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

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|---|---|
| In the Matter of the First Amended Accusation Against: | |
| Roger Bryant Olsson, M.D. | Case No. 800-2020-072604 |
| Physician's and Surgeon's Certificate No. G 89405 | |
| Respondent | |

## DECISION

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 16, 2021.

IT IS SO ORDERED July 9, 2021.

MEDICAL BOARD OF CALIFORNIA

William Prasifka
Executive Director

ROB BONTA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General
CAROLYNE EVANS
Deputy Attorney General
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455 Golden Gate Avenue, Suite 11000
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*Attorneys for Complainant*

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

| | |
|---|---|
| In the Matter of the First Amended Accusation Against:<br><br>**ROGER BRYANT OLSSON, M.D.**<br>**The Renewal Center**<br>**11601 Harbour Pointe Blvd., Suite 200**<br>**Mukilteo, WA 98275**<br><br>**Physician's and Surgeon's Certificate No.**<br><br>**G 89405**<br><br>Respondent. | Case No. 800-2020-072604<br><br>**STIPULATED SURRENDER OF LICENSE AND ORDER** |

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

## PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Carolyne Evans, Deputy Attorney General.

2. Roger Bryant Olsson, M.D. (Respondent) is representing himself in this proceeding and has chosen not to exercise his right to be represented by counsel.

3. On or about July 12, 2013, the Board issued Physician's and Surgeon's Certificate No. G 89405 to Roger Bryant Olsson, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2020-072604 but expired on April 30, 2021.

## JURISDICTION

4. On March 16, 2021, Accusation No. 800-2020-072604 was filed before the Board. The Accusation and all other statutorily required documents were properly served on Respondent on March 16, 2021. Respondent filed a Notice of Defense contesting the Accusation. On June 16, 2021, a First Amended Accusation was filed and served on Respondent. A copy of First Amended Accusation No. 800-2020-072604 is attached as Exhibit A and incorporated by reference.

## ADVISEMENT AND WAIVERS

5. Respondent has carefully read, and understands the charges and allegations in First Amended Accusation No. 800-2020-072604. Respondent also has carefully read, and understands the effects of this Stipulated Surrender of License and Order.

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

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

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## CULPABILITY

8. Respondent understands that the charges and allegations in First Amended Accusation No. 800-2020-072604, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

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

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

## CONTINGENCY

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

## ADDITIONAL PROVISIONS

12. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final, and exclusive embodiment of the agreements of the parties in the above-entitled matter.

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13. The parties agree that copies of this Stipulated Settlement and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice to or opportunity to be heard by Applicant, issue and enter the following Disciplinary Order:

**ORDER**

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 89405, issued to Respondent Roger Bryant Olsson, M.D., is surrendered and accepted by the Board.

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

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

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

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in First Amended Accusation No. 800-2020-072604 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in First Amended Accusation, No. 800-2020-072604 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

## ACCEPTANCE

I have carefully read the Stipulated Surrender of License and Order. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 7-8-2021

ROGER BRYANT OLSSON, M.D.
*Respondent*

## ENDORSEMENT

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

DATED: July 9, 2021

Respectfully submitted,

ROB BONTA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General

CAROLYNE EVANS
Deputy Attorney General
*Attorneys for Complainant*

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# Exhibit A

**First Amended Accusation No. 800-2020-072604**

ROB BONTA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General
CAROLYNE EVANS
Deputy Attorney General
State Bar No. 289206
455 Golden Gate Avenue, Suite 11000
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Facsimile: (415) 703-5480
*Attorneys for Complainant*

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

| | |
|---|---|
| In the Matter of the First Amended Accusation Against:<br><br>**Roger Bryant Olsson, M.D.**<br>**The Renewal Center**<br>**11601 Harbour Pointe Blvd., Suite 200**<br>**Mukilteo, WA 98275**<br><br>**Physician's and Surgeon's Certificate No. G 89405,**<br><br>Respondent. | Case No. 800-2020-072604<br><br>**FIRST AMENDED ACCUSATION** |

## PARTIES

1. William Prasifka (Complainant) brings this First Amended Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 12, 2013, the Medical Board issued Physician's and Surgeon's Certificate Number G 89405 to Roger Bryant Olsson, M.D. (Respondent). The Physician's and

Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2021.

**JURISDICTION**

3. This First Amended Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. 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 Board deems proper.

5. Section 2234 of the Code provides that the Board shall take action against any licensee who is charged with "unprofessional conduct," which includes but is not limited to, "[v]iolating . . . any provision of this chapter."

6. Section 2305 of the Code provides, in pertinent part, that the revocation, suspension, or other discipline, restriction, or limitation imposed by another state upon a license to practice medicine issued by that state, or the revocation, suspension, or restriction of the authority to practice medicine by any agency of the federal government, that would have been grounds for discipline in California, shall constitute grounds for disciplinary action for unprofessional conduct.

7. Section 141 of the Code provides:

(a) For any licensee holding a license issued by a board under the jurisdiction of the department, a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice regulated by the California license, may be a ground for disciplinary action by the respective state licensing board. A certified copy of the record of the disciplinary action taken against the licensee by another state, an agency of the federal government, or another country shall be conclusive evidence of the events related therein.

(b) Nothing in this section shall preclude a board from applying a specific statutory provision in the licensing act administered by that board that provides for discipline based upon a disciplinary action taken against the licensee by another state, an agency of the federal government or another country.

**CAUSE FOR DISCIPLINE**

**(Discipline, Restriction, or Limitation Imposed by Another State)**

8. On October 20, 2020, the State of Washington Medical Commission (Washington Medical Commission) issued an order (Washington Order) Case No. M2017-527, attached herewith as Exhibit A, which disciplines Respondent's Washington medical license. After holding an evidentiary hearing, the Washington Medical Commission determined that from October 2015 through December 2016, Respondent inappropriately treated eight patients.

9. For instance, Respondent prescribed testosterone injections to four patients by unproven means (subcutaneous), at a high frequency (three times per week), at high dosages, and without any documentation of the rationale. Respondent also failed to manage two patients' high red blood counts while administering the testosterone therapy. A high red blood count and hematocrit can cause strokes and heart attacks.

10. The Washington Medical Commission additionally found that Respondent prescribed Arimidex (anastrozole)[1] to three male patients without documenting a rationale for prescribing the Arimidex or without documenting a discussion of the risks and benefits of taking this drug.

11. The Washington Medical Commission determined that Respondent prescribed high doses of thyroid hormone to six patients without appropriately monitoring their thyroid stimulating hormones (TSH) concentrations. High TSH concentrations increase the risk of heart disease.

12. The Washington Medical Commission concluded that Respondent "failed to document an evaluation of or determine the cause of male hypogonadism"[2] for four patients.

[1] Anastrozole is used to treat breast cancer in women after menopause. Anastrozole decreases the amount of estrogen the body makes and helps to slow or reverse the growth of these breast cancers.

[2] Male hypogonadism is a condition where the body does not produce enough testosterone or sperm. Hypogonadism can affect many organ functions.

Minimal testing would include a measurement of follicle-stimulating hormone (FSH) and luteinizing hormone (LH). Further treatment would depend on the results of these tests. "This evaluation is important to exclude diseases such as a tumor in the pituitary gland. Respondent's testimony that records exist for FSH and LH was not credible."

13. Respondent also failed to meet the standard of care when prescribing testosterone therapy to four female patients, all postmenopausal women. Respondent failed to document any discussion regarding the potential risks and benefits of testosterone therapy. "Testosterone therapy is not indicated for the treatment of menopausal symptoms in women, there are also cardiovascular risks of testosterone therapy in postmenopausal women, and it is known to cause hirsutism (excessive hair) in postmenopausal women."

14. Respondent diagnosed one patient with primary adrenal insufficiency but failed to perform a cosyntropin[3] stimulation test to confirm this potentially life threatening-diagnosis. Without appropriate confirmation, Respondent could not have known if the treatment was adequate. Inadequate treatment of adrenal insufficiency may cause death. Respondent also prescribed human growth hormone to this patient but failed to adjust the dosage of the growth hormone despite the patient's lab results showing elevated insulin-like growth factor-1 concentrations on more than one occasion (IGF-1 regulates the effects of growth hormone in the body). Excessive growth hormone dosing resulting in elevated IGF-1 concentrations may cause or worsen diabetes and hypertension.

15. Overall, the Washington Medical Commission concluded that Respondent's care and treatment of eight patients fell below the standard of care and created an unreasonable risk of harm to patients. As a result of Respondent's unprofessional conduct, the Washington Medical Board ordered that Respondent complete a Physician Assessment Clinical Education (PACE) evaluation and be prohibited from prescribing opioids and hormones until "such time as the Commission is confident Respondent no longer poses a danger to the public and that Respondent is in compliance with any PACE Recommendation. The Washington Medical Commission

[3] Cosyntropin is a man-made form of a hormone called adrenocorticotropic hormone (ACTH). ACTH is a hormone that is normally produced by the pituitary gland in the brain.

ordered that Respondent's practice be subject to monitoring for a period of five years and that he allow the Washington Medical Commission to review Respondent's patient records bi-annually. Respondent was also ordered to pay a $10,000.00 fine.

16. On May 12, 2021, the Washington Medical Commission issued an Amended Findings of Fact, Conclusions of Law and Final Order (Washington Amended Order), attached herewith as Exhibit B. The Washington Order was amended to add additional opioid prescribing restrictions and additional PACE training requirements. The Washington Amended Order states that:

> Respondent is PERMANENTLY RESTRICTED from prescribing opioids for chronic pain patients.
>
> A. Respondent is also PERMANENTLY RESTRICTED from prescribing opioids for acute pain except for a two-week period for prescribing hydrocodone, codeine, or oxycodone for post-procedure acute pain related to the cosmetic procedures performed at the Renewal Center, and for his family practice patients. If the patient requires more than two weeks of hydrocodone, codeine, or oxycodone treatment, the patient shall be referred out.
>
> B. Respondent REMAINS RESTRICTED as to prescribing benzodiazepines. Respondent may prescribe benzodiazepines for his family practice patients with generalized anxiety for no more than 90 days after which Respondent must refer the patient to another provider or board-certified psychiatrist for management.
>
> 3.3 Evaluation. Respondent must complete an evaluation of his internal medicine clinical skills at the Physician Assessment and Clinical Education Program offered at the University of California at San Diego School of Medicine (PACE), or at another Commission-approved program.
>
> 3.3.1 Respondent must fully cooperate with the evaluation process and provide PACE with any information, documents, or releases that are requested. Respondent must contact PACE within 30 days of the effect date of this Order to schedule the clinical competence assessment. Respondent must schedule the assessment to take place within 90 days of the effective date of this Order unless PACE is unable to provide any dates for assessment within such a time period. If PACE is unable to provide Respondent with a date for assessment within 90 days of the effective dates of this Order, Respondent must notify the Commission, in writing, within 10 days of the communication with PACE and inform the Commission of the date or dates on which the assessment will take place. The assessment must include screening examinations, including at minimum, a history, physical, cognitive, and psychological screening.

17. In 2014, the Washington Medical Commission disciplined Respondent's Washington medical license for inappropriately prescribing controlled substances, including opioids and other

dangerous drugs, to 14 patients. Because of Respondent's unprofessional conduct, the Washington Medical Commission ordered that Respondent be permanently prohibited from prescribing opioids to chronic pain patients and from treating chronic pain patients.

18. Respondent's foregoing conduct and the actions of the Washington Medical Commission, as set forth in paragraphs 8 through 17, above, and Exhibit A and Exhibit B, constitute cause for discipline, pursuant to section 2234 and/or section 2305 and/or section 141 of the Code.

**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 89405, issued to Roger Bryant Olsson, M.D.;

2. Revoking, suspending or denying approval of Roger Bryant Olsson, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Roger Bryant Olsson, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: JUN 16 2021

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
*Complainant*

SF202140035

EXHIBIT A

STATE OF WASHINGTON

# DEPARTMENT OF HEALTH

Olympia, Washington 98504

RE: Roger B. Olsson, M.D.,
Master Case No.: M2017-527
Document: Final Order

Regarding your request for information about the above-named practitioner; attached is a true and correct copy of the document on file with the State of Washington, Department of Health, Adjudicative Clerk Office. These records are considered Certified by the Department of Health.

Certain information may have been withheld pursuant to Washington state laws. While those laws require that most records be disclosed on request, they also state that certain information should not be disclosed.

The following information has been withheld: **NONE**

If you have any questions or need additional information regarding the information that was withheld, please contact:

Customer Service Center
P.O. Box 47865
Olympia, WA 98504-7865
Phone: (360) 236-4700
Fax: (360) 586-2171

You may appeal the decision to withhold any information by writing to the Privacy Officer, Department of Health, P.O. Box 47890, Olympia, WA 98504-7890.

**STATE OF WASHINGTON**
**DEPARTMENT OF HEALTH**
**WASHINGTON MEDICAL COMMISSION**

| In the Matter of: | Master Case No. M2017-527 |
|---|---|
| ROGER B. OLSSON, M.D.,<br>Credential No. MD.MD.00015303,<br><br>Respondent. | FINDINGS OF FACT,<br>CONCLUSIONS OF LAW,<br>AND FINAL ORDER |

APPEARANCES:

Roger B. Olsson, M.D., the Respondent, by
Gerald Tarutis, Attorney at Law

Department of Health Medical Program (Department), by
Office of the Attorney General, per
Kristin G. Brewer, Assistant Attorney General

PANEL: Warren Howe, M.D., Chair
Thomas Fairchild, M.D., Pro Tem
Scott Rodgers, Public Member

PRESIDING OFFICER: Roman S. Dixon Jr., Chief Health Law Judge

A hearing was held in this matter on October 18, 2019, regarding allegations of unprofessional conduct. CREDENTIAL RESTRICTED.

## ISSUES

Did the Respondent commit unprofessional conduct as defined by RCW 18.130.180(4) and (9)?

If the Department proves unprofessional conduct, what are the appropriate sanctions under RCW 18.130.160?

## SUMMARY OF PROCEEDINGS

At the hearing, the Department presented the testimony of:

1. Respondent as an adverse witness; and,

2. Bradley Anawalt, M.D., FACP, Department expert.

At the hearing, the Respondent presented the testimony of:

1. Roger B. Olsson, M.D.; and,

2. Kevin Ware, D.O.

The Presiding Officer admitted the following Department exhibits:

Exhibit D-1: Credential View Screen for Respondent (Updated Copy).

Exhibit D-2: Letter of Cooperation sent to Respondent, dated February 9, 2017.

Exhibit D-3: Respondent's statement, dated February 27, 2017.

Exhibit D-4: Prescription Monitoring Program report for Respondent.

Exhibit D-5: Records for Patient A received from Respondent.

Exhibit D-6: Prescription Monitoring Program report for Patient A.

Exhibit D-7: Records for Patient B from Respondent.

Exhibit D-8: Prescription Monitoring Program report for Patient B.

Exhibit D-9: Records for Patient C from Respondent.

Exhibit D-10: Prescription Monitoring Program report for Patient C.

Exhibit D-11: Records for Patient D from Respondent.

Exhibit D-12: Prescription Monitoring Program report for Patient D.

Exhibit D-13: Records for Patient E from Respondent.

Exhibit D-14: Prescription Monitoring Program report for Patient E.

Exhibit D-15: Records for Patient F from Respondent.

Exhibit D-16: Prescription Monitoring Program report for Patient F.

Exhibit D-17: Records for Patient G from Respondent.

Exhibit D-18: Prescription Monitoring Program report for Patient G.

Exhibit D-19: Records for Patient H from Respondent.

Exhibit D-20: Records for Patient H from Polyclinic.

Exhibit D-21: Prescription Monitoring Program report for Patient H.

The Presiding Officer admitted the following Respondent exhibits:

Exhibit R-2: Morgentaler, A, Zitzmann, M, et al. Fundamental Concepts Regarding Testosterone Deficiency and Treatment: International Expert Consensus Resolutions. Mayo Clinic Proceedings: July 2016; 91(7): 881-896. Pursuant to ER 803(18), admitted as a DEMONSTRATIVE EXHIBIT only. Department may object upon reference and prior to usage.

Exhibit R-3: Morgentaler, A. Commentary: Guideline for Male Testosterone Therapy; A Clinicians Perspective. The Journal of Clinical Endocrinology and Metabolism 92(2); 416-417. Pursuant to ER 803(18), admitted as a DEMONSTRATIVE EXHIBIT only. Department may object upon reference and prior to usage.

Exhibit R-4: Spratt, Stewart, et al. Subcutaneous Injection of Testosterone Is an Effective and Preferred Alternative to Intramuscular Injection: Demonstration in Female-to-Male Transgender Patients. Journal of Clinical Endocrinologic Metabolism. 2017 July 1; 102(7): 2349-2355. Pursuant to ER 803(18), admitted as a DEMONSTRATIVE EXHIBIT only. Department may object upon reference and prior to usage.

Exhibit R-5: Olson, J, Sheree, M, et al. Subcutaneous Testosterone: An Effective Delivery Mechanism for Masculinizing Transgender Men. Published Online: 30 July 2014, Doi: https://doi.org/10.1089/lgbt.2014. 0018. Pursuant to ER 803(18), admitted as a DEMONSTRATIVE EXHIBIT only. Department may object upon reference and prior to usage.

Exhibit R-7: Wittich, C, Burkle, C, Lanier, W. Ten Common Questions (and Their Answers) About Off-label Drug Use. Mayo Clinical Proceedings. 2012 Oct; 87(10): 982-990. Pursuant to ER 803(18), admitted as a

DEMONSTRATIVE EXHIBIT only. Department may object upon reference and prior to usage.

Exhibit R-14: Hoermann, R, Midgley, J, et al. Recent Advances in Thyroid Hormone Regulation: Toward a New Paradigm for Optimal Diagnosis and Treatment. Frontiers in Endocrinology (Lausanne). 2017; 8: 364. Published online 2017 Dec 22. Doi: 10.3389/fendo.2017 00364. Pursuant to ER 803(18), admitted as a DEMONSTRATIVE EXHIBIT only. Department may object upon reference and prior to usage.

Exhibit R-21: DeLong, J, Miles-Thomas, J. Laser vaginal rejuvenation: What urologists need to know. Urology Times; March 2018. Pursuant to ER 803(18), admitted as a DEMONSTRATIVE EXHIBIT only. Department may object upon reference and prior to usage.

Exhibit R-24: Svartberg, J, Braekkan, S, et al. Endogenous sex hormone levels in men are not associated with risk of venous thromboembolism: The Tromso study. European Journal of Endocrinology (2009) 160 833-838. Pursuant to ER 803(18), admitted as a DEMONSTRATIVE EXHIBIT only. Department may object upon reference and prior to usage.

## I. FINDINGS OF FACT

1.1 The Respondent was granted a license to practice as a physician and surgeon in the state of Washington on July 16, 1976.

1.2 During the course of treating Patients B, D, G, and H, Respondent prescribed testosterone injections by unproven and unapproved route of administration (subcutaneous), at high frequency (up to three times weekly), and at high dosages, without any documentation of the rationale.

1.3 Respondent also failed to manage erythrocytosis (high red blood cell count) and high hematocrit values while administering testosterone therapy to Patients D and H.

1.4 Patient H also exhibited a high testosterone concentration for at least one year and Respondent made no therapeutic intervention during that year. A persistently high red blood cell count and hematocrit may cause strokes and myocardial infarctions (heart attacks).

1.5 Respondent prescribed Arimidex (anastrozole) to Patients B, G, and H and failed to document his rationale for prescribing this drug. Respondent further failed to document discussion of the benefits and risk with Patient B, G, and H, such as increased body fat and decreased bone mineral density in normal men and that the drug is not prescribed long term to men due to the adverse effects.

1.6 Respondent failed to document evaluation of or determine the cause of male hypogonadism for Patients B, D, G, and H. Minimal testing would include measurement of serum follicle-stimulating hormone (FSH) and luteinizing hormone (LH). Further treatment would depend on the results of these tests. This evaluation is important to exclude diseases such as a tumor in the pituitary gland. Respondent's testimony that records exist for FSH and LH was not credible.

1.7 Respondent failed to document measurement of two low blood testosterone concentrations measured in the early morning hours (between 7:00 a.m. and 10:00 a.m.) before initiating testosterone therapy for Patients B, D, G, and H. Testosterone concentrations must be low in at least two blood samples obtained in the

early morning on two different days and when the patient is not acutely ill because blood testosterone concentrations vary widely from day-to-day, and the diagnosis of male hypogonadism depends on reproducibly low blood testosterone concentrations. Here, the Commission found Dr. Anawalt's testimony more credible and more persuasive concerning the proper protocols before initiating testosterone therapy.

1.8 Respondent failed to meet the standard of care when prescribing testosterone therapy for Patients A, C, E, and F; all postmenopausal women. Respondent failed to document his rationale for prescribing testosterone therapy to Patients A, C, E, and F and failed to document any discussion regarding the potential risks and benefits with them. Testosterone therapy is not indicated for the treatment of menopausal symptoms in women, there are also cardiovascular risks of testosterone therapy in postmenopausal women, and it is known to cause hirsutism (excessive hair) in postmenopausal women.

1.9 Patient C's blood total testosterone concentration prior to initiation of testosterone treatment by Respondent was at the upper limit of normal for women. Patient C's serum total testosterone concentration during Respondents prescribed testosterone treatment was in the normal range for a man, but about five-to-ten times the upper limit of normal for a woman.

1.10 Respondent prescribed high dosages of thyroid hormone, but failed to appropriately monitor serum thyroid stimulating hormone (TSH) concentrations in Patients A, B, C, E, F, and G. Appropriate monitoring of serum TSH (which is considered the single most important test for the management of hypothyroidism, due to

thyroid gland dysfunction) ensures that a patient's blood thyroid hormone concentrations are in the normal range for that specific patient. High blood thyroid hormone concentrations that result in suppressed TSH concentrations increase the risk of cardiac arrhythmias, heart disease and loss of bone mineral density (resulting in osteoporosis).

1.11 Respondent diagnosed Patient H with primary adrenal insufficiency, but failed to perform a cosyntropin stimulation test to confirm this potentially life-threatening diagnosis. Without appropriate confirmation, Respondent could not have known if the treatment was adequate. Inadequate treatment of adrenal insufficiency may cause death. In addition, if Respondent believed Patient H had primary adrenal insufficiency, he failed to document informing Patient H about the necessity for supplemental corticosteroid (adrenal hormone) therapy for major surgeries or illnesses to ensure proper medical care.

1.12 Patient H presented to Respondent having already been diagnosed with a pituitary disorder and taking growth hormone from another provider. Respondent prescribed Patient H growth hormone but failed to adjust the dosage of growth hormone despite Patient H's lab results showing elevated insulin-like growth factor-1 concentrations on more than one occasion (IGF-1 regulates the effects of growth hormone in the body). Excessive growth hormone dosing resulting in elevated IGF-1 concentrations may cause or worsen diabetes mellitus and hypertension.

1.13 In 2014, Respondent's license was restricted pursuant to Stipulated Findings of Fact, Conclusions of Law, and Agreed Order (Agreed Order) entered with

the Commission on November 6, 2014. The Agreed Order (Paragraph 4.12) requires Respondent to obey all federal, state, and local laws and all administrative rules governing the practice of the profession in Washington. The Commission found that Respondent's conduct in this case violated the 2014 Agreed Order.

1.14 The Commission used its experience, competency, and specialized knowledge to evaluate the evidence. RCW 34.05.461(5).

1.15 The Commission concluded that the Respondent's treatment of the patients in this case fell beneath the standard of care and created an unreasonable risk of patient harm. Further, the Commission found Dr. Anawalt's testimony more credible and more persuasive than the testimony of the Respondent and Dr. Ware.

## II. CONCLUSIONS OF LAW

2.1 The Commission has jurisdiction over the Respondent and subject of this proceeding. RCW 18.130.040.

2.2 The Washington Supreme Court has held the standard of proof in disciplinary proceedings against physicians is proof by clear and convincing evidence. *Nguyen v. Department of Health*, 144 Wn.2d 516, 534 (2001), *cert. denied*, 535 U.S. 904 (2002).

2.3 As such, the Department bears the burden of proving the allegations set forth in the Statement of Charges by clear and convincing evidence.

2.4 The Department proved by clear and convincing evidence that the Respondent committed unprofessional conduct as defined in RCW 18.130.180(4), which outlines unprofessional conduct as:

> Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;

2.5 The Department proved by clear and convincing evidence that the Respondent committed unprofessional conduct as defined in RCW 18.130.180(9), which outlines unprofessional conduct as:

> Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;

2.6 The Department requests that: the Statement of Charges be affirmed; Respondent undergo a full evaluation by PACE; the restrictions that prohibit Respondent from prescribing opioids and hormones be continued until such time as the Commission is confident the Respondent is in compliance with any PACE recommendation; Respondent appear before the Commission and present a written Practice Plan, within six months of completing the PACE evaluation; Respondent pay a $10,000 fine within six months; monitoring for five years; and Respondent participate in Practice Reviews. The Respondent requests that he be allowed to continue to practice and see patients and that he only be required to take a course (or two) in charting in order to learn how to be more thorough in charting patient records. In determining appropriate sanctions, public safety must be considered before the rehabilitation of the Respondent. RCW 18.130.160. The Respondent's conduct falls in Tier B of the Practice Below the Standard of Care. WAC 246-16-810. The panel considered the following aggravating factors when determining the sanction in this matter: past

disciplinary record, number of the acts of misconduct, and ill repute on the profession. No mitigating factors were considered.

## III. ORDER

3.1 The Respondent's license to practice as a physician and surgeon in the state of Washington is RESTRICTED.

3.2 Respondent is RESTRICTED from prescribing opioids and hormones until such time as the Commission is confident Respondent no longer poses a danger to the public and that the Respondent is in compliance with any PACE recommendation. Further, all remaining active restrictions as detailed in the 2014 Agreed Order REMAIN IN PLACE until such time as the Commission is confident Respondent no longer poses a danger to the public and that the Respondent is in compliance with any PACE recommendation.

3.3 Evaluation. Respondent must complete an evaluation of his internal medicine clinical skills at the Physician Assessment and Clinical Education Program offered at the University of California at San Diego School of Medicine (PACE), or at another Commission-approved program.

3.3.1 Respondent must fully cooperate with the evaluation process and provide PACE with any information, documents, or releases that are requested.

3.3.2 PACE will provide a written report to the Commission or its designee regarding the evaluation, including recommendations for the scope and length of any additional evaluation or clinical training, treatment for any medical or psychological conditions, or anything else affecting Respondent's practice of medicine. Respondent must contract with PACE at his own expense to monitor

his satisfactory compliance of all recommendations and request that PACE provide quarterly reports to the Commission regarding Respondent's progress.

3.3.3 Respondent must provide PACE with a copy of this Order. The Commission or its designee may provide PACE with documents and records from its investigative files.

3.3.4 Respondent must authorize PACE and third party evaluators to discuss with the Commission or its designee any matters relating to Respondent's evaluation and compliance with recommendations. Respondent must waive any privileges or privacy rights under federal and state law regarding disclosures by PACE and third party evaluators to the Commission or its designee.

3.3.5 PACE and third party evaluators must provide a copy of evaluations and written reports to the Commission or its designee and must communicate as necessary to keep the Commission informed of Respondent's progress. The Commission or its designee will provide a copy of all evaluations and written reports received from PACE or third-party evaluators to Respondent in the event that PACE does not do so. Respondent must provide the Commission or its designee with copies of evaluations and written reports if PACE or third-party evaluators fail to do so.

3.3.6 Respondent is not entitled to dispute the reports or recommendations by PACE or third-party evaluators to the Commission. The Commission may amend this Order to incorporate PACE recommendations into this Order.

3.3.7 Within six months of completing the PACE evaluation, the Respondent shall appear before the commission and present a written Practice Plan.

3.4 Personal Appearances. As stated above, Respondent must personally appear at a date and location determined by the Commission in approximately

nine months after the effective date of this Final Order, or as soon thereafter as the Commission's schedule permits. Thereafter, Respondent must make personal appearances annually or as frequently as the Commission requires unless the Commission waives the need for an appearance. Respondent must participate in a brief telephone call with the Commission's Compliance Unit prior to the appearance. The purpose of appearances is to provide meaningful oversight over Respondent's compliance with the requirements of this Final Order. The Commission will provide reasonable notice of all scheduled appearances.

3.5 Monitoring. The Respondent shall be subject to monitoring by the Commission for a period of five years from the effective date of this Order. During this period, the Respondent shall be subject to practice reviews.

3.6 Practice Reviews. Respondent must permit or make arrangements with his employer to allow a representative or designee of the Commission to review Respondent's patient records biannually and make announced visits to Respondent's practice in order to interview Respondent and staff and to copy records regarding Respondent's practice until this Stipulation is terminated. The review may include: Inspection of office and personnel records, medication logs, and medical records; Interview of Respondent, Respondent's partners, and office staff; and review of other aspects of Respondent's practice. Any costs associated with these practice reviews will be borne by Respondent.

3.7 Modification. The Respondent may not seek modification of this Order.

3.8 Fine. The Respondent will pay a fine to the Commission in the amount of $10,000 dollars within 6 months of the effective date of this Order. The fine must be

paid by certified or cashier's check or money order, made payable to the Department of Health and mailed to: Department of Health, Washington Medical Commission, P.O. Box 1099, Olympia, Washington 98507-1099.

3.9 Change of Address. The Respondent shall inform the program manager and the Adjudicative Service Unit, in writing, of changes in his residential and/or business address within 30 days of such change.

3.10 Assume Compliance Costs. The Respondent shall assume all costs of complying with all requirements, terms, and conditions of this Order.

3.11 Failure to Comply. Protecting the public requires practice under the terms and conditions imposed in this Order. Failure to comply with the terms and conditions of this Order may result in suspension and/or revocation of the Respondent's license after a show cause hearing. If the Respondent fails to comply with the terms and conditions of this Order, the Commission may hold a hearing. At that hearing, the Respondent must show cause why his license should not be suspended. Alternatively, the Commission may bring additional charges of unprofessional conduct under RCW 18.130.180(9). In either case, the Respondent will be given notice and an opportunity for a hearing on the issue of non-compliance.

Dated this 20th day of October, 2020.

*Washington Medical Commission*

THOMAS FAIRCHILD, M.D., Pro Tem
Panel Chair

## CLERK'S SUMMARY

| Charge | Action |
|---|---|
| RCW 18.130.180(4) | Violated |
| RCW 18.130.180(9) | Violated |

## NOTICE TO PARTIES

This order is subject to the reporting requirements of RCW 18.130.110, Section 1128E of the Social Security Act, and any other applicable interstate or national reporting requirements. If discipline is taken, it must be reported to the Healthcare Integrity Protection Data Bank.

Either party may file a **petition for reconsideration.** RCW 34.05.461(3); 34.05.470. The petition must be filed within 10 days of service of this order with:

Adjudicative Service Unit
P.O. Box 47879
Olympia, WA 98504-7879

and a copy must be sent to:

Department of Health Medical Program
P.O. Box 47866
Olympia, WA 98504-7866

The petition must state the specific grounds for reconsideration and what relief is requested. WAC 246-11-580. The petition is denied if the Commission does not respond in writing within 20 days of the filing of the petition.

A **petition for judicial review** must be filed and served within 30 days after service of this order. RCW 34.05.542. The procedures are identified in chapter 34.05 RCW, Part V, Judicial Review and Civil Enforcement. A petition for reconsideration is not required before seeking judicial review. If a petition for reconsideration is filed, the above 30-day period does not start until the petition is resolved. RCW 34.05.470(3).

The order is in effect while a petition for reconsideration or review is filed. "Filing" means actual receipt of the document by the Adjudicative Service Unit.

RCW 34.05.010(6). This order is "served" the day it is deposited in the United States mail. RCW 34.05.010(19).

For more information, visit our website at:
http://www.doh.wa.gov/PublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/Hearings.aspx

STATE OF WASHINGTON
MEDICAL QUALITY ASSURANCE COMMISSION

| | |
|---|---|
| In the Matter of:<br><br>**ROGER B. OLSSON, M.D.,**<br>License No. MD.MD.00015303<br><br>Respondent. | Master No. M2017-527<br><br>EX PARTE ORDER OF SUMMARY RESTRICTION |

PRESIDING OFFICER: Roman S. Dixon Jr., Chief Health Law Judge

COMMISSION PANEL: Warren B. Howe, M.D., Chair
Harry Harrison, M.D.
Mimi Winslow, Public Member

This matter came before the Medical Quality Assurance Commission (Commisson) on May 10, 2019, on an Ex Parte Motion for Summary Restriction (Ex Parte Motion) brought by the Office of the Attorney General. The Commission issued a Statement of Charges alleging Respondent violated RCW 18.130.180(4) and (9). After reviewing the Statement of Charges, Ex Parte Motion, and supporting evidence, the Commission GRANTS the Ex Parte Motion. Respondent's license to practice as a physician and surgeon is SUMMARILY RESTRICTED pending further action.

## I. FINDINGS OF FACT

1.1 Roger B. Olsson, M.D., (Respondent), is a physician and surgeon licensed by the state of Washington at all times applicable to this matter.

1.2 The Commission issued a Statement of Charges alleging Respondent violated RCW 18.130.180(4) and (9). The Statement of Charges was accompanied by all other documents required by WAC 246-11-250.

1.3 As set forth in the allegations in the Statement of Charges, as well as the Ex Parte Motion, during the relevant period of time, Respondent was under an Order of the Commission which required him to obey all laws and rules related to the practice of medicine. Respondent's practice with regards to prescription of hormones (including testosterone, a controlled substance) and evaluation and management of possible endocrinological conditions was outside the standard of care.

1.4 Respondent failed to document any rational for administration of testosterone injections by an unproven and unapproved route of administration, at a high frequency and at high dosages. Respondent put Patients D and H, patients with persistently high red blood cell counts and high hematocrit levels at risk for strokes and heart attacks by failing to implement any therapeutic interventions.

1.5 Respondent's chart notes fail to demonstrate any rationale for prescribing the medication Arimidex to Patients B, G, and H and fail to reveal communication of the risks and benefits of such a medication to the patients. This medication placed patients at risk of increased body fat and reduced bone density.

1.6 Respondent failed to document an appropriate evaluation of Patients B, D, G, and H for hypogonadism, as well as failed to identify the cause of the condition before initiating testosterone therapy. Additionally, Respondent failed to document proper testing methods for these patients. Respondent's failure to evaluate these patients, put them at risk of undiscovered diseases such as tumors in the pituitary gland.

1.7 Respondent prescribed testosterone to Patients A, C, E, and F, all of whom were post-menopausal women, for treatment of menopausal symptoms. However, testosterone therapy is not indicated for the treatment of menopausal symptoms. Respondent failed to document his rationale for this treatment, and whether he discussed the risks and benefits of this treatment with any of the patients. Respondent placed these patients at increased risk for cardiovascular disease and development of excessive hair growth, particularly Patient C, whose serum total testosterone concentration levels were elevated approximately five-to-ten times the upper limit normal for a woman.

1.8 Respondent prescribed high doses of thyroid hormone to Patients A, B, C, E, F, and G without appropriately monitoring the patients' thyroid stimulating hormone concentrations. Respondent failed to make necessary medication adjustments despite lab work indicating the dosages were outside of normal ranges. Respondent placed these patients at increased risk of cardiac arrhythmias, heart disease, and osteoporosis resulting from suppressed TSH concentrations.

1.9 Respondent diagnosed Patient H with primary adrenal insufficiency, but failed to document discussion of the necessity of corticosteroid therapy during major surgeries or illnesses. Additionally, Respondent failed to confirm the diagnosis with a cosyntropin stimulation test. Respondent put Patient H at severe risk. The risk of inadequate treatment of adrenal insufficiency is death.

1.10 Respondent prescribed Patient H growth hormone, but failed to adjust the dosage of growth hormone despite Patient H's lab results showing elevated insulin-like

growth factor-1 concentrations on more than one occasion. Through excessive growth hormone dosing resulting in elevated IGF-1 concentrations, Respondent placed Patient H at risk of worsening his diabetes and hypertension and causing the life-threatening disease acromegaly.

1.11 The above allegations, supported by the Declaration of Supervising Health Care Investigator In Support of Motion for Summary Action, together with the attached exhibits A through H, and the Declaration of Bradley Anawalt, M.D., together with attached exhibits 1 and 2, justify the determination of immediate danger in this case and a decision to immediately restrict the credential until a hearing on the matter is held.

## II. CONCLUSIONS OF LAW

2.1 The Commission, has jurisdiction over Respondent's credential to practice as a physician and surgeon. RCW 18.130.040.

2.2 The Commission has authority to take emergency adjudicative action to address an immediate danger to the public health, safety, or welfare. RCW 34.05.422(4); RCW 34.05.479; RCW 18.130.050(8); and WAC 246-11-300.

2.3 The Findings of Fact establish the existence of an immediate danger to the public health, safety, or welfare if Respondent has an unrestricted credential. The Findings of Fact establish that the requested summary action is necessary and adequately addresses the danger to the public health, safety, or welfare.

## III. ORDER

3.1 Based on the Findings of Fact and the Conclusions of Law, it is ORDERED that Respondent's license to practice as a physician and surgeon is

SUMMARILY RESTRICTED pending further disciplinary proceedings by the Commission. Respondent is prohibited from prescribing hormones. Additionally, the restrictions on prescribing set forth in the Agreed Order in Master Case No. M2011-1437 are still in effect. Respondent shall immediately deliver all licenses (including wall, display, and/or wallet, if any) to the Commission.

3.2 It is HEREBY ORDERED that a protective order in this case is GRANTED. RCW 34.05.446(1) and WAC 246-11-400(2) and (5). This Protective Order prohibits the release of health care information outside of these proceedings. Unless required by law, anyone involved in these proceedings must keep confidential and not disclose health care information obtained through these proceedings. Health care information includes information in any form "that identifies or can readily be associated with the identity of a patient and directly relates to the patient's health care." RCW 70.02.010(16). The parties may share the information with their attorney, if any.

DATED this 10th day of May, 2019.

*Medical Quality Assurance Commission*

WARREN B. HOWE, M.D.
PANEL CHAIR

For more information, visit our Web site at http://www.doh.wa.gov/hearings



STATE OF WASHINGTON * DEPARTMENT OF HEALTH * OFFICIAL SEAL

I certify that this is a true and correct copy of the original document on file with the Washington Department of Health
Michael J. Kramer
Date
12-21-20

STATE OF WASHINGTON
MEDICAL QUALITY ASSURANCE COMMISSION

| | |
|---|---|
| In the Matter of the License to Practice as a Physician and Surgeon of:<br><br>ROGER B. OLSSON, MD<br>License No. MD00015303<br><br>Respondent. | No. M2017-527<br><br>STATEMENT OF CHARGES |

The Executive Director of the Medical Quality Assurance Commission (Commission) is authorized to make the allegations below, which are supported by the evidence contained in Commission file number 2016-11791. The patients referred to in this Statement of Charges are identified in the attached Confidential Schedule.

## 1. ALLEGED FACTS

1.1 On July 16, 1976, the state of Washington issued Respondent a license to practice as a physician and surgeon. Respondent's license is active with restrictions. Respondent specializes in family medicine, but is not board certified.

1.2 In 2014 Respondent's license was restricted pursuant to Stipulated Findings of Fact, Conclusions of Law, and Agreed Order (Agreed Order) entered with the Commission entered on November 6, 2014. The Agreed Order Paragraph 4.12 of the 2014 Order requires Respondent to obey all federal, state and local laws and all administrative rules governing the practice of the profession in Washington.

1.2 The Commission reviewed eight (8) of Respondent's records for Patients A through H. The records spanned from October 2015 through December 2016. Respondent's treatment of these patients failed to meet the standard of care in multiple ways.

Testosterone

1.3 Respondent prescribed testosterone injections to Patients B, D, G, and H by an unproven and unapproved route of administration (subcutaneous), at high frequency (up to three times weekly), and at high dosages, without any documentation of the rationale.



ORIGINAL

1.4 Respondent failed to manage erythrocytosis (high red blood cell count) and high hematocrit values while administering testosterone therapy to Patients D and H. The appropriate management options are to reduce the dosage of testosterone, discontinue testosterone therapy, or reduce the excessive red blood cell count by taking a large volume of blood from the patient.

1.5 Respondent failed to document any plans for treatment or follow up for Patient D.

1.6 Patient H also exhibited a high testosterone concentration for at least one year and Respondent made no therapeutic intervention during that year. A persistently high red blood cell count and hematocrit may cause strokes and myocardial infarctions (heart attacks).

1.7 Respondent prescribed Arimidex (anastrozole) to Patients B, G, and H and failed to document his rationale for prescribing this drug. Respondent further failed to document discussion of the benefits and risks with Patient B, G, and H such as increased body fat and decreased bone mineral density in normal men and that the drug is not prescribed long term to men because of these effects.

Male Hypogonadism

1.8 Respondent failed to document evaluation of or determine the cause of male hypogonadism for Patients B, D, G, and H. Minimal testing would include measurement of serum follicle-stimulating hormone (FSH) and luteinizing hormone (LH). Further treatment would depend on the results of these tests. This evaluation is important to exclude diseases such as a tumor in the pituitary gland.

1.9 Respondent failed to document measurement of two low blood testosterone concentrations measured in the early morning hours (between 7:00 a.m. and 10:00 a.m.) before initiating testosterone therapy for Patients B, D, G, and H. Testosterone concentrations must be low in at least two blood samples obtained in the early morning on two different days and when the patient is not acutely ill because blood testosterone concentrations vary widely from day-to-day, and the diagnosis of male hypogonadism depends on reproducibly low blood testosterone concentrations.

Testosterone in Women

1.10 Respondent failed to meet the standard of care when prescribing testosterone therapy for Patients A, C, E, and F, all postmenopausal women.

Respondent failed to document his rationale for prescribing testosterone therapy to Patients A, C, E, and F and failed to document any discussion regarding the potential risks and benefits with them. Testosterone therapy is not indicated for the treatment of menopausal symptoms in women, there are cardiovascular risks of testosterone therapy in postmenopausal women, and it is known to cause hirsutism (excessive hair) in postmenopausal women.

1.11 Patient C's blood total testosterone concentration prior to initiation of testosterone treatment by Respondent was at the upper limit of normal for women. Patient C's serum total testosterone concentration during Respondent's prescribed testosterone treatment was in the normal range for a man (about five-to-ten times the upper limit of normal for a woman).

Thyroid Disease

1.12 Respondent prescribed high dosages of thyroid hormone, but failed to appropriately monitor serum thyroid stimulating hormone (TSH) concentrations in Patients A, B, C, E, F, and G. Appropriate monitoring of serum TSH (which is considered the single most important test for the management of hypothyroidism due to thyroid gland dysfunction) ensures that a patient's blood thyroid hormone concentrations are in the normal range for that specific patient. High blood thyroid hormone concentrations that result in suppressed TSH concentrations increase the risk of cardiac arrhythmias, heart disease and loss of bone mineral density (resulting in osteoporosis).

Patient A

1.13 Patient A had blood tests indicating markedly excessive thyroid dosing on October 2015 and January 2016 (based on high thyroid hormone concentrations and very abnormal TSH concentrations) but Respondent failed to decrease the thyroid hormone dosage. Respondent failed to check a serum TSH from January 2016 through November 2016, but continued prescribing the same excessive and harmful dosage of levothyroxine.

Patient G

1.14 On or about March 30, 2016, Respondent ordered an increased dosage of levothyroxine for Patient G despite the fact that Patient G's serum TSH clearly indicated the current dosage of levothyroxine was already too high.

Primary Adrenal Insufficiency

1.15 Respondent diagnosed Patient H with primary adrenal insufficiency, but failed to perform a cosyntropin stimulation test to confirm this potentially life-threatening diagnosis. Without appropriate confirmation, Respondent could not have known if the treatment was adequate. Inadequate treatment of adrenal insufficiency may cause death. Additionally, if Respondent believed Patient H had primary adrenal insufficiency, he failed to document informing Patient H about the necessity for supplemental corticosteroid (adrenal hormone) therapy for major surgeries or illnesses.

Growth Hormone

1.16 Patient H presented to Respondent having already been diagnosed with a pituitary disorder and taking growth hormone from another provider. Respondent prescribed Patient H growth hormone but failed to adjust the dosage of growth hormone despite Patient H's lab results showing elevated insulin-like growth factor-1 concentrations (IGF-1 regulates the effects of growth hormone in the body) on more than one occasion. Excessive growth hormone dosing resulting in elevated IGF-1 concentrations may cause or worsen diabetes mellitus and hypertension, both of which Patient H suffered from, and may eventually result in the life-threatening disease acromegaly (enlargement of the hands, feet, forehead, jaw, etc.).

FemiLift Procedures

1.17 Respondent performed a FemiLift procedure four times on Patient E. The procedure consists of vaginal wall laser therapy to "rejuvenate the vagina." FemiLift is not approved by the Food and Drug Administration. Respondent failed to document informed consent from Patient E prior to performing the procedures, discussion of the risks and benefits of the procedures, or if an assistant was present during the procedures.

## 2. ALLEGED VIOLATIONS

2.1 Based on the Alleged Facts, Respondent has committed unprofessional conduct in violation of RCW 18.130.180(4) and (9).

> RCW 18.130.180 **Unprofessional conduct.** The following conduct, acts, or conditions constitute unprofessional conduct for any license holder under the jurisdiction of this chapter:
>
> ...

(4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed.

....

(9) Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;

....

2.2 The above violation provides grounds for imposing sanctions under RCW 18.130.160.

## 3. NOTICE TO RESPONDENT

The charges in this document affect the public health, safety and welfare. The Executive Director of the Commission directs that a notice be issued and served on Respondent as provided by law, giving Respondent the opportunity to defend against these charges. If Respondent fails to defend against these charges, Respondent shall be subject to discipline and the imposition of sanctions under Chapter 18.130 RCW.

DATED: May 8, 2019.

STATE OF WASHINGTON
MEDICAL QUALITY ASSURANCE
COMMISSION

MELANIE DE LEON
EXECUTIVE DIRECTOR

I certify that this is a true and correct copy of the original document on file with the Washington Department of Health

Michael J. Kramer

Date 12-28-20

ROBERT W. FERGUSON
ATTORNEY GENERAL

KRISTIN G. BREWER, WSBA# 38494
SENIOR COUNSEL

STATE OF WASHINGTON * OFFICIAL SEAL * DEPARTMENT OF HEALTH



ORIGINAL

CONFIDENTIAL SCHEDULE

**This information is confidential and is NOT to be released without the consent of the individual or individuals named below. RCW 42.56.240(1)**

Patient A

Patient B

Patient C

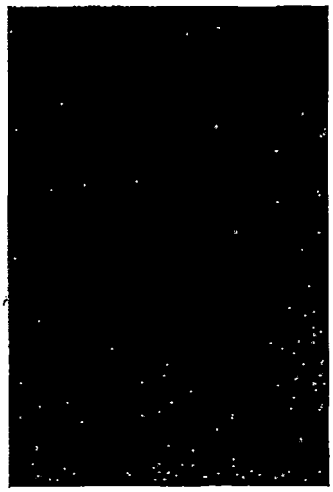
Patient D

Patient E

Patient F

Patient G

Patient H





ORIGINAL

# EXHIBIT B
## Expert Reports

STATE OF WASHINGTON

# DEPARTMENT OF HEALTH

*Olympia, Washington 98504*

May 17, 2021

Roger B. Olsson, MD
Dr.olsson@therenewalcenter.com
rbolsson@comcast.net

RE Master Case No. M2017-527

Dear Dr. Olsson:

Enclosed please find Declaration of Service and Amended Findings of Fact, Conclusions of Law, and Final Order dated May 12, 2021.

Any questions regarding the terms and conditions of the Order should be directed to Mike Kramer, Compliance Officer at (360) 236-2781.

Sincerely,

Michelle Singer, Lead Adjudicative Clerk
Adjudicative Clerk's Office
PO Box 47879
Olympia, WA 98504-7879

cc: Kristin Brewer, AAG
Jenelle Houser, Case Manager
Mike Kramer, Compliance Officer
Ariele Page Landstrom, Staff Attorney

Enclosure

**STATE OF WASHINGTON**
**DEPARTMENT OF HEALTH**
**ADJUDICATIVE CLERK'S OFFICE**

| | | |
|---|---|---|
| In the Matter of:<br><br>**ROGER B. OLSSON, MD**<br>Credential No. MD.MD.00015303<br><br>Respondent. | ) | Master Case No. M2017-527<br><br>DECLARATION OF SERVICE |

I declare under penalty of perjury, under the laws of the state of Washington, that the following is true and correct:

On May 17, 2021, I served a true and correct copy of the Amended Findings of Fact, Conclusions of Law, and Final Order, signed by the Panel Chair on May 12, 2021; and in the manner indicated, on the following parties to this case:

| | |
|---|---|
| Roger B. Olsson, MD<br>Dr.olsson@therenewalcenter.com<br>rbolsson@comcast.net | ☒ECF/Email<br>☐1st Class Mail |
| Kristin Brewer, AAG<br>Kristin.brewer@atg.wa.gov | ☒ECF/Email<br>☐1st Class Mail |

DATED: This 17th day of May, 2021.

Michelle Singer, Lead Adjudicative Clerk
Adjudicative Clerk's Office

cc: Jenelle Houser, Case Manager
Mike Kramer, Compliance Officer
Ariele Page Landstrom, Staff Attorney

**STATE OF WASHINGTON**
**DEPARTMENT OF HEALTH**
**WASHINGTON MEDICAL COMMISSION**

| | |
|---|---|
| In the Matter of:<br><br>ROGER B. OLSSON, M.D.,<br>Credential No. MD.MD.00015303,<br><br>Respondent. | Master Case No. M2017-527<br><br>**AMENDED** FINDINGS OF FACT,<br>CONCLUSIONS OF LAW,<br>AND FINAL ORDER |

APPEARANCES:

Roger B. Olsson, M.D., the Respondent, by
Gerald Tarutis, Attorney at Law

Department of Health Medical Program (Department), by
Office of the Attorney General, per
Kristin G. Brewer, Assistant Attorney General

PANEL: Warren Howe, M.D., Chair
Thomas Fairchild, M.D., Pro Tem
Scott Rodgers, Public Member

PRESIDING OFFICER: Roman S. Dixon Jr., Chief Health Law Judge

**AMENDMENT**

This Final Order was served on October 22, 2020. On November 2, 2020, the Department filed its Petition for Reconsideration.[1] Therein, the Department requested reconsideration of two provisions of the Final Order as related to opioid prescribing and the training at PACE (and the requirements for doing so). In addition, the Department identified a scrivener's error that referred to the "Order" as a "Stipulation." On November 10, 2020, the Adjudicative Service Unit issued Post Hearing Order No. 3: Order Setting Briefing Schedule (Briefing Schedule). The Respondent filed his Response to Department's Petition for Reconsideration on November 23, 2020. The Department filed its Reply on November 30, 2020. After review of the Petition, Response/Reply and the Final Order, the Commission amends the Findings of Fact, Conclusions of Law, and Final Order issued as follows in **bold** type.

[1] The Department's Petition for Reconsideration was timely and conformed to the requirements of WAC 246-11-580.

## SCRIVENER'S ERROR

The Commission notes that a Scrivener's error occurred in the Final Order. A Scrivener's error appears in Paragraph 3.6, which reads, "Respondent must permit or make arrangements with his employer to allow a representative or designee of the Commission to review Respondent's patient records bi-annually and make announced visits to Respondent's practice in order to interview Respondent and staff and to copy records regarding Respondent's practice until this Stipulation is terminated." The provision should have read as, ". . . Respondent's practice until this **Order** is terminated." Under the rationale of Civil Rule (CR) 60(a) and the significant decision *In re Jantz*, OPS No. 90-07-31-065 MA (June 28, 1993), this correction is entered and the correction is in **bold** type.

## INTRODUCTION

A hearing was held in this matter on October 18, 2019, regarding allegations of unprofessional conduct. CREDENTIAL RESTRICTED.

## ISSUES

Did the Respondent commit unprofessional conduct as defined by RCW 18.130.180(4) and (9)?

If the Department proves unprofessional conduct, what are the appropriate sanctions under RCW 18.130.160?

## SUMMARY OF PROCEEDINGS

At the hearing, the Department presented the testimony of:

1. Respondent as an adverse witness; and
2. Bradley Anawalt, M.D., FACP, Department expert.

At the hearing, the Respondent presented the testimony of:

1. Roger B. Olsson, M.D.; and
2. Kevin Ware, D.O.

The Presiding Officer admitted the following Department exhibits:

Exhibit D-1: Credential View Screen for Respondent (Updated Copy).

Exhibit D-2: Letter of Cooperation sent to Respondent, dated February 9, 2017.

Exhibit D-3: Respondent's statement, dated February 27, 2017.

Exhibit D-4: Prescription Monitoring Program report for Respondent.

Exhibit D-5: Records for Patient A received from Respondent.

Exhibit D-6: Prescription Monitoring Program report for Patient A.

Exhibit D-7: Records for Patient B from Respondent.

Exhibit D-8: Prescription Monitoring Program report for Patient B.

Exhibit D-9: Records for Patient C from Respondent.

Exhibit D-10: Prescription Monitoring Program report for Patient C.

Exhibit D-11: Records for Patient D from Respondent.

Exhibit D-12: Prescription Monitoring Program report for Patient D.

Exhibit D-13: Records for Patient E from Respondent.

Exhibit D-14: Prescription Monitoring Program report for Patient E.

Exhibit D-15: Records for Patient F from Respondent.

Exhibit D-16: Prescription Monitoring Program report for Patient F.

Exhibit D-17: Records for Patient G from Respondent.

Exhibit D-18: Prescription Monitoring Program report for Patient G.

Exhibit D-19: Records for Patient H from Respondent.

Exhibit D-20: Records for Patient H from Polyclinic.

Exhibit D-21: Prescription Monitoring Program report for Patient H.

The Presiding Officer admitted the following Respondent exhibits:

Exhibit R-2: Morgentaler, A, Zitzmann, M, et al. Fundamental Concepts Regarding Testosterone Deficiency and Treatment: International Expert Consensus Resolutions. Mayo Clinic Proceedings: July 2016; 91(7): 881-896. Pursuant to ER 803(18), admitted as a DEMONSTRATIVE EXHIBIT only. Department may object upon reference and prior to usage.

Exhibit R-3: Morgentaler, A. Commentary: Guideline for Male Testosterone Therapy; A Clinicians Perspective. The Journal of Clinical Endocrinology and Metabolism 92(2); 416-417. Pursuant to ER 803(18), admitted as a DEMONSTRATIVE EXHIBIT only. Department may object upon reference and prior to usage.

Exhibit R-4: Spratt, Stewart, el al. Subcutaneous Injection of Testosterone Is an Effective and Preferred Alternative to Intramuscular Injection: Demonstration in Female-to-Male Transgender Patients. Journal of Clinical Endocrinologic Metabolism. 2017 July 1; 102(7): 2349-2355. Pursuant to ER 803(18), admitted as a DEMONSTRATIVE EXHIBIT only. Department may object upon reference and prior to usage.

Exhibit R-5: Olson, J, Sheree, M, et al. Subcutaneous Testosterone: An Effective Delivery Mechanism for Masculinizing Transgender Men. Published Online: 30 July 2014, Doi: https://doi.org/10.1089/lgbt.2014. 0018. Pursuant to ER 803(18), admitted as a DEMONSTRATIVE EXHIBIT only. Department may object upon reference and prior to usage.

Exhibit R-7: Wittich, C, Burkle, C, Lanier, W. Ten Common Questions (and Their Answers) About Off-label Drug Use. Mayo Clinical Proceedings. 2012 Oct; 87(10): 982-990. Pursuant to ER 803(18), admitted as a DEMONSTRATIVE EXHIBIT only. Department may object upon reference and prior to usage.

Exhibit R-14: Hoermann, R, Midgley, J, et al. Recent Advances in Thyroid Hormone Regulation: Toward a New Paradigm for Optimal Diagnosis and Treatment. Frontiers in Endocrinology (Lausanne). 2017; 8: 364. Published online 2017 Dec 22. Doi: 10.3389/fendo.2017 00364. Pursuant to ER 803(18), admitted as a

DEMONSTRATIVE EXHIBIT only. Department may object upon reference and prior to usage.

Exhibit R-21: DeLong, J, Miles-Thomas, J. Laser vaginal rejuvenation: What urologists need to know. Urology Times; March 2018. Pursuant to ER 803(18), admitted as a DEMONSTRATIVE EXHIBIT only. Department may object upon reference and prior to usage.

Exhibit R-24: Svartberg, J, Braekkan, S, et al. Endogenous sex hormone levels in men are not associated with risk of venous thromboembolism: The Tromso study. European Journal of Endocrinology (2009) 160 833-838. Pursuant to ER 803(18), admitted as a DEMONSTRATIVE EXHIBIT only. Department may object upon reference and prior to usage.

## I. FINDINGS OF FACT

1.1 The Respondent was granted a license to practice as a physician and surgeon in the state of Washington on July 16, 1976.

1.2 During the course of treating Patients B, D, G, and H, Respondent prescribed testosterone injections by unproven and unapproved route of administration (subcutaneous), at high frequency (up to three times weekly), and at high dosages, without any documentation of the rationale.

1.3 Respondent also failed to manage erythrocytosis (high red blood cell count) and high hematocrit values while administering testosterone therapy to Patients D and H.

1.4 Patient H also exhibited a high testosterone concentration for at least one year and Respondent made no therapeutic intervention during that year. A persistently high red blood cell count and hematocrit may cause strokes and myocardial infarctions (heart attacks).

1.5 Respondent prescribed Arimidex (anastrozole) to Patients B, G, and H and failed to document his rationale for prescribing this drug. Respondent further failed to document discussion of the benefits and risk with Patient B, G, and H, such as increased body fat and decreased bone mineral density in normal men and that the drug is not prescribed long term to men due to the adverse effects.

1.6 Respondent failed to document evaluation of or determine the cause of male hypogonadism for Patients B, D, G, and H. Minimal testing would include measurement of serum follicle-stimulating hormone (FSH) and luteinizing hormone (LH). Further treatment would depend on the results of these tests. This evaluation is important to exclude diseases such as a tumor in the pituitary gland. Respondent's testimony that records exist for FSH and LH was not credible.

1.7 Respondent failed to document measurement of two low blood testosterone concentrations measured in the early morning hours (between 7:00 a.m. and 10:00 a.m.) before initiating testosterone therapy for Patients B, D, G, and H. Testosterone concentrations must be low in at least two blood samples obtained in the early morning on two different days and when the patient is not acutely ill because blood testosterone concentrations vary widely from day-to-day, and the diagnosis of male hypogonadism depends on reproducibly low blood testosterone concentrations. Here, the Commission found Dr. Anawalt's testimony more credible and more persuasive concerning the proper protocols before initiating testosterone therapy.

1.8 Respondent failed to meet the standard of care when prescribing testosterone therapy for Patients A, C, E, and F; all postmenopausal women.

Respondent failed to document his rationale for prescribing testosterone therapy to Patients A, C, E, and F and failed to document any discussion regarding the potential risks and benefits with them. Testosterone therapy is not indicated for the treatment of menopausal symptoms in women, there are also cardiovascular risks of testosterone therapy in postmenopausal women, and it is known to cause hirsutism (excessive hair) in postmenopausal women.

1.9 Patient C's blood total testosterone concentration prior to initiation of testosterone treatment by Respondent was at the upper limit of normal for women. Patient C's serum total testosterone concentration during Respondents prescribed testosterone treatment was in the normal range for a man, but about five-to-ten times the upper limit of normal for a woman.

1.10 Respondent prescribed high dosages of thyroid hormone, but failed to appropriately monitor serum thyroid stimulating hormone (TSH) concentrations in Patients A, B, C, E, F, and G. Appropriate monitoring of serum TSH (which is considered the single most important test for the management of hypothyroidism, due to thyroid gland dysfunction) ensures that a patient's blood thyroid hormone concentrations are in the normal range for that specific patient. High blood thyroid hormone concentrations that result in suppressed TSH concentrations increase the risk of cardiac arrhythmias, heart disease and loss of bone mineral density (resulting in osteoporosis).

1.11 Respondent diagnosed Patient H with primary adrenal insufficiency but failed to perform a cosyntropin stimulation test to confirm this potentially life-threatening

diagnosis. Without appropriate confirmation, Respondent could not have known if the treatment was adequate. Inadequate treatment of adrenal insufficiency may cause death. In addition, if Respondent believed Patient H had primary adrenal insufficiency, he failed to document informing Patient H about the necessity for supplemental corticosteroid (adrenal hormone) therapy for major surgeries or illnesses to ensure proper medical care.

1.12 Patient H presented to Respondent having already been diagnosed with a pituitary disorder and taking growth hormone from another provider. Respondent prescribed Patient H growth hormone but failed to adjust the dosage of growth hormone despite Patient H's lab results showing elevated insulin-like growth factor-1 concentrations on more than one occasion (IGF-1 regulates the effects of growth hormone in the body). Excessive growth hormone dosing resulting in elevated IGF-1 concentrations may cause or worsen diabetes mellitus and hypertension.

1.13 In 2014, Respondent's license was restricted pursuant to Stipulated Findings of Fact, Conclusions of Law, and Agreed Order (Agreed Order) entered with the Commission on November 6, 2014. The Agreed Order (Paragraph 4.12) requires Respondent to obey all federal, state, and local laws and all administrative rules governing the practice of the profession in Washington. The Commission found that Respondent's conduct in this case violated the 2014 Agreed Order.

1.14 The Commission used its experience, competency, and specialized knowledge to evaluate the evidence. RCW 34.05.461(5).

1.15 The Commission concluded that the Respondent's treatment of the patients in this case fell beneath the standard of care and created an unreasonable risk of patient harm. Further, the Commission found Dr. Anawalt's testimony more credible and more persuasive than the testimony of the Respondent and Dr. Ware.

## II. CONCLUSIONS OF LAW

2.1 The Commission has jurisdiction over the Respondent and subject of this proceeding. RCW 18.130.040 RCW.

2.2 The Washington Supreme Court has held the standard of proof in disciplinary proceedings against physicians is proof by clear and convincing evidence. *Nguyen v. Department of Health*, 144 Wn.2d 516, 534 (2001), *cert. denied*, 535 U.S. 904 (2002).

2.3 As such, the Department bears the burden of proving the allegations set forth in the Statement of Charges by clear and convincing evidence.

2.4 The Department proved by clear and convincing evidence that the Respondent committed unprofessional conduct as defined in RCW 18.130.180(4), which outlines unprofessional conduct as:

> Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;

2.5 The Department proved by clear and convincing evidence that the Respondent committed unprofessional conduct as defined in RCW 18.130.180(9), which outlines unprofessional conduct as:

> Failure to comply with an order issued by the disciplining authority or a stipulation for informal disposition entered into with the disciplining authority;

2.6 The Department requests that: the Statement of Charges be affirmed; Respondent undergo a full evaluation by PACE; the restrictions that prohibit Respondent from prescribing opioids and hormones be continued until such time as the Commission is confident the Respondent is in compliance with any PACE recommendation; Respondent appear before the Commission and present a written Practice Plan, within six months of completing the PACE evaluation; Respondent pay a $10,000 fine within six months; monitoring for five years; and Respondent participate in Practice Reviews. The Respondent requests that he be allowed to continue to practice and see patients and that he only be required to take a course (or two) in charting in order to learn how to be more thorough in charting patient records. In determining appropriate sanctions, public safety must be considered before the rehabilitation of the Respondent. RCW 18.130.160. The Respondent's conduct falls in Tier B of the Practice Below the Standard of Care. WAC 246-16-810. The panel considered the following aggravating factors when determining the sanction in this matter: past disciplinary record; number of the acts of misconduct; and ill repute on the profession. No mitigating factors were considered.

## III. ORDER

3.1 The Respondent's license to practice as a physician and surgeon in the state of Washington is RESTRICTED.

3.2 Respondent is **PERMANENTLY** RESTRICTED from prescribing opioids for chronic pain patients.

**A. Respondent is also PERMANENTLY RESTRICTED from prescribing opioids for acute pain except for a two-week period for prescribing hydrocodone, codeine, or oxycodone for post-procedure acute pain related to the cosmetic procedures performed at the Renewal Center, and for his family practice patients. If the patient requires more than two weeks of hydrocodone, codeine, or oxycodone treatment, the patient shall be referred out.**

**B. Respondent REMAINS RESTRICTED as to prescribing benzodiazepines. Respondent may prescribe benzodiazepines for his family practice patients with generalized anxiety for no more than 90 days after which Respondent must refer the patient to another provider or board-certified psychiatrist for management.**

C. Further, all remaining active restrictions as detailed in the 2014 Agreed Order REMAIN IN PLACE until such time as the Commission is confident Respondent no longer poses a danger to the public and that the Respondent is in compliance with any PACE recommendation.

3.3 Evaluation. Respondent must complete an evaluation of his internal medicine clinical skills at the Physician Assessment and Clinical Education Program offered at the University of California at San Diego School of Medicine (PACE), or at another Commission-approved program.

3.3.1 Respondent must fully cooperate with the evaluation process and provide PACE with any information, documents, or releases that are requested. **Respondent must contact PACE within 30 days of the effect date of this Order to schedule the clinical competency assessment. Respondent must schedule the assessment to take place within 90 days of the effective date of this Order unless PACE is unable to provide any dates for assessment within such a time period. If PACE is unable to provide Respondent with a date for assessment within 90 days of the effective date of this Order, Respondent must notify the Commission, in writing, within 10 days of the communication with PACE and inform the Commission of the date or dates on which the assessment will take place.**

**The assessment must include screening examinations, including at minimum, a history and physical, cognitive, and psychological screening.**

3.3.2 PACE will provide a written report to the Commission or its designee regarding the evaluation, including recommendations for the scope and length of any additional evaluation or clinical training, treatment for any medical or psychological conditions, or anything else affecting Respondent's practice of medicine. Respondent must contract with PACE at his own expense to monitor his satisfactory compliance of all recommendations and request that PACE provide quarterly reports to the Commission regarding Respondent's progress.

3.3.3 Respondent must provide PACE with a copy of this Order **and the 2014 Agreed Order**. The Commission or its designee may provide PACE with documents and records from its investigative files.

3.3.4 Respondent must authorize PACE and third-party evaluators to discuss with the Commission or its designee any matters relating to Respondent's evaluation and compliance with recommendations. Respondent must waive any privileges or privacy rights under federal and state law regarding disclosures by PACE and third-party evaluators to the Commission or its designee.

3.3.5 PACE and third-party evaluators must provide a copy of evaluations and written reports to the Commission or its designee and must communicate as necessary to keep the Commission informed of Respondent's progress. The Commission or its designee will provide a copy of all evaluations and written reports received from PACE or third-party evaluators to Respondent in the event that PACE does not do so. Respondent must provide the Commission or its designee with copies of evaluations and written reports if PACE or third-party evaluators fail to do so.

3.3.6 Respondent is not entitled to dispute the reports or recommendations by PACE or third-party evaluators to the Commission. The Commission may amend this Order to incorporate PACE recommendations into this Order.

3.3.7 Within six months of completing the PACE evaluation, the Respondent shall appear before the commission and present a written Practice Plan.

3.4 Personal Appearances. As stated above, Respondent must personally appear at a date and location determined by the Commission in approximately nine months after the effective date of this Final Order, or as soon thereafter as the Commission's schedule permits. Thereafter, Respondent must make personal appearances annually or as frequently as the Commission requires unless the Commission waives the need for an appearance. Respondent must participate in a brief telephone call with the Commission's Compliance Unit prior to the appearance. The purpose of appearances is to provide meaningful oversight over Respondent's compliance with the requirements of this Final Order. The Commission will provide reasonable notice of all scheduled appearances.

3.5 Monitoring. The Respondent shall be subject to monitoring by the Commission for a period of five years from the effective date of this Order. During this period, the Respondent shall be subject to practice reviews.

3.6 Practice Reviews. Respondent must permit or make arrangements with his employer to allow a representative or designee of the Commission to review Respondent's patient records bi-annually and make announced visits to Respondent's practice in order to interview Respondent and staff and to copy records regarding Respondent's practice until this **Order** is terminated. The review may include: inspection of office and personnel records, medication logs, and medical records; interview of Respondent, Respondent's partners, and office staff; and review of other aspects of Respondent's practice. Any costs associated with these practice reviews will be borne by Respondent.

3.7 Modification. The Respondent may not seek modification of this Order.

3.8 Fine. The Respondent will pay a fine to the Commission in the amount of $10,000 dollars within 6 months of the effective date of this Order. The fine must be paid by certified or cashier's check or money order, made payable to the Department of Health and mailed to: Department of Health, Washington Medical Commission, P.O. Box 1099, Olympia, Washington 98507-1099.

3.9 Change of Address. The Respondent shall inform the program manager and the Adjudicative Service Unit, in writing, of changes in his residential and/or business address within 30 days of such change.

3.10 Assume Compliance Costs. The Respondent shall assume all costs of complying with all requirements, terms, and conditions of this Order.

3.11 Failure to Comply. Protecting the public requires practice under the terms and conditions imposed in this Order. Failure to comply with the terms and conditions of this Order may result in suspension and/or revocation of the Respondent's license after a show cause hearing. If the Respondent fails to comply with the terms and conditions of this Order, the Commission may hold a hearing. At that hearing, the Respondent must show cause why his license should not be suspended. Alternatively, the Commission may bring additional charges of unprofessional conduct under RCW 18.130.180(9). In either case, the Respondent will be given notice and an opportunity for a hearing on the issue of non-compliance.

Dated this 12th day of May, 2021.

*Washington Medical Commission*

Scott E. Rodgers

SCOTT RODGERS, Public Member
Panel Chair

**CLERK'S SUMMARY**

| Charge | Action |
|---|---|
| RCW 18.130.180(4) | Violated |
| RCW 18.130.180(9) | Violated |

## NOTICE TO PARTIES

This order is subject to the reporting requirements of RCW 18.130.110, Section 1128E of the Social Security Act, and any other applicable interstate or national reporting requirements. If discipline is taken, it must be reported to the Healthcare Integrity Protection Data Bank.

Either party may file a **petition for reconsideration**. RCW 34.05.461(3); 34.05.470. The petition must be filed within 10 days of service of this order with:

Adjudicative Service Unit
P.O. Box 47879
Olympia, WA 98504-7879

and a copy must be sent to:

Department of Health Medical Program
P.O. Box 47866
Olympia, WA 98504-7866

The petition must state the specific grounds for reconsideration and what relief is requested. WAC 246-11-580. The petition is denied if the Commission does not respond in writing within 20 days of the filing of the petition.

A **petition for judicial review** must be filed and served within 30 days after service of this order. RCW 34.05.542. The procedures are identified in chapter 34.05 RCW, Part V, Judicial Review and Civil Enforcement. A petition for reconsideration is not required before seeking judicial review. If a petition for reconsideration is filed, the above 30-day period does not start until the petition is resolved. RCW 34.05.470(3).

The order is in effect while a petition for reconsideration or review is filed. "Filing" means actual receipt of the document by the Adjudicative Service Unit. RCW 34.05.010(6). This order is "served" the day it is deposited in the United States mail. RCW 34.05.010(19).

For more information, visit our website at:
http://www.doh.wa.gov/PublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/Hearings.aspx