystitis, also called painful bladder syndrome, is a chronic condition associated with bladder pressure, bladder pain, and sometimes pelvic pain that can range from mild discomfort to severe pain.

recorded and a "normal" examination was noted, but no details of the examination are documented in the record. Respondent noted that ES was taking Norco to treat chronic pelvic pain. Respondent's assessment was "chronic pelvic pain, controlled," and "desire for nursing school entrance." Respondent prescribed Norco 10/325 mg., 60 tablets, as needed for pain.

12. Respondent saw ES on August 28, 2008 to discuss starting the patient on Elmiron[4] for cystitis and weaning ES off of Norco. Respondent noted that ES was being followed by a neurologist and that she had been given a prescription for Elmiron but that she did not take it for very long. ES reported that she was taking 6 Norco per day and that she wanted to get off Norco if possible. Respondent's records do not indicate whether he, or another physician, was prescribing Norco to the patient at this time. Respondent noted an examination. There is no documentation in the record of a discussion regarding ES's desire to get off Norco. Respondent prescribed Norco 10/325 mg., 1-2 tablets every 4-6 hours, #180, 5 refills; and, Elmiron 100 mg., 1 tablet 3 times daily, #100, 11 refills.

13. On or about January 5, 2009, ES underwent a laparoscopic cholecystectomy (gallbladder removal) for chronic cholecystitis. The procedure was performed by a surgeon, not Respondent. ES saw Respondent on January 30, 2009, at which time she reported some increased post-operative pain. ES reported that she was taking up to 12 Norco a day following surgery. ES reported that she tried getting a narcotic other than Norco in order to avoid overuse of Norco. Respondent documented an examination and noted that he emphasized to ES that she not exceed 8 Norco a day to avoid acetaminophen hepatoxicity. Respondent prescribed Oxycodone HCL 5 mg., 1 tablet every 4 hrs. for 10 days, #60.

14. Pharmacy prescribing records indicate that on January 16, 2009, ES filled a prescription from Respondent for Norco 10/325 mg., #180, for 30 days. There is no documentation in Respondent's medical record that he saw the patient on this date, nor that he gave ES a prescription for Norco on or about this date. Respondent's medical record throughout 2009 lists Norco as one of ES's "current medications." However, the only prescription for Norco

[4] Elmiron is a trade name for pentosan, a semi-synthetic drug that resembles the anticoagulant heparin and is used for treating the symptoms of interstitial cystitis.

documented in the record during 2009 was on December 30, 2009 for Norco 10/325 mg., 1-2 tablets every 4-6 hours, #720, 5 refills. Over the course of his treatment of ES, Respondent consistently prescribed large quantities of Norco, increasing the monthly prescription from 180 to 240 pills in February 2009 without explanation in the record, and again increasing from 240 to 300 pills per month in June 2011, without a documented explanation. Pharmacy records indicate that ES routinely filled prescriptions early and that she filled prescriptions at multiple pharmacies.

15. ES saw Respondent on March 5, 2009 and reported that she wanted to see a counselor as she was experiencing increased stress, having difficulty sleeping, and having daytime anxiety. Respondent's plan included referral for psychotherapy and he prescribed Xanax 0.25 mg., 1 tablet every 6 hours as needed, #100, 5 refills. The records contain an authorization request for referral to a therapist. There is no documentation in the record of any follow-up regarding this referral and there is no indication in the record that ES ever saw a therapist. Respondent continued to prescribe Xanax to ES for generalized anxiety during the time period his care was reviewed. Over the course of his treatment of ES, Respondent increased ES's prescription for Xanax to 0.5 mg., #120 in or about December 2009, to #180 in or about June 2011, and to #240 in or about February 2012, all without documentation of the reasons for increasing the prescription amounts.

16. Respondent saw ES on December 27, 2012 to go over her medications. ES signed a pain contract with Respondent on this date.

17. There is no documentation in the record of a complete history and physical exam being done. Past medical records were not obtained and there are no details in the record of ES's prior treatments with Norco or Xanax. Substance abuse history is not noted in the record, nor is documentation of treatment for the interstitial cystitis. There is no documentation of assessment of ES's pain or the effect of the symptoms on activities of daily living. There is no documentation anywhere in the record of the patient's level of pain throughout the 5 years of Respondent's treatment of ES that was reviewed. Respondent failed to document objectives of treatment and/or a treatment plan. Respondent failed to document all prescriptions issued to ES in the medical record. Respondent's medical record documentation is at times garbled and incomprehensible.

18. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, and/or 2234(b), and/or 2234(c) of the Code in that Respondent was grossly negligent, and/or committed repeated negligent acts, and/or was incompetent in the practice of medicine in his care and treatment of Patient ES, including but not limited to the following:

A. Respondent failed to conduct or to document that he conducted a complete history and physical examination.

B. Respondent undertook to treat Patient ES for chronic pelvic pain related to interstitial cystitis, prescribing high doses of narcotic and sedative medications, without obtaining prior treatment records and without conducting the necessary examination and assessment and documentation of clinical symptoms of the condition to support his diagnosis or the prescribing of medication.

C. Respondent failed to document a treatment plan, objectives of treatment, or ES's response to treatment.

D. Respondent prescribed short-acting opioids without any documented rationale and dosages were increased without documentation of the rationale for the increases.

E. Respondent failed to obtain and document informed consent from ES until December 2012, after he had been treating the patient for over 5 years.

F. Respondent failed to conduct periodic review of the patient, such as pain levels, activity levels, and response to treatment or consideration of alternative treatments.

G. Respondent failed to consider referring ES for treatment of interstitial cystitis, anxiety, and/or drug detoxification.

H. Respondent failed to monitor the patient's medication use for early refills and he failed to consider drug diversion or abuse in spite of evidence that this might be a concern.

19. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, and/or 2242, and/or 725 of the Code in that he inappropriately and excessively prescribed high doses of Norco and Xanax for Patient ES, without an appropriate prior medical examination and medical indication.

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20. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, and/or 2266 of the Code in that he failed to keep adequate and accurate records related to his care and treatment of Patient ES, including but not limited to the following:

A. Respondent's medical record fails to adequately document a patient history, medical examination, assessment, treatment plan, objectives of treatment, response to treatment, informed consent, or rationale for the medications prescribed.

B. Respondent's medical record fails to adequately document a medical basis or indication for the ongoing prescribing of controlled substances, or to document physical examination findings that supported his clinical diagnoses.

C. Respondent's medical record fails to accurately and/or completely document all medications prescribed to Patient ES.

D. Respondent's medical record documentation is at times garbled and incomprehensible.

SECOND CAUSE FOR DISCIPLINE

(Re: Patient DA)

(Unprofessional Conduct/Gross Negligence/Negligence/Incompetence/Excessive Prescribing/Inadequate Records)

21. Patient DA, a 45-year-old male truck driver, was first seen by Respondent on August 18, 2005, for evaluation of arthritis in his fingers, cervical radiculopathy, a thyroid disorder, a possible hernia, and emphysema. The patient reported having triple bypass surgery in December 2004, at which point he stopped smoking and was started on Lipitor and low dose aspirin. DA reported using Vicodin ES "sometimes" for chronic neck pain and Temazepam 15 mg. occasionally for insomnia. The patient completed a medical questionnaire reporting medical history and Respondent documented a physical examination. No medications were prescribed on this date. In December 2005 and July 2006, Respondent saw DA in follow up regarding his coronary heart disease and hyperlipidemia and hypothyroidism.

22. On May 3, 2007, DA saw Respondent regarding a lump on his right foot. Examination revealed a small abscess, which was drained and covered. Respondent prescribed

Septra, a combination antibiotic, for 10 days. DA was next seen by Respondent on December 5, 2007, at which time DS reported that he had claudication[5] and would be having leg stent surgery. DA asked Respondent to place him on disability because he was unable to drive due to the pain in his leg. Respondent placed DS on disability with an estimated return to work date in March 2008.

23. Respondent next saw DA on May 27, 2009, in follow-up regarding his hyperlipidemia, coronary and peripheral vascular disease and hypothyroidism. DA reported he had a peripheral vascular procedure done during his absence. Respondent noted that DA was on pain medication. Respondent documented an examination and he prescribed Vicodin ES 7.5/750 mg., 1-2 tablets every 4 hours, #180, 5 refills, and Flurazepam HCL 30 mg., 1 tablet at bedtime, #30, 5 refills. Respondent did not document a medical indication for the prescriptions.

24. Pharmacy prescribing records for Patient DA indicate that as early as January 7, 2009, DA began receiving monthly prescriptions for Vicodin ES 7.5/750 mg., #180 and Flurazepam 30 mg., #30 from Respondent. Respondent's records do not document prescribing of these medications to DA until the progress note of May 27, 2009. Pharmacy prescribing records indicate that DA received monthly prescriptions for Vicodin ES #180 through August 2010.

25. Respondent saw DA on August 21, 2010 and for the first time documented that the patient was taking Vicodin ES for cervical degenerative disc disease, at "perhaps 5 to 6 doses a week," and Flurazepam for sleep once or twice a month. Respondent also noted that DA was also taking some plain Tylenol. Respondent noted that DA appeared well, that cervical range of motion was diminished but no radicular pain with extension, no weakness, and no atrophy in the upper extremities. Respondent discontinued Vicodin ES and started DS on Norco 10/325 mg., 1 tablet every 6 hrs. as needed, #100, 5 refills.

26. On March 9, 2011, Respondent saw DA for an examination for a commercial driver's license. The Health History section of the DMV Medical Examination Report was left blank and Respondent noted no abnormal findings on examination. Peripheral pulses were marked as

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[5] Claudication is pain caused by too little blood flow during exercise. This condition generally affects the blood vessels in the legs, but it can affect the arms, too. Most often, claudication is a symptom of peripheral artery disease.

normal. Respondent certified that DA met the required standards and that he was qualified for a 2 year certificate. No mention is made in the progress note nor on the Examination Report of DA's narcotic and benzodiazepine medication use. Respondent increased DA's monthly Norco prescription from #100 per month to #240, without explanation in the record for the increased amount.

27. On August 6, 2011, Respondent saw DA for shingles and apparent restenosis of the peripheral arteries. Respondent's prescriptions on this date included Norco 10/325 mg., #240, 5 refills and Gabapentin 300 mg., 3 times per day, #90. On December 17, 2011, Respondent saw DA in follow up and prescribed Norco 10/325 mg., #720, 1 refill. No explanation is documented in the record for the increased amount. Respondent's records indicate that DA was seen on January 19, 2012 and given another prescription of Norco #720, 1 refill.

28. On April 28, 2012, DA was seen by Respondent for a medication check. Respondent prescribed Norco #720, 5 refills. Pharmacy records indicate that the patient was dispensed the following amounts of Norco prescribed by Respondent: on 12/17/2011, #720; on 3/12/2012, #480; on 4/25/2012, #270; on 6/22/2012, #720; and, on 9/18/2012, #720. DA also received prescriptions for Norco #50 on 7/30/2012 and Norco #60 on 8/6/2012, both prescribed by a physician other than Respondent. Respondent's records do not address the fact that DA was filling prescriptions early or that he was receiving prescriptions for Norco from other prescribers.

29. Respondent saw Patient DA on August 8, 2012, and impression was "peripheral vascular disease status post bypass left leg." DA complained of low back pain. Plan included lumbar spine films. Respondent noted that Norco was adequate during the day but that it did not allow the patient to sleep at night. Respondent added Methadone 10 mg., 1-2 at bedtime, #100, to DA's prescribed medications. This is very unusual to prescribe Methadone only one time per day. Respondent failed to document an explanation for the addition of Methadone to DS's prescribed medications. Lumbar spine x-rays taken on October 30, 2012, showed mild degenerative changes with no indication of any painful process. Methadone was refilled on October 31, 2012, at which time Respondent noted that DA was also taking lorazepam, a benzodiazepine used to treat anxiety

disorders, for occasional insomnia. Respondent's records do not document that he prescribed lorazepam to Patient DA.

30. Respondent last saw Patient DA on November 30, 2012 for a recheck. Respondent prescribed Norco #720, 5 refills and Methadone #100. At his Medical Board interview on October 29, 2013, Respondent reported that he "dismissed" DA from his practice on December 18, 2012, after he learned that DA attempted to obtain an early refill of Norco. Respondent did not document the event in the patient record.

31. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, and/or 2234(b), and/or 2234(c) of the Code in that Respondent was grossly negligent, and/or committed repeated negligent acts, and/or was incompetent in the practice of medicine in his care and treatment Patient DA, including but not limited to the following:

A. Respondent failed to obtain and document clear indication of a medical condition that required the high-dose controlled substances that were prescribed.

B. Respondent failed to document a treatment plan, objectives to treatment, or DA's response to treatment.

C. Respondent prescribed opioids for several years without any documented rationale and dosages were increased without documentation of the rationale for the increases.

D. Respondent failed to obtain and document informed consent to treatment.

E. Respondent failed to conduct periodic review of the patient, such as pain levels, and response to treatment or consideration of alternative treatments.

F. Respondent failed to monitor the patient's medication use for early refills and he failed to consider drug diversion or abuse in spite of evidence that this might be a concern.

G. Respondent failed to accurately and completely report on the patient's medical conditions on the DMV Medical Examination Report and whether any medical condition interfered with DA's ability to operate a commercial vehicle; and, he failed to report that DA was taking short-acting opiates every 6 hours as needed.

H. Respondent failed to advise and document that he had discussed with DA precautions and/or prohibitions regarding the use of controlled substances and driving.

I. Respondent failed to provide DA with notice that he would be terminating the physician-patient relationship and to provide DA with a tapering dose prescription of his controlled substance medications.

32. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, and/or 2242, and/or 725 of the Code in that he inappropriately and excessively prescribed high doses of Norco for Patient DA, without an appropriate prior medical examination and medical indication.

33. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, and/or 2266 of the Code in that he failed to keep adequate and accurate records related to his care and treatment of Patient DA, including but not limited to the following:

A. Respondent's medical records fail to adequately document a treatment plan, objectives to treatment, response to treatment, informed consent, or rationale for the medications prescribed.

B. Respondent's medical records indicate that he prescribed controlled substances for pain for several years to Patient DA without documentation of the pain for which the controlled substances were prescribed.

C. Respondent's medical records fail to document an explanation for the prescribing of Methadone.

D. Respondent's medical records fail to adequately document a medical basis or indication for the ongoing prescribing of controlled substances, or to document physical examination findings that supported his clinical diagnoses.

E. Respondent's medical records fail to accurately and/or completely document all medications prescribed to Patient DA.

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THIRD CAUSE FOR DISCIPLINE

(Re: Patient RA)

(Unprofessional Conduct/Gross Negligence/Negligence/Incompetence/Excessive Prescribing/Inadequate Records)

34. Patient RA, a 53-year-old man, has been a patient of Respondent's for over 10 years. Respondent's records document that RA was treated for chronic low back pain, knee pain, neck pain, and insomnia. On July 27, 2007, Respondent saw RA for a complaint of shortness of breath with exertion. Respondent noted that due to new insurance, the patient needed a new prescription for Vicodin, Temazepam, and Flonase. Evaluation was normal. Plan included scheduling an EKG stress test. Respondent prescribed Vicodin 5/500 mg., 1-2 tablets every 4 hrs. as needed, #300, 6 refills. An in-office exercise treadmill test on August 29, 2007, was negative.

35. On December 5, 2007, Respondent saw RA with a complaint of worsening symptoms due to a deviated septum. Respondent noted that RA was on Prevacid[6] and would like to try Prilosec, a proton pump inhibitor, due to its lower cost. Respondent also noted that RA wanted to switch from 6 Vicodin daily to 3 Norco at the suggestion of his pharmacist. Respondent documented an exam. No pain is documented in the history or on physical examination. Respondent's assessment was chronic peptic disease, chronic low back pain, and symptomatic snoring. The patient was given a referral for consideration of an anti-snoring procedure. Respondent prescribed a trial of Prilosec, Norco 10/325 mg., 1 tablet every 6 hours as needed, #200, 5 refills, and Temazepam 30 mg. 1-2 tablets at bedtime, 5 refills.

36. Respondent's records contain a hospital emergency department report of February 2, 2008, regarding examination of RA following a motor vehicle accident. RA is reported to have T-boned another vehicle that pulled in front of him while exiting a parking lot. RA complained of right knee and foot pain, and right-sided chest wall discomfort. RA was examined. Documented past medical history included knee surgeries on both knees. Impression was right foot pain,

[6] Prevacid (lansoprazole) belongs to a group of drugs called proton pump inhibitors. Prevacid decreases the amount of acid produced in the stomach. It is used to treat and prevent stomach and intestinal ulcers, erosive esophagitis, and other conditions involving excessive stomach acid.

possible fracture and multiple aches secondary to the accident. RA declined an x-ray of the right foot stating that he would follow up with his doctor.

37. Respondent saw RA on February 7, 2008, at which time RA reported that he was seeing a podiatrist that afternoon regarding right foot pain. At RA's request, Respondent provided a referral to an orthopedist regarding right knee pain. On March 5, 2008, RA saw Respondent and reported that he was scheduled for right knee arthroscopic exploration. RA reported that the knee pain had caused back pain and that he was using more pain medicine. Respondent examined the right knee and prescribed Vicoprofen[7] 10/200 mg., 1 every 4 hours as needed for 30 days, #180, and Temazepam 30 mg., 1 daily for 30 days, #30. There is no documentation in the medical record regarding the indication for Temazepam.

38. Respondent next saw RA on June 6, 2008 for a complaint of left hand pain. A history of negative evaluations for Carpal Tunnel Syndrome is noted. RA complained of an exacerbation of osteoarthritis in the knee and reported that he was using up to 8 Norco a day. Exam of the left hand was essentially normal; x-ray of the hand was normal. Impression included overuse injury left hand and chronic back pain. There is no examination noted nor discussion in the record regarding back pain. Respondent prescribed Norco 10/325 mg., 2 every 6 hours as needed, #240, 5 refills and Temazepam 30 mg., 1-2 tablets at bedtime as needed, #100, 5 refills.

39. Respondent's records contain an ENT consultation report of October 14, 2008 regarding an exam of RA for obstructed breathing. RA reported that he takes Vicodin 4 times daily for knee pain and Temazepam for sleep. The ENT consultant reported that RA was going to try to discontinue the two medications and discuss alternatives with Respondent because RA attributed his insomnia to the Vicodin and use of Temazepam to treat the insomnia.

40. On October 30, 2008, Respondent saw RA for a complaint of flare up of right knee pain. Respondent's records do not document a discussion regarding RA's reported wish to discontinue taking pain and sleep medications nor regarding any alternatives to the medications. Respondent prescribed Norco #240, 5 refills, and Temazepam #100, 5 refills.

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[7] Vicoprofen contains a combination of hydrocodone and ibuprofen. Vicoprofen is used short-term to relieve severe pain.

41. On February 2, 2009, Respondent saw RA for a complaint of right hand pain. Chronic back pain is noted. Range of motion of the wrist was normal and x-ray of the wrist was noted to be negative. Respondent increased Norco to #720 and 5 refills were given. There is no explanation in the record for the increased amount of Norco prescribed. On April 1, 2009, Respondent again saw RA for a complaint of right wrist pain. Respondent again prescribed Norco #720, 5 refills, and he prescribed Temazepam 30 mg., 2 tablets a bedtime, #200, 5 refills. Respondent's records do no document an explanation for the increased amount of Temazepam prescribed.

42. On August 13, 2009, Respondent saw RA for a complaint of right shoulder pain. Respondent prescribed Temazepam #200, 5 refills. On December 28, 2009, Respondent saw RA and noted that RA had seen an orthopedist and that he had postsurgical arthritis in his right knee. RA reported that he was still not sleeping well and asked to try Ambien instead of Temazepam. Respondent prescribed Ambien 10 mg., 1 as needed at bedtime, #100, 5 refills.

43. Pharmacy prescribing records for Patient RA indicate that during 2009, RA obtained prescriptions for Norco and Temazepam far in excess of the amounts documented by Respondent in the medical record. For example, pharmacy records indicate that RA was dispensed, from multiple pharmacies, Norco #240 prescribed by Respondent on the following dates: 7/8/2009, 8/2/2009, 8/13/2009, 8/26/2009, 9/7/2009, 9/19/2009, 10/1/2009, 10/14/2009, 10/26/2009, 11/12/2009, 11/19/2009, 12/6/2009, and 12/14/2009. In addition, pharmacy records indicate that RA was dispensed the following amounts of Temazepam, from multiple pharmacies, prescribed by Respondent: on 8/2/2009, #100; on 8/13/2009, #200; on 8/14/2009, #100; on 8/18/2009, #100; on 8/25/2009, #100; on 9/29/2009, #200; on 11/12/ 2009, #180; on 13/3/2009, #180; and, on 12/15, 2009, #180. Respondent's medical records for Patient RA fail to address the excessive amounts of Norco and Temazepam the patient was obtaining from multiple pharmacies during 2009.

44. On January 15, 2010, Respondent saw RA for a complaint of back pain. Respondent diagnosed lumbago. On March 17, 2010, RA was seen for back pain which Respondent diagnosed as possible right sciatica. Respondent prescribed Prednisone 20 mg., 2 daily, #14,

without explanation in the record. On May 7, 2010, RA reported worsening pain radiating down the left leg and right foot numb. Respondent again prescribed Prednisone 20 mg., 2 daily, #30.

45. On July 17, 2010, RA reported exacerbation of chronic neck and back pain from driving long distances. Respondent's plan was "continue present narcotic regimen patient does wish to increase those 12 Valium 5 to 10 mg. q.6 hours as needed." Respondent's records, however, do not document that he was prescribing Valium to RA at or about this time. Respondent prescribed Valium 5 mg., 1-2 every 6 hours as needed, #60, 5 refills. Respondent continued to see RA throughout the remainder of 2010 for complaints of back pain and right knee and foot pain.

46. Respondent's records throughout 2010 document that RA's "current medications" included Norco and Temazepam. However, other than the prescription for Valium provided on July 17, 2010 and the prescriptions for Prednisone provided on March 17 and May 7, 2010, Respondent's progress notes for 2010 do not document that he gave RA any other prescriptions for controlled substances for pain. Pharmacy prescribing records for Patient RA indicate that during 2010, RA was dispensed, from multiple pharmacies, Norco #240 prescribed by Respondent on, e.g., the following dates: 1/4/2010, 1/14/2010, 2/8/2010, 3/5/2010, 3/19/2010, 3/29/2010, 4/12/2010, 4/22/2010, 5/6/2010, 5/7/2010, 5/17/2010, 10/5/2010, 10/8/2010, 10/31/2010, 11/5/2010, 11/30/2010, 12/2/2010, 12/22/2010, 12/26/2010, and 12/29/2010. This pattern of the patient receiving multiple prescriptions for a month's worth of Norco during a single month continued throughout 2011 and 2012.

47. Pharmacy records show a similar pattern of Respondent excessively prescribing Temazepam to Patient RA. For example, pharmacy records indicate that RA was dispensed, from multiple pharmacies, the following amounts of Temazepam prescribed by Respondent during 2010: on 1/15/2010, #200; on 3/9/2010, #60; on 3/10/2010, # 60; on 4/14/2010, #60 from two different pharmacies; on 5/8/10, #60; on 5/9/2010, #200; on 5/11/2010, #60; on 6/2/2010, #60; on 10/26/2010, #60; on 11/5/2010, #200; on 11/20/2010, #60; and, on 12/26,2010, #60. This pattern of the patient receiving multiple prescriptions of Temazepam during some months continued during 2011 and 2012. Respondent's medical records for Patient RA fail to address the excessive

amounts of Norco and Temazepam the patient was obtaining from multiple pharmacies throughout the years 2010 through 2012.

48. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, and/or 2234(b), and/or 2234(c) of the Code in that Respondent was grossly negligent, and/or committed repeated negligent acts, and/or was incompetent in the practice of medicine in his care and treatment Patient RA, including but not limited to the following:

A. Respondent failed to obtain and document clear indication of a medical condition that required the high-dose controlled substances that were prescribed.

B. Respondent failed to document a treatment plan, objectives to treatment, or RA's response to treatment.

C. Respondent prescribed opioids for several years without any documented rationale and dosages were increased without documentation of the rationale for the increases.

D. Respondent failed to obtain and document informed consent to treatment.

E. Respondent failed to conduct periodic review of the patient, such as pain levels, review of CURES Reports, and response to treatment or consideration of alternative treatments.

F. Respondent failed to monitor the patient's medication use for early refills and he failed to consider drug diversion or abuse in spite of evidence that this might be a concern.

G. Respondent failed to advise and document that he had discussed with RA precautions and/or prohibitions regarding the use of controlled substances and driving.

49. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, and/or 2242, and/or 725 of the Code in that he inappropriately and excessively prescribed high doses of Norco and Temazepam for Patient RA, without an appropriate prior medical examination and medical indication.

50. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, and/or 2266 of the Code in that he failed to keep adequate and accurate records related to his care and treatment of Patient RA, including but not limited to the following:

A. Respondent's medical records fail to adequately document a treatment plan, objectives to treatment, response to treatment, informed consent, or rationale for the medications prescribed.

B. Respondent's medical records indicate that he prescribed controlled substances for pain for several years to Patient RA without documentation of the pain for which the controlled substances were prescribed.

C. Respondent's medical records fail to adequately document a medical basis or indication for the ongoing prescribing of controlled substances, or to document physical examination findings that supported his clinical diagnoses.

D. Respondent's medical records fail to accurately and/or completely document all medications prescribed to Patient RA.

E. Respondent's medical record documentation is at times garbled and incomprehensible.

FOURTH CAUSE FOR DISCIPLINE

(Patient SP)

(Unprofessional Conduct/Gross Negligence/Negligence/Incompetence/Excessive Prescribing/Inadequate Records)

51. Patient SP is a 59-year-old woman who began treatment with Respondent in 2000. She was treated continuously by Respondent for back pain, knee pain, anxiety, depression and other medical problems until she was dismissed from Respondent's practice in December 2012 for abusing her medications. Respondent's records document that SP had a history of alcohol dependency and abuse, including binge drinking, and that she lived in a social situation that Respondent referred to at various points in the medical record as "stressful."

52. At the initial visit on June 7, 2000, SP complained of chronic low back pain, not the result of an injury, and Temporomandibular joint (TMJ) Syndrome. Respondent documented that SP requested, and that he gave her, a prescription for medical marijuana. Respondent's records document that over the next several years, Respondent saw SP on a regular basis and treated her

with Vicodin and Norco for pain, Wellbutrin for depression, Valium for sleep, and he authorized the patient's use of medical marijuana.

53. Respondent's medical records for SP do not document a coordinated treatment plan and nowhere in the records does Respondent discuss objectives to treatment. There is no documentation of SP's pain level and no determination or quantification of the patient's response to treatment. Respondent's records do not document a work up that actually provided any indication of the patient's pathology and cause of her pain. SP's pain is never described in the records in terms of location, intensity, character, effects of activities, or benefits from the medications. The patient was known to be an alcoholic and the medical records document multiple red flags indicating possible abuse of controlled substances. For example, on October 5, 2006, Respondent documented that SP was taking 15-18 Vicodin per day when she had been prescribed only 6 per day. On October 30, 2006, it was again noted that the patient was overusing Vicodin. On December 15, 2006 SP was noted to be binge drinking.

54. Respondent saw SP on January 11, 2007, regarding left hip and back pain. SP reported running out of Vicodin because she was overusing it and she reported that Vicodin and Norco were not controlling her pain. Respondent noted that SP appeared anxious and pained. Respondent discontinued Vicodin and Norco and he prescribed methadone 10 mg., 1-2 every 6 hours. On January 16, 2007, SP reported that she felt much better.

55. On February 16, 2007, SP reported that she ran out of methadone 2 days prior and had been sweating, shaking, and having diarrhea since. SP was noted to be tremulous, pale, and diaphoretic. Vital signs were normal. Respondent cautioned SP against opiate withdrawal and advised her that she needed to let him know so that he could fill her prescription before this happened again. Respondent prescribed methadone 10 mg., 2 tablets every 6 hours, #240. On April 3, 2007, Respondent saw SP and noted that her pain was controlled with the prescribed amount of methadone. Respondent gave SP a prescription for methadone #720 for 3 months. On July 10, 2007, Respondent saw SP and prescribed Norco for breakthrough pain. The dosage and quantity is not documented in the medical record.

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56. On August 27, 2008, Respondent saw SP for a medication check and noted that she was using methadone 20 mg. a day and Norco "more infrequently." SP reported that she was drinking a 14 oz. drink of vodka daily usually and she reported thinking that her short-term memory was somewhat impaired. Respondent prescribed Valium 5 mg., 1-2 tablets every 6 hours, #60, 5 refills and Norco 10/325 mg., 1-2 tablets every 4 hours, #100, 5 refills.

57. On October 24, 2008, SP reported having fatigue and "perhaps short-term memory impairment." SP reported that her employer felt she was impaired at work a couple of times. Respondent noted that SP was still having one large vodka drink at night, using Valium 10-15 mg. in the morning, methadone 30 mg. in the morning, and "maybe" marijuana. Impression was anxiety, depression, probable narcotic Valium cognitive impairment. Plan was to gradually reduce dose of both Valium and methadone. On November 20, 2008, SP reported reducing methadone use to 10 mg., 3 times a day, 6-8 Norco a day, and 15 mg. of Valium a day. She reported functioning much better and no longer seemed impaired to her employer. Respondent prescribed methadone #100, and Norco #240, 5 refills.

58. On August 13, 2009, SP reported that she regularly drank herself to sleep and would blackout and feel poorly the day afterward. She reported that she stopped drinking one week prior. Respondent prescribed methadone #100.

59. On January 13, 2010, SP reported that her knee gave out 2 weeks prior causing her to fall and injure her tail bone and that she had pain since the incident. Respondent increased methadone 10 mg. to 1 tablet 4 times daily.

60. Respondent's records document that throughout 2010 he prescribed SP methadone 10 mg., 4 times daily and Norco 10/325 mg., 2 tablets 4 times daily. Pharmacy records, however, indicate that SP was dispensed medications, from multiple pharmacies, in excess of the amounts documented by Respondent. For example, pharmacy records indicate that SP was dispensed the following quantities of methadone 10 mg. prescribed by Respondent: on 7/9/10, #100 and on 7/17/2010, # 360; on 11/20/2010, #360 and on 12/7/2010, #360. Pharmacy records indicate that SP was dispensed Norco #240 prescribed by Respondent on: 4/1/2010, 4/22/2010, 5/6/2010, 5/26/2010, 6/11/ 2010, 7/7/2010, 8/6/2010, 9/2/2010, 9/28/2010, 11/1/2010, 11/29/2010, and

12/22/2010. The patient also filled prescriptions from Respondent for Norco #720 on 7/17/2010, 10/18/2010, and 12/22/2010. Respondent's medical records fail to address the excessive amounts of methadone and Norco the patient was obtaining from multiple pharmacies during 2010.

61. On February 25, 2011, Respondent saw SP to review her medications. Respondent noted on examination that SP appeared slightly sleepy with meiotic pupils. Plan was to continue her medications. Respondent prescribed Norco #720, 5 refills. Respondent's records document that at SP's prior visit, on December 4, 2010, he gave SP a prescription for Norco #720, 5 refills. The prescribed dosage remained at 2 tablets, 4 times daily.

62. On May 25, 2010, SP complained of increased back pain. SP reported being off methadone but stated that she wanted to resume taking it. Respondent prescribed Norco #720, 5 refills and Prednisone 20 mg. 2 tablets daily, #20. Respondent's records do not document that he prescribed methadone on this date. However, pharmacy records indicate that SP was dispensed methadone 10 mg. #360 on this date, prescribed by Respondent. On July 2, 2011, Respondent saw SP and again prescribed Prednisone #20, 4 refills.

63. On August 26, 2011, Respondent documented that SP was using "a bit more" Norco. Respondent prescribed Norco #720, 5 refills, and increased the daily dosage to 2 tablets, 5 times daily. On November 9, 2011, Respondent increased SP's methadone dose to 1.5 tablets, 4 times daily without explanation in the record. Respondent prescribed methadone 10 mg., # 180 and Norco, #900.

64. Pharmacy records show that throughout 2011, SP was dispensed, from multiple pharmacies, excessive quantities of Norco prescribed by Respondent. For example, pharmacy records show that SP was dispensed Norco #720 on: 1/20/2011, 3/11/2011, 4/8/2011, 4/20/2011, 7/7/2011, 7/19/2011; 9/1/2011, 10/16/2011, 11/16/2011, and 12/28/2011. During this same time period pharmacy records show that SP was dispensed methadone #360 prescribed by Respondent on: 2/23/2011, 5/25/2011, 8/4/2011; and, on 10/1/2011, #120; on 11/1/2011, #56; on 11/20/2011, #180; and, on 12/27/2011, #540.

65. On May 10, 2012, Respondent saw SP and added MS Contin 60 mg., 1 tablet 3 times daily to her medication regimen. On June 1, 2012, SP reported that she was having difficulty

filling her prescriptions as the pharmacists said she was getting early refills. SP stated that she was not getting early refills. Respondent increased MS Contin to 100 mg., 1 tablet 3 times daily. There is no documentation in medical record that Respondent discussed medication overuse or abuse with Patient SP.

66. Respondent continued SP on the regimen of Norco and methadone throughout the remainder of 2012. Pharmacy records indicate that SP continued to receive excessive quantities of Norco prescribed by Respondent as follows: #720 on 1/27/2012, 3/14/2012, 6/12/2012, 9/15/2012, and 10/18/2012; and, #900 on 3/8/2012 and 6/20/2012. Pharmacy records show that during this same time period SP was dispensed methadone 10 mg. #540 prescribed by Respondent on: 3/8/2012, 3/25/2012, 6/1/2012, 6/23/2012, 9/20/2012 and 9/24/2012.

67. Respondent stated at his Medical Board interview on October 19, 2013, that he dismissed Patient SP from his practice when he learned that she had attempted to fill both an original prescription for Norco and methadone and a duplicate prescription he had given her when she reported that the original prescription had been destroyed. Respondent's medical record does not document that he provided SP with a duplicate prescription, nor that he terminated SP from his practice.

68. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, and/or 2234(b), and/or 2234(c) of the Code in that Respondent was grossly negligent, and/or committed repeated negligent acts, and/or was incompetent in the practice of medicine in his care and treatment Patient SP, including but not limited to the following:

A. Respondent failed to obtain and document clear indication of a medical condition that required the high-dose controlled substances that were prescribed.

B. Respondent failed to document a treatment plan, objectives to treatment, or SP's response to treatment.

C. Respondent prescribed opioids for several years without any documented rationale and dosages were increased without documentation of the rationale for the increases.

D. Respondent failed to obtain and document informed consent to treatment.

E. Respondent failed to conduct periodic review of the patient, such as pain levels, activity levels, and review of CURES Reports, and response to treatment or consideration of alternative treatments.

F. Respondent failed to monitor the patient's medication use for early refills and he failed to consider drug diversion or abuse in spite of evidence that this might be a concern.

G. Respondent failed to consider and/or failed to refer SP to a pain specialist or for substance abuse treatment.

H. Respondent failed to provide SP with notice that he would be terminating the physician-patient relationship and to provide and/or recommend to SP a tapering dose of her controlled substance medications.

69. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, and/or 2242, and/or 725 of the Code in that he inappropriately and excessively prescribed high doses of Norco and methadone for Patient SP, without an appropriate prior medical examination and medical indication.

70. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, and/or 2266 of the Code in that he failed to keep adequate and accurate records related to his care and treatment of Patient SP, including but not limited to the following:

A. Respondent's medical records fail to adequately document a treatment plan, objectives to treatment, response to treatment, informed consent, or rationale for the medications prescribed.

B. Respondent's medical records indicate that he prescribed controlled substances for pain for several years to Patient SP without documentation of the pain for which the controlled substances were prescribed.

C. Respondent's medical records fail to adequately document a medical basis or indication for the ongoing prescribing of controlled substances, or to document physical examination findings that supported his clinical diagnoses.

D. Respondent's medical records fail to accurately and/or completely document all medications prescribed to Patient SP.

E. Respondent's medical record documentation is at times garbled and incomprehensible.

FIFTH CAUSE FOR DISCIPLINE

(Patient RT)

(Unprofessional Conduct/Gross Negligence/Negligence/Incompetence/Excessive Prescribing/Inadequate Records)

71. Patient RT, a 55-year-old man, has been a patient of Respondent's for over 10 years. Respondent's records document that RT's medical history included controlled hypertension, obesity, dependent edema, and chronic obstructive pulmonary disease (COPD). Respondent documented that RT was a smoker. He was treated by Respondent for chronic neck, low back, ankle and foot pain. At his Medical Board interview, Respondent reported that RT was disabled on the basis of cervical spondylosis and cervical degenerative disc disease. Respondent's records document that he saw Patient RT between 3 to 5 times per year regarding his ongoing medical conditions.

72. On May 29, 2007, Respondent saw RT for a 3-month check up. Medications were noted to include methadone 70 mg., 3 times daily; D-amphetamine 30 mg., 3 times daily to counter the sedating effect of methadone; Norco for breakthrough pain; Nortriptyline, a tricyclic antidepressant; and, Baclofen, a muscle relaxer and antispastic agent. Respondent noted that RT appeared "chronically ill." Assessment was chronic neck and back pain, COPD, and hypertension. Plan was to continue medication regimen. Respondent documented that prescriptions for methadone and D-amphetamine were written, but the dose and quantity are not noted in the record.

73. On July 9, 2008, Respondent saw RT and noted that RT had "changed" his methadone dose to 60 mg., 4 times a day from 70 mg. 3 times a day, and that he had changed his D-amphetamine dose from 30 mg., 3 times a day to 20 mg., 4 times a day. Respondent prescribed methadone HCL 10 mg., 6 tablets 4 times a day, and Dextroamphetamine sulfate 10 mg., 2 tablets 4 times a day.

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1 74. On January 15, 2009, RT reported he was using more Norco because he was having
2 more pain. RT asked to increase his methadone dose to 80 mg., 4 times a day. BP was 170/82.
3 No inquiry is documented as to whether the patient had cardiac symptoms and no EKG was done.
4 Impression included chronic pain with probable increasing narcotic tolerance. Respondent's
5 prescriptions included Norco 10/325 mg., 1-2 tablets every 4 hours as needed, #90, 5 refills,
6 methadone HCL 10 mg., 6 tablets 4 times daily, #700, and Dextroamphetamine sulfate 10 mg., 2
7 tablets 4 times daily, #270. Respondent's "Current Medications" list for RT on February 26,
8 2009, indicates that RT's methadone dose is 8 – 10 mg. tablets 4 times daily.
9 75. On April 15, 2009, Respondent saw RT and prescribed methadone 10 mg., 8 tablets 4
10 times daily, #1000 and Dextroamphetamine sulfate 10 mg., 2 tablets 4 times daily, #360.
11 Respondent continued RT's prescriptions at this dosage throughout the remainder of 2009.
12 76. On January 28, 2010, RT reported that he had decreased his dose of D-amphetamine
13 from 20 mg. 4 times a day to 10 mg. 4 times a day. Respondent prescribed methadone #1000 and
14 D-amphetamine #180. On April 23, 2010, Respondent noted that RT had reduced his dose of
15 amphetamines, but the medication list does not indicate a change. Respondent prescribed
16 methadone #1000. No prescription for amphetamine is noted in the record.
17 77. Respondent saw RT on July 23, 2010 at which time BP was 170/98. No discussion of
18 cardiac complaints is noted. Respondent noted that RT was not smoking. The patient reported
19 increasing his baclofen and nortriptyline to twice a day from once a day. Respondent prescribed
20 nortriptyline HCL 75 mg., 1 tablet twice daily, #200, 11 refills and baclofen 10 mg., 1 tablet twice
21 daily, #200, 11 refills. On November 4, 2011, RT reported that his pain control was stable
22 although he increased his methadone dose to 100 mg. 4 times a day. Respondent prescribed
23 methadone #1200.
24 78. On March 4, 2011, RT reported that he was feeling somewhat more short of breath
25 and was having more dyspnea on exertion. The patient denied chest pain or palpitations.
26 Impression included COPD with worsening oxygen saturation and increasing obesity. Plan was
27 weight loss, diet, and exercise. Respondent prescribed methadone #1200 and D-amphetamine
28 #130. On July 7, 2011, RT was seen by Respondent and BP was 160/90. No inquiry into cardiac

or respiratory symptoms is noted. Plan was to monitor home BP, limit salt intake and attempt 5 pound weight loss. No prescriptions are noted. Pharmacy records indicate that RT was dispensed methadone 10 mg., #1200 monthly throughout 2011, and that he was dispensed D-amphetamine 10 mg., #120 to #130 from January through September 2011, prescribed by Respondent.

79. On March 14, 2012, RT was seen by Respondent regarding his hypertension and lumbago. BP was 220/120 and on repeat 160/90-95. There is no documentation in the record of discussion regarding cardiac or respiratory symptoms nor regarding chest pain. Respondent added Amlodipine 10 mg. to the patient's hypertension medications.

80. On July 28, 2012 Respondent saw RT. The history is garbled and the discussion regarding RT's dose of amphetamine, which was apparently changed to a long-acting form, is incomprehensible. Respondent prescribed methadone #1200, D-amphetamine #130 and he added Adderall 10 mg., 1 tablet every 6 hours, #120. Respondent noted that he was prescribing a trial of Adderall "because it appears to be more available." However, it is unclear from the record whether Adderall was intended to replace the D-amphetamine.

81. On February 15, 2013, RT reported that methadone was not controlling his pain as "smoothly" as it had. Respondent noted that RT may be withdrawing before he takes the next dose as he gets sweaty, shaky, and anxious. RT asked to try a longer acting drug and reported that he was no longer using amphetamines. Impression was neck pain and narcotic habituation suboptimal control. Plan was to reduce methadone and begin MS Contin. Respondent prescribed MS Contin 100 mg., 3 tablets 3 times a day, #270.

82. On March 15, 2013, RT reported that he was doing better with pain control with MS Contin. He reported using 100 mg. 3 times a day and 20 mg. of methadone 4 times a day. On examination, neck range of motion was noted to be diminished and Respondent documented that RT had a somewhat bizarre affect with a rolling tongue and some diaphoresis. Impression was chronic pain with cervical spondylosis and "narcotic habituation possible draw." Plan was to increase MS Contin to between 115 and 145 mg., 3 times daily and use methadone 10-20 mg. every 6 hours as needed for breakthrough pain. Respondent prescribed MS Contin 15 mg., #200, MS Contin 100 mg., #100, and methadone 10 mg., #200.

83. Respondent is guilty of unprofessional conduct and subject to disciplinary action under section 2234, and/or 2234(b), and/or 2234(c) of the Code in that Respondent was grossly negligent, and/or committed repeated negligent acts, and/or was incompetent in the practice of medicine in his care and treatment Patient RT, including but not limited to the following:

A. Respondent prescribed high doses of methadone to Patient RT who had hypertension and reason to suspect structural heart disease without explicit discussion of the risks and without specific monitoring to detect possible QT prolongation.

B. Respondent prescribed D-amphetamine and Adderall to offset the sedative adverse effects of methadone.

C. Respondent prescribed D-amphetamine and Adderall to RT who had uncontrolled hypertension.

D. Respondent allowed Patient RT to increase and adjust his methadone and nortriptyline medications.

E. Respondent failed to recognize that combining high-dose methadone and nortriptyline subjected RT to excess risk of lethal cardiac arrhythmia.

F. Respondent failed to undertake and document investigation and/or testing of RT, an obese patient with hypertension, dyspnea, sedation, and edema, for obstructive sleep apnea and right-sided heart failure.

G. Respondent prescribed high doses of opiate medication to RT who possibly had obstructive sleep apnea without evidence from polysomnography that such treatment was safe.

H. Respondent failed to take aggressive measures to control RT's blood pressure and to follow him more closely than quarterly while adjusting antihypertensive medication.

I. Respondent failed to obtain and document clear indication of a medical condition that required the high-dose controlled substances that were prescribed.

J. Respondent failed to document a treatment plan, objectives to treatment, or RT's response to treatment.

K. Respondent prescribed opioids for several years without any documented rationale and dosages were increased without documentation of the rationale for the increases.

L. Respondent failed to obtain and document informed consent to treatment.

M. Respondent failed to conduct periodic review of the patient, such as pain levels, and response to treatment or consideration of alternative treatments.

N. Respondent failed to consider and/or to refer RT to a cardiologist for evaluation; or to seek consultation regarding RT's ongoing complaints of neck and back pain; and, he failed to consider referrals for physical therapy and/or psychological counseling.

84. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, and/or 2242, and/or 725 of the Code in that he inappropriately and/or excessively prescribed high doses of methadone, and he prescribed D-amphetamine and Adderall, without an appropriate prior medical examination and medical indication.

85. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234, and/or 2266 of the Code in that he failed to keep adequate and accurate records related to his care and treatment of Patient RT, including but not limited to the following:

A. Respondent's medical records fail to adequately document a treatment plan, objectives to treatment, response to treatment, informed consent, or rationale for the medications prescribed.

B. Respondent's medical records indicate that he prescribed controlled substances for pain for several years to Patient RT without documentation of the pain for which the controlled substances were prescribed.

C. Respondent's medical records fail to adequately document a medical basis or indication for the ongoing prescribing of controlled substances, or to document physical examination findings that supported his clinical diagnoses.

D. Respondent's medical records fail to accurately and/or completely document all medications prescribed to Patient RT.

E. Respondent's medical record documentation is at times garbled and incomprehensible.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 25166, issued to Edward Charles Olsgard, M.D.;

2. Prohibiting Respondent from supervising physician assistants pursuant to section 3527 of the Code;

3. Ordering Respondent, if placed on probation, to pay the Medical Board of California the costs of probation monitoring; and,

4. Taking such other and further action as deemed necessary and proper.

DATED: November 7, 2014

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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