

**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.	)	Case No. 12-2012-226067
	)	
Physician's and Surgeon's	)	
Certificate No. G 25166	)	
	)	
Respondent	)	
_____	)	

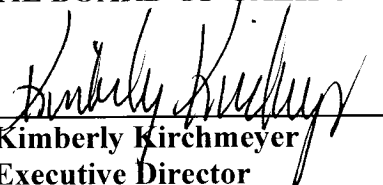
**DECISION AND ORDER**

The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on July 27, 2016.

IT IS SO ORDERED July 20, 2016.

**MEDICAL BOARD OF CALIFORNIA**

By:   
Kimberly Kirchmeyer  
Executive Director

1 KAMALA D. HARRIS  
Attorney General of California  
2 JANE ZACK SIMON  
Supervising Deputy Attorney General  
3 BRENDA P. REYES  
Deputy Attorney General  
4 State Bar No. 129718  
455 Golden Gate Avenue, Suite 11000  
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*Attorneys for Complainant*  
7

8 **BEFORE THE**  
9 **MEDICAL BOARD OF CALIFORNIA**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:  
12 **EDWARD CHARLES OLSGARD, M.D.**  
13 **2675 Harris Street**  
**Eureka, CA 95503**  
14 Physician's and Surgeon's Certificate  
15 No. G 25166  
16 Respondent.

Case No. 12-2012-226067  
**STIPULATED SURRENDER OF  
LICENSE AND ORDER**

17  
18 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-  
19 entitled proceedings that the following matters are true:

20 PARTIES

21 1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board  
22 of California. She brought this action solely in her official capacity and is represented in this  
23 matter by Kamala D. Harris, Attorney General of the State of California, by Brenda P. Reyes,  
24 Deputy Attorney General.

25 2. Edward Charles Olsgard, M.D. (Respondent) is represented in this proceeding by  
26 attorney Michael Morrison, Esq., whose address is Janssen Malloy LLP, 730 Fifth Street,  
27 Eureka, CA 95501.

28 ///

1           3.     On or about July 24, 1973, the Medical Board of California issued Physician's and  
2 Surgeon's Certificate No. G 25166 to Edward Charles Olsgard, M.D. (Respondent). The  
3 Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the  
4 charges brought in Accusation No. 12-2012-226067. The certificate expired on April 30, 2016,  
5 and has not been renewed.

6   JURISDICTION

7           4.     Accusation No. 12-2012-226067 was filed before the Medical Board of California  
8 (Board), Department of Consumer Affairs, and is currently pending against Respondent. The  
9 Accusation and all other statutorily required documents were properly served on Respondent on  
10 November 7, 2014. Respondent timely filed his Notice of Defense contesting the Accusation. A  
11 copy of Accusation No. 12-2012-226067 is attached as Exhibit A and incorporated by reference.

12   ADVISEMENT AND WAIVERS

13           5.     Respondent has carefully read, fully discussed with counsel, and understands the  
14 charges and allegations in Accusation No. 12-2012-226067. Respondent also has carefully read,  
15 fully discussed with counsel, and understands the effects of this Stipulated Surrender of License  
16 and Order.

17           6.     Respondent is fully aware of his legal rights in this matter, including the right to a  
18 hearing on the charges and allegations in the Accusation; the right to be represented by counsel, at  
19 his own expense; the right to confront and cross-examine the witnesses against him; the right to  
20 present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel  
21 the attendance of witnesses and the production of documents; the right to reconsideration and  
22 court review of an adverse decision; and all other rights accorded by the California  
23 Administrative Procedure Act and other applicable laws.

24           7.     Respondent voluntarily, knowingly, and intelligently waives and gives up each and  
25 every right set forth above.

26     ///

27     ///

28     ///

1 CULPABILITY

2 8. Respondent understands that the charges and allegations in Accusation No. 12-2012-  
3 226067, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and  
4 Surgeon's Certificate.

5 9. For the purpose of resolving the Accusation without the expense and uncertainty of  
6 further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual  
7 basis for the charges in the Accusation and that those charges constitute cause for discipline.  
8 Respondent hereby gives up his right to contest that cause for discipline exists based on those  
9 charges.

10 10. Respondent understands that by signing this stipulation he enables the Board to issue  
11 an order accepting the surrender of his Physician's and Surgeon's Certificate without further  
12 process.

13 CONTINGENCY

14 11. This stipulation shall be subject to approval by the Medical Board of California.  
15 Respondent understands and agrees that counsel for Complainant and the staff of the Medical  
16 Board of California may communicate directly with the Board regarding this stipulation and  
17 surrender, without notice to or participation by Respondent or his counsel. By signing the  
18 stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek  
19 to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails  
20 to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary  
21 Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal  
22 action between the parties, and the Board shall not be disqualified from further action by having  
23 considered this matter.

24 12. The parties understand and agree that Portable Document Format (PDF) and facsimile  
25 copies of this Stipulated Surrender of License and Order, including Portable Document Format  
26 (PDF) and facsimile signatures thereto, shall have the same force and effect as the originals.

27 13. In consideration of the foregoing admissions and stipulations, the parties agree that  
28 the Board may, without further notice or formal proceeding, issue and enter the following Order:

**ORDER**

1  
2 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 25166, issued  
3 to Respondent Edward Charles Olsgard, M.D., is surrendered and accepted by the Medical Board  
4 of California.

5 1. The surrender of Respondent's Physician's and Surgeon's Certificate and the  
6 acceptance of the surrendered license by the Board shall constitute the imposition of discipline  
7 against Respondent. This stipulation constitutes a record of the discipline and shall become a part  
8 of Respondent's license history with the Medical Board of California.

9 2. Respondent shall lose all rights and privileges as a physician and surgeon in  
10 California as of the effective date of the Board's Decision and Order.

11 3. Respondent shall cause to be delivered to the Board his pocket license and, if one was  
12 issued, his wall certificate on or before the effective date of the Decision and Order.

13 4. If Respondent ever files an application for licensure or a petition for reinstatement in  
14 the State of California, the Board shall treat it as a petition for reinstatement. Respondent must  
15 comply with all the laws, regulations and procedures for reinstatement of a revoked license in  
16 effect at the time the petition is filed, and all of the charges and allegations contained in  
17 Accusation No. 12-2012-226067 shall be deemed to be true, correct and admitted by Respondent  
18 when the Board determines whether to grant or deny the petition.

19 5. If Respondent should ever apply or reapply for a new license or certification, or  
20 petition for reinstatement of a license, by any other health care licensing agency in the State of  
21 California, all of the charges and allegations contained in Accusation, No. 12-2012-226067 shall  
22 be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of  
23 Issues or any other proceeding seeking to deny or restrict licensure.

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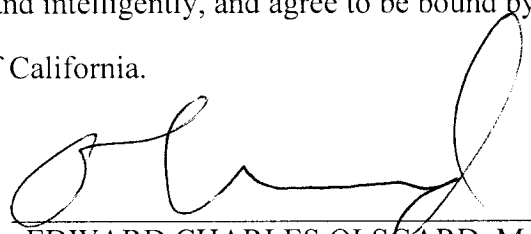
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1 ACCEPTANCE

2 I have carefully read the above Stipulated Surrender of License and Order and have fully  
3 discussed it with my attorney, Michael Morrison, Esq. I understand the stipulation and the effect  
4 it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of  
5 License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the  
6 Decision and Order of the Medical Board of California.

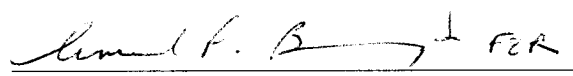
7  
8 DATED: 6/1/2016

9 

EDWARD CHARLES OLSGARD, M.D.  
Respondent

10 I have read and fully discussed with Respondent Edward Charles Olsgard, M.D. the terms  
11 and conditions and other matters contained in this Stipulated Surrender of License and Order. I  
12 approve its form and content.

13  
14 DATED: 26.01.16

15 

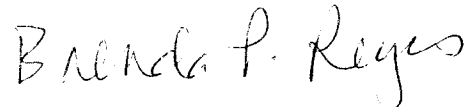
MICHAEL MORRISON, ESQ.  
Attorney for Respondent

16  
17 ENDORSEMENT

18 The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted  
19 for consideration by the Medical Board of California of the Department of Consumer Affairs.

20 DATED: June 14, 2016

21 KAMALA D. HARRIS  
Attorney General of California  
JANE ZACK SIMON  
Supervising Deputy Attorney General

22 

23 BRENDA P. REYES  
24 Deputy Attorney General  
25 Attorneys for Complainant  
26

**Exhibit A**

**Accusation No. 12-2012-226067**

1 KAMALA D. HARRIS  
Attorney General of California  
2 JANE ZACK SIMON  
Supervising Deputy Attorney General  
3 BRENDA P. REYES  
Deputy Attorney General  
4 State Bar No. 129718  
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5 San Francisco, CA 94102-7004  
Telephone: (415) 703-5541  
6 Facsimile: (415) 703-5480  
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8 **BEFORE THE**  
9 **MEDICAL BOARD OF CALIFORNIA**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

Case No. 12-2012-226067

12 **EDWARD CHARLES OLSGARD, M.D.**  
13 **2675 Harris Street**  
**Eureka, CA 95503**

**A C C U S A T I O N**

14 Physician's and Surgeon's Certificate  
15 No. G 25166

16 Respondent.

17  
18 Complainant alleges:

19 **PARTIES**

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

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

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27 ///

28 ///



1 **JURISDICTION**

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

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

6 "The board shall have the responsibility for the following:

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

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

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

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

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

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

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

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

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

26 "(b) Gross negligence.

27 <sup>1</sup> The term "board" means the Medical Board of California. "Division of Medical  
28 Quality" shall also be deemed to refer to the Medical Board. (Bus. & Prof. Code, § 2002.)



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

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

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

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

22 E. **MS Contin (morphine sulfate)** is for use in patients who require a potent opioid  
23 analgesic for relief of moderate to severe pain. Morphine is a dangerous drug as defined in  
24 section 4022 of the Code, a Schedule II controlled substance and narcotic as defined by section  
25 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance  
26 as defined by Section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations. Morphine  
27 can produce drug dependence and has a potential for being abused. Tolerance and psychological  
28 and physical dependence may develop upon repeated administration. Abrupt cessation or a

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

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

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

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

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

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

12 J. **Temazepam** is a hypnotic agent, sold under the trade name **Restoril**. It is a  
13 dangerous drug as defined in section 4022 of the Code, a Schedule IV controlled substance and  
14 narcotic as defined by section 11057, subdivision (d) of the Health and Safety Code, and a  
15 Schedule IV controlled substance as defined by Section 1308.14 of Title 21 of the Code of  
16 Federal Regulations. Temazepam is indicated for the short-term treatment of insomnia (generally  
17 7-10 days). Patients using temazepam should be warned about the possible combined effects with  
18 alcohol and other central nervous system depressants. As with any hypnotic, caution must be  
19 exercised in administering temazepam to individuals known to be addiction prone. The  
20 recommended usual adult dosage is one 15 mg. tablet before retiring.

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

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

6 M. **Xanax** is a trade name for **alprazolam** tablets. Alprazolam is a psychotropic  
7 triazolo analogue of the benzodiazepine class of central nervous system-active compounds.  
8 Xanax is used for the management of anxiety disorders or for the short-term relief of the  
9 symptoms of anxiety. It is a schedule IV controlled substance and narcotic as defined by section  
10 11057, subdivision (d) of the Health and Safety Code, and a schedule IV controlled substance as  
11 defined by Section 1308.14 (c) of Title 21 of the Code of Federal Regulations, and a dangerous  
12 drug as defined in Business and Professions Code section 4022. Xanax has a central nervous  
13 system depressant effect and patients should be cautioned about the simultaneous ingestion of  
14 alcohol and other CNS depressant drugs during treatment with Xanax.

#### 15 **FIRST CAUSE FOR DISCIPLINE**

16 **(Re: Patient ES)**

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

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

25 \_\_\_\_\_  
26 <sup>2</sup> Patient names are kept confidential to protect their right to privacy but will be identified  
to Respondent in discovery.

27 <sup>3</sup> Interstitial cystitis, also called painful bladder syndrome, is a chronic condition  
28 associated with bladder pressure, bladder pain, and sometimes pelvic pain that can range from  
mild discomfort to severe pain.

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

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

14 13. On or about January 5, 2009, ES underwent a laparoscopic cholecystectomy  
15 (gallbladder removal) for chronic cholecystitis. The procedure was performed by a surgeon, not  
16 Respondent. ES saw Respondent on January 30, 2009, at which time she reported some increased  
17 post-operative pain. ES reported that she was taking up to 12 Norco a day following surgery. ES  
18 reported that she tried getting a narcotic other than Norco in order to avoid overuse of Norco.  
19 Respondent documented an examination and noted that he emphasized to ES that she not exceed  
20 8 Norco a day to avoid acetaminophen hepatotoxicity. Respondent prescribed Oxycodone HCL 5  
21 mg., 1 tablet every 4 hrs. for 10 days, #60.

22 14. Pharmacy prescribing records indicate that on January 16, 2009, ES filled a  
23 prescription from Respondent for Norco 10/325 mg., #180, for 30 days. There is no  
24 documentation in Respondent’s medical record that he saw the patient on this date, nor that he  
25 gave ES a prescription for Norco on or about this date. Respondent’s medical record throughout  
26 2009 lists Norco as one of ES’s “current medications.” However, the only prescription for Norco

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27 <sup>4</sup> Elmiron is a trade name for pentosan, a semi-synthetic drug that resembles the  
28 anticoagulant heparin and is used for treating the symptoms of interstitial cystitis.

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

7 15. ES saw Respondent on March 5, 2009 and reported that she wanted to see a counselor  
8 as she was experiencing increased stress, having difficulty sleeping, and having daytime anxiety.  
9 Respondent's plan included referral for psychotherapy and he prescribed Xanax 0.25 mg., 1 tablet  
10 every 6 hours as needed, #100, 5 refills. The records contain an authorization request for referral  
11 to a therapist. There is no documentation in the record of any follow-up regarding this referral  
12 and there is no indication in the record that ES ever saw a therapist. Respondent continued to  
13 prescribe Xanax to ES for generalized anxiety during the time period his care was reviewed. Over  
14 the course of his treatment of ES, Respondent increased ES's prescription for Xanax to 0.5 mg.,  
15 #120 in or about December 2009, to #180 in or about June 2011, and to #240 in or about February  
16 2012, all without documentation of the reasons for increasing the prescription amounts.

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

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



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

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

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

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

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

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

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

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

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

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

28       ///



1 Septra, a combination antibiotic, for 10 days. DA was next seen by Respondent on December 5,  
2 2007, at which time DS reported that he had claudication<sup>5</sup> and would be having leg stent surgery.  
3 DA asked Respondent to place him on disability because he was unable to drive due to the pain in  
4 his leg. Respondent placed DS on disability with an estimated return to work date in March 2008.

5 23. Respondent next saw DA on May 27, 2009, in follow-up regarding his  
6 hyperlipidemia, coronary and peripheral vascular disease and hypothyroidism. DA reported he  
7 had a peripheral vascular procedure done during his absence. Respondent noted that DA was on  
8 pain medication. Respondent documented an examination and he prescribed Vicodin ES 7.5/750  
9 mg., 1-2 tablets every 4 hours, #180, 5 refills, and Flurazepam HCL 30 mg., 1 tablet at bedtime,  
10 #30, 5 refills. Respondent did not document a medical indication for the prescriptions.

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

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

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

26 \_\_\_\_\_  
27 <sup>5</sup> Claudication is pain caused by too little blood flow during exercise. This condition  
28 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.

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

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

12 28. On April 28, 2012, DA was seen by Respondent for a medication check. Respondent  
13 prescribed Norco #720, 5 refills. Pharmacy records indicate that the patient was dispensed the  
14 following amounts of Norco prescribed by Respondent: on 12/17/2011, #720; on 3/12/2012,  
15 #480; on 4/25/2012, #270; on 6/22/2012, #720; and, on 9/18/2012, #720. DA also received  
16 prescriptions for Norco #50 on 7/30/2012 and Norco #60 on 8/6/2012, both prescribed by a  
17 physician other than Respondent. Respondent's records do not address the fact that DA was  
18 filling prescriptions early or that he was receiving prescriptions for Norco from other prescribers.

19 29. Respondent saw Patient DA on August 8, 2012, and impression was "peripheral  
20 vascular disease status post bypass left leg." DA complained of low back pain. Plan included  
21 lumbar spine films. Respondent noted that Norco was adequate during the day but that it did not  
22 allow the patient to sleep at night. Respondent added Methadone 10 mg., 1-2 at bedtime, #100, to  
23 DA's prescribed medications. This is very unusual to prescribe Methadone only one time per day.  
24 Respondent failed to document an explanation for the addition of Methadone to DS's prescribed  
25 medications. Lumbar spine x-rays taken on October 30, 2012, showed mild degenerative changes  
26 with no indication of any painful process. Methadone was refilled on October 31, 2012, at which  
27 time Respondent noted that DA was also taking lorazepam, a benzodiazepine used to treat anxiety  
28

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

3 30. Respondent last saw Patient DA on November 30, 2012 for a recheck. Respondent  
4 prescribed Norco #720, 5 refills and Methadone #100. At his Medical Board interview on  
5 October 29, 2013, Respondent reported that he "dismissed" DA from his practice on December  
6 18, 2012, after he learned that DA attempted to obtain an early refill of Norco. Respondent did  
7 not document the event in the patient record.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 **THIRD CAUSE FOR DISCIPLINE**

2 **(Re: Patient RA )**

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

5 34. Patient RA, a 53-year-old man, has been a patient of Respondent's for over 10 years.  
6 Respondent's records document that RA was treated for chronic low back pain, knee pain, neck  
7 pain, and insomnia. On July 27, 2007, Respondent saw RA for a complaint of shortness of breath  
8 with exertion. Respondent noted that due to new insurance, the patient needed a new prescription  
9 for Vicodin, Temazepam, and Flonase. Evaluation was normal. Plan included scheduling an  
10 EKG stress test. Respondent prescribed Vicodin 5/500 mg., 1-2 tablets every 4 hrs. as needed,  
11 #300, 6 refills. An in-office exercise treadmill test on August 29, 2007, was negative.

12 35. On December 5, 2007, Respondent saw RA with a complaint of worsening symptoms  
13 due to a deviated septum. Respondent noted that RA was on Prevacid<sup>6</sup> and would like to try  
14 Prilosec, a proton pump inhibitor, due to its lower cost. Respondent also noted that RA wanted to  
15 switch from 6 Vicodin daily to 3 Norco at the suggestion of his pharmacist. Respondent  
16 documented an exam. No pain is documented in the history or on physical examination.  
17 Respondent's assessment was chronic peptic disease, chronic low back pain, and symptomatic  
18 snoring. The patient was given a referral for consideration of an anti-snoring procedure.  
19 Respondent prescribed a trial of Prilosec, Norco 10/325 mg., 1 tablet every 6 hours as needed,  
20 #200, 5 refills, and Temazepam 30 mg. 1-2 tablets at bedtime, 5 refills.

21 36. Respondent's records contain a hospital emergency department report of February 2,  
22 2008, regarding examination of RA following a motor vehicle accident. RA is reported to have  
23 T-boned another vehicle that pulled in front of him while exiting a parking lot. RA complained of  
24 right knee and foot pain, and right-sided chest wall discomfort. RA was examined. Documented  
25 past medical history included knee surgeries on both knees. Impression was right foot pain,

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

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

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

11 38. Respondent next saw RA on June 6, 2008 for a complaint of left hand pain. A history  
12 of negative evaluations for Carpal Tunnel Syndrome is noted. RA complained of an exacerbation  
13 of osteoarthritis in the knee and reported that he was using up to 8 Norco a day. Exam of the left  
14 hand was essentially normal; x-ray of the hand was normal. Impression included overuse injury  
15 left hand and chronic back pain. There is no examination noted nor discussion in the record  
16 regarding back pain. Respondent prescribed Norco 10/325 mg., 2 every 6 hours as needed, #240,  
17 5 refills and Temazepam 30 mg., 1-2 tablets at bedtime as needed, #100, 5 refills.

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

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

27 <sup>7</sup> Vicoprofen contains a combination of hydrocodone and ibuprofen. Vicoprofen is used  
28 short-term to relieve severe pain.



1           41. On February 2, 2009, Respondent saw RA for a complaint of right hand pain.  
2 Chronic back pain is noted. Range of motion of the wrist was normal and x-ray of the wrist was  
3 noted to be negative. Respondent increased Norco to #720 and 5 refills were given. There is no  
4 explanation in the record for the increased amount of Norco prescribed. On April 1, 2009,  
5 Respondent again saw RA for a complaint of right wrist pain. Respondent again prescribed  
6 Norco #720, 5 refills, and he prescribed Temazepam 30 mg., 2 tablets a bedtime, #200, 5 refills.  
7 Respondent's records do not document an explanation for the increased amount of Temazepam  
8 prescribed.

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

14           43. Pharmacy prescribing records for Patient RA indicate that during 2009, RA obtained  
15 prescriptions for Norco and Temazepam far in excess of the amounts documented by Respondent  
16 in the medical record. For example, pharmacy records indicate that RA was dispensed, from  
17 multiple pharmacies, Norco #240 prescribed by Respondent on the following dates: 7/8/2009,  
18 8/2/2009, 8/13/2009, 8/26/2009, 9/7/2009, 9/19/2009, 10/1/2009, 10/14/2009, 10/26/2009,  
19 11/12/2009, 11/19/2009, 12/6/2009, and 12/14/2009. In addition, pharmacy records indicate that  
20 RA was dispensed the following amounts of Temazepam, from multiple pharmacies, prescribed  
21 by Respondent: on 8/2/2009, #100; on 8/13/2009, #200; on 8/14/2009, #100; on 8/18/2009, #100;  
22 on 8/25/2009, #100; on 9/29/2009, #200; on 11/12/2009, #180; on 12/3/2009, #180; and, on  
23 12/15, 2009, #180. Respondent's medical records for Patient RA fail to address the excessive  
24 amounts of Norco and Temazepam the patient was obtaining from multiple pharmacies during  
25 2009.

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

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

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

10 46. Respondent's records throughout 2010 document that RA's "current medications"  
11 included Norco and Temazepam. However, other than the prescription for Valium provided on  
12 July 17, 2010 and the prescriptions for Prednisone provided on March 17 and May 7, 2010,  
13 Respondent's progress notes for 2010 do not document that he gave RA any other prescriptions  
14 for controlled substances for pain. Pharmacy prescribing records for Patient RA indicate that  
15 during 2010, RA was dispensed, from multiple pharmacies, Norco #240 prescribed by  
16 Respondent on, e.g., the following dates: 1/4/2010, 1/14/2010, 2/8/2010, 3/5/2010, 3/19/2010,  
17 3/29/2010, 4/12/2010, 4/22/2010, 5/6/2010, 5/7/2010, 5/17/2010, 10/5/2010, 10/8/2010,  
18 10/31/2010, 11/5/2010, 11/30/2010, 12/2/2010, 12/22/2010, 12/26/2010, and 12/29/2010. This  
19 pattern of the patient receiving multiple prescriptions for a month's worth of Norco during a  
20 single month continued throughout 2011 and 2012.

21 47. Pharmacy records show a similar pattern of Respondent excessively prescribing  
22 Temazepam to Patient RA. For example, pharmacy records indicate that RA was dispensed, from  
23 multiple pharmacies, the following amounts of Temazepam prescribed by Respondent during  
24 2010: on 1/15/2010, #200; on 3/9/2010, #60; on 3/10/2010, # 60; on 4/14/2010, #60 from two  
25 different pharmacies; on 5/8/10, #60; on 5/9/2010, #200; on 5/11/2010, #60; on 6/2/2010, #60; on  
26 10/26/2010, #60; on 11/5/2010, #200; on 11/20/2010, #60; and, on 12/26,2010, #60. This pattern  
27 of the patient receiving multiple prescriptions of Temazepam during some months continued  
28 during 2011 and 2012. Respondent's medical records for Patient RA fail to address the excessive

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

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

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

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

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

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

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

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

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

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

24 50. Respondent is guilty of unprofessional conduct and subject to disciplinary action  
25 under sections 2234, and/or 2266 of the Code in that he failed to keep adequate and accurate  
26 records related to his care and treatment of Patient RA, including but not limited to the following:  
27  
28



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

3 53. Respondent's medical records for SP do not document a coordinated treatment plan  
4 and nowhere in the records does Respondent discuss objectives to treatment. There is no  
5 documentation of SP's pain level and no determination or quantification of the patient's response  
6 to treatment. Respondent's records do not document a work up that actually provided any  
7 indication of the patient's pathology and cause of her pain. SP's pain is never described in the  
8 records in terms of location, intensity, character, effects of activities, or benefits from the  
9 medications. The patient was known to be an alcoholic and the medical records document  
10 multiple red flags indicating possible abuse of controlled substances. For example, on October 5,  
11 2006, Respondent documented that SP was taking 15-18 Vicodin per day when she had been  
12 prescribed only 6 per day. On October 30, 2006, it was again noted that the patient was overusing  
13 Vicodin. On December 15, 2006 SP was noted to be binge drinking.

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

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

28 ///

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

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

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

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

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

1 12/22/2010. The patient also filled prescriptions from Respondent for Norco #720 on 7/17/2010,  
2 10/18/2010, and 12/22/2010. Respondent's medical records fail to address the excessive amounts  
3 of methadone and Norco the patient was obtaining from multiple pharmacies during 2010.

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

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

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

20 64. Pharmacy records show that throughout 2011, SP was dispensed, from multiple  
21 pharmacies, excessive quantities of Norco prescribed by Respondent. For example, pharmacy  
22 records show that SP was dispensed Norco #720 on: 1/20/2011, 3/11/2011, 4/8/2011, 4/20/2011,  
23 7/7/2011, 7/19/2011; 9/1/2011, 10/16/2011, 11/16/2011, and 12/28/2011. During this same time  
24 period pharmacy records show that SP was dispensed methadone #360 prescribed by Respondent  
25 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,  
26 #180; and, on 12/27/2011, #540.

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

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

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

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

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

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

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

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

27 D. Respondent failed to obtain and document informed consent to treatment.  
28



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

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

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

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

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

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

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

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

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

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

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

3 **FIFTH CAUSE FOR DISCIPLINE**

4 **(Patient RT)**

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

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

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

23 73. On July 9, 2008, Respondent saw RT and noted that RT had "changed" his  
24 methadone dose to 60 mg., 4 times a day from 70 mg. 3 times a day, and that he had changed his  
25 D-amphetamine dose from 30 mg., 3 times a day to 20 mg., 4 times a day. Respondent prescribed  
26 methadone HCL 10 mg., 6 tablets 4 times a day, and Dextroamphetamine sulfate 10 mg., 2 tablets  
27 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

1 or respiratory symptoms is noted. Plan was to monitor home BP, limit salt intake and attempt 5  
2 pound weight loss. No prescriptions are noted. Pharmacy records indicate that RT was dispensed  
3 methadone 10 mg., #1200 monthly throughout 2011, and that he was dispensed D-amphetamine  
4 10 mg., #120 to #130 from January through September 2011, prescribed by Respondent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 1 L. Respondent failed to obtain and document informed consent to treatment.
- 2 M. Respondent failed to conduct periodic review of the patient, such as pain levels,  
3 and response to treatment or consideration of alternative treatments.
- 4 N. Respondent failed to consider and/or to refer RT to a cardiologist for  
5 evaluation; or to seek consultation regarding RT's ongoing complaints of neck and back pain;  
6 and, he failed to consider referrals for physical therapy and/or psychological counseling.
- 7 84. Respondent is guilty of unprofessional conduct and subject to disciplinary action  
8 under sections 2234, and/or 2242, and/or 725 of the Code in that he inappropriately and/or  
9 excessively prescribed high doses of methadone, and he prescribed D-amphetamine and Adderall,  
10 without an appropriate prior medical examination and medical indication.
- 11 85. Respondent is guilty of unprofessional conduct and subject to disciplinary action  
12 under sections 2234, and/or 2266 of the Code in that he failed to keep adequate and accurate  
13 records related to his care and treatment of Patient RT, including but not limited to the following:
- 14 A. Respondent's medical records fail to adequately document a treatment plan,  
15 objectives to treatment, response to treatment, informed consent, or rationale for the medications  
16 prescribed.
- 17 B. Respondent's medical records indicate that he prescribed controlled substances  
18 for pain for several years to Patient RT without documentation of the pain for which the  
19 controlled substances were prescribed.
- 20 C. Respondent's medical records fail to adequately document a medical basis or  
21 indication for the ongoing prescribing of controlled substances, or to document physical  
22 examination findings that supported his clinical diagnoses.
- 23 D. Respondent's medical records fail to accurately and/or completely document all  
24 medications prescribed to Patient RT.
- 25 E. Respondent's medical record documentation is at times garbled and  
26 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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