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

In the Matter of the Accusation Against: **ULRICH BERG, M.D.** **3022 Fillmore St. (at Union)** **San Francisco, CA 94123** **Physician's and Surgeon's Certificate No. A 26459,** Respondent.	Case No. 800-2019-054107 **ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this 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 December 20, 1974, the Medical Board issued Physician's and Surgeon's Certificate Number A 26459 to Ulrich Berg, 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 November 30, 2022, unless renewed.

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JURISDICTION

3. This 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 states:

(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

(1) Have his or her license revoked upon order of the board.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

5. Section 2234 of the Code states:

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

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

(b) Gross negligence.

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

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

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

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

6. Section 2228 of the Code states:

The authority of the board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:

(a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.

(b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.

(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.

(d) Providing the option of alternative community service in cases other than violations relating to quality of care.

7. Section 2228.1 of the Code states:

(a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board and the Podiatric Medical Board of California shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information internet web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the

probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client as defined in Section 726 or 729.

(B) Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely.

(C) Criminal conviction directly involving harm to patient health.

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendere or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information internet web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) Section 2314 shall not apply to this section.

8. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of the patient's practitioner, but in any case no longer than 72 hours.

(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code.

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

10. Section 725 of the Code states:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5.

11. Health and Safety Code § 11165.4 states:

(a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(ii) If a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance is not required, pursuant to an exemption described in subdivision (c), to consult the CURES database the first time he or she prescribes, orders, administers, or furnishes a controlled substance to a patient, he or she shall consult the CURES database to review the patient's controlled substance history before subsequently prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(B) For purposes of this paragraph, first time means the initial occurrence in which a health care practitioner, in his or her role as a health care practitioner, intends to prescribe, order, administer, or furnish a Schedule II, Schedule III, or Schedule IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

(2) A health care practitioner shall obtain a patient's controlled substance history from the CURES database no earlier than 24 hours, or the previous business day, before he or she prescribes, orders, administers, or furnishes a Schedule II, Schedule III, or Schedule IV controlled substance to the patient.

(b) The duty to consult the CURES database, as described in subdivision (a), does not apply to veterinarians or pharmacists.

(c) The duty to consult the CURES database, as described in subdivision (a), does not apply to a health care practitioner in any of the following circumstances:

(1) If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities for use while on facility premises:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(2) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance in the emergency department of a general acute care hospital and the quantity of the controlled substance does not exceed a nonrefillable seven-day supply of the controlled substance to be used in accordance with the directions for use.

(3) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient as part of the patient's treatment for a surgical procedure and the quantity of the controlled substance does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use, in any of the following facilities:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(E) A place of practice, as defined in Section 1658 of the Business and Professions Code.

(4) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient currently receiving hospice care, as defined in Section 1339.40.

(5) (A) If all of the following circumstances are satisfied:

(i) It is not reasonably possible for a health care practitioner to access the information in the CURES database in a timely manner.

(ii) Another health care practitioner or designee authorized to access the CURES database is not reasonably available.

(iii) The quantity of controlled substance prescribed, ordered, administered, or furnished does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use and no refill of the controlled substance is allowed.

(B) A health care practitioner who does not consult the CURES database under subparagraph (A) shall document the reason he or she did not consult the database in the patient's medical record.

(6) If the CURES database is not operational, as determined by the department, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. A health care practitioner shall, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within his or her control.

(7) If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of a health care practitioner.

(8) If consultation of the CURES database would, as determined by the health care practitioner, result in a patient's inability to obtain a prescription in a timely manner and thereby adversely impact the patient's medical condition, provided that the quantity of the controlled substance does not exceed a nonrefillable five-day supply if the controlled substance were used in accordance with the directions for use.

(d) (1) A health care practitioner who fails to consult the CURES database, as described in subdivision (a), shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

(2) This section does not create a private cause of action against a health care practitioner. This section does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

(e) This section is not operative until six months after the Department of Justice certifies that the CURES database is ready for statewide use and that the department has adequate staff, which, at a minimum, shall be consistent with the appropriation authorized in Schedule (6) of Item 0820-001-0001 of the Budget Act of 2016 (Chapter 23 of the Statutes of 2016), user support, and education. The department shall notify the Secretary of State and the office of the Legislative Counsel of the date of that certification.

(f) All applicable state and federal privacy laws govern the duties required by this section.

(g) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

(h) This section shall become inoperative on July 1, 2021, or upon the date the department promulgates regulations to implement this section and posts those regulations on its internet website, whichever date is earlier, and, as of January 1, 2022, is repealed.

COST RECOVERY

12. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

DESCRIPTION OF PERTINENT DRUGS

13. Adderall is a trade name for a combination drug containing four salts of amphetamine, also known as mixed amphetamine salts (MAS), and is a central nervous system (CNS) stimulant of the phenethylamine class. It is a Schedule II controlled substance under Health and Safety Code Section 11055(d) and is a dangerous drug as defined in Business and Professions Code Section 4022. It is used in the treatment of attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), and narcolepsy. It may cause new or worsening psychosis (unusual thoughts or behavior), especially in those with a history of depression, mental illness, or bipolar disorder.

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

15. Ativan, a trade name for lorazepam, is a benzodiazepine and central nervous system (CNS) depressant used in the management of anxiety disorder for short-term relief from the symptoms of anxiety or anxiety associated with depressive symptoms. It is a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code and by section

1308.14 of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022. Long-term or excessive use of Ativan can cause dependency. Concomitant use of alcohol or other CNS depressants may have an additive effects.

16. Celexa is a trade name for citalopram, an antidepressant of the selective serotonin reuptake inhibitor (SSRI) class that is used to treat depression and major depressive disorder. It is a prescription medication and is a dangerous drug as defined in Business and Professions Code Section 4022.

17. Clonazepam, known by the trade named Klonopin, is an anti-convulsant of the benzodiazepine class of drugs. It is a Schedule IV controlled substance under Health and Safety Code section 11057(d)(7) and is a dangerous drug as defined in Business and Professions Code section 4022. It produces central nervous system (CNS) depression and should be used with caution with other CNS depressant drugs. Like other benzodiazepines, it can produce psychological and physical dependence. Withdrawal symptoms similar to those associated with withdrawal from barbiturates and alcohol have been noted upon abrupt discontinuance of Klonopin.

18. Concerta is a trade name for methylphenidate hydrochloride extended release tablets. It is a central nervous system (CNS) stimulant prescription medicine used to treat attention deficit hyperactivity disorder (ADHD) in children six years of age and older, adolescents, and in adults up to the age of 65. It should be used as part of a total treatment program for ADHD that may include counseling or other therapies. Concerta may cause new or worsening psychosis (unusual thoughts or behavior), especially in those with a history of depression, mental illness, bipolar disorder, or severe anxiety. It is a Schedule II controlled substance under Health and Safety Code Section 11055 and is a dangerous drug as defined in Business and Professions Code Section 4022.

19. Diazepam, known by the trade name Valium, is a psychotropic drug used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code and section 1308.14 of Title 21 of the Code of Federal Regulations, and is a dangerous drug as

defined in Business and Professions Code section 4022. Diazepam can produce psychological and physical dependence and it should be prescribed with caution particularly to addiction-prone individuals (such as drug addicts and alcoholics) because of the predisposition of such patients to habituation and dependence.

20. Librium is a former trade name for chlordiazepoxide hydrochloride. It is a benzodiazepine that is used to treat anxiety disorders and may also be used on a short-term basis to treat symptoms of alcohol withdrawal. It should not be used concomitantly with opioids or alcohol consumption because of an increased risk of slowing or stopping respiration. It is a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022. In early 2021, the Librium brand name was discontinued by its manufacturer in the United States.

21. Nuvigil is a trade name for armodafinil, a central nervous system (CNS) stimulant medication that promotes wakefulness and is used to treat excessive sleepiness caused by sleep apnea, narcolepsy, or shift-work sleep disorder. It is a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022. It may be habit-forming, especially for someone with a history of drug abuse or addiction. It is usually given for up to 12 weeks. It should not be taken concomitantly with alcohol.

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

depressants, including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers, and alcohol.

23. Temazepam, known by the trade name Restoril, is in the class of medications known as sedative/hypnotics. It is used in the treatment of symptoms of insomnia. It is a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022.

24. Zolpidem tartrate, known by the trade name Ambien, is a non-benzodiazepine hypnotic of the imidazopyridine class. It is a Schedule IV controlled substance under Health and Safety Code section 11057(d)(32) and is a dangerous drug as defined in Business and Professions Code section 4022. It is indicated for the short-term treatment of insomnia. It is a central nervous system (CNS) depressant and should be used cautiously in combination with other CNS depressants. Any CNS depressant could potentially enhance the CNS depressive effects of Ambien. It should be administered cautiously to patients exhibiting signs or symptoms of depression because of the risk of suicide. Because of the risk of habituation and dependence, individuals with a history of addiction to or abuse of drugs or alcohol should be carefully monitored while receiving Ambien.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient A[1]: Repeated Negligent Acts and/or Prescribing Without Appropriate Exam and Medical Indication and/or Excessive Prescribing)

25. Respondent Ulrich Berg, M.D. is subject to disciplinary action for unprofessional conduct through his acts and omissions regarding Patient A under Code section 2234 subd. (c) [repeated negligent acts] and/or section 2242 [furnishing dangerous drugs without appropriate examination and medical indication] and/or section 725 [excessive prescribing]. The circumstances are as follows:

[1] To protect the privacy rights of the patients, they will be identified by letters. Respondent will be provided the patients' names through discovery.

26. On or about June 7, 2016, Patient A, a female born in June 1983, first saw Respondent. Respondent's notes for the June 7, 2016 initial visit are handwritten and often illegible, with no appropriate examination (history and physical) documented with findings to support Respondent's prescribing of controlled substances. In fact, all of Respondent's visit notes for Patient A are handwritten and are often illegible.

27. Respondent's notes for the initial visit are unclear as to the details of the medications prescribed. According to the CURES database, in June 2016, Patient A filled the following prescriptions from Respondent: (on June 7) #30 Concerta 36 mg. and #30 clonazepam 0.25 mg.; (on June 12) #75 lorazepam 1 mg.; and (on June 21) #30 diazepam 10 mg.

28. According to the CURES database and CVS pharmacy prescribing records, Patient A also received, in June 2016, opioids and diazepam from other prescribers.

29. In a written Clinical Summary dated February 9, 2022, Respondent stated that Patient A was referred to him for "continued treatment of depression, anxiety, insomnia, and ADHD." Respondent, however, obtained none of the records from the referring physician and/or did not document an appropriate examination with findings to support any of these diagnoses.

30. On or about July 7, 2016, Patient A next saw Respondent. Respondent's notes of the visit are scant and mostly illegible, with no examination or findings documented. Respondent's notes are unclear about what he prescribed, except for prescribing Xanax 1 mg. However, the CURES database notes that, on July 7, 2016, Patient A filled the following three prescriptions from Respondent: #30 methylphenidate hcl 10 mg. (Adderall; 15-day supply); #90 alprazolam 1 mg. (Xanax); and #30 Concerta 36 mg.

31. In his written Clinical Summary dated February 9, 2022, Respondent listed five diagnoses for Patient A that he was treating: (1) Major Depression, Recurrent; (2) Anxiety Disorder with Insomnia; (3) Acute Panic Attack; (4) Adult Attention Deficit Disorder; and (5) Borderline Personality Disorder. Respondent's records for Patient A, however, document no appropriate examinations or findings and no medical indications to support these diagnoses.[2]

[2] Respondent produced to the Board records for Patient A with visit notes from 06/07/2016 through 12/07/2018 and billing records for therapy sessions through 12/20/2018.

32. Patient A had a history of alcohol abuse, which Respondent failed to document or otherwise acknowledge and evaluate. It appears that, on or about September 5, 2018, Respondent noted that Patient A had been hospitalized for five days after binge-drinking for two days. Yet, Respondent continued to prescribed benzodiazepines and psychostimulants to Patient A without conducting a periodic review of his treatments and the patient's condition.

33. According to the CURES database, Respondent prescribed #56 chlordiazepoxide hcl 25 mg. (Librium; 9 day supply) to Patient A in February 2019. During his investigation interview on February 23, 2022, Respondent stated that the prescriptions for Librium were because the patient was withdrawing from alcohol, after another drinking binge.

34. On or about March 28, 2019, the Board received an online complaint about Respondent from a physician who had reviewed the CURES database while evaluating Patient A, whom he described as "a known alcoholic," for an inpatient psychiatric admission. The physician complained that Respondent's prescribing to Patient A in February 2019 was dangerous to the patient when combined with alcohol. The physician stated that he contacted Respondent and was concerned that Respondent knew the patient was an alcoholic, that Respondent misquoted the et. doses of benzodiazepines and Adderall being prescribed to Patient A ("indicating possible issues with tracking or documenting medications properly"), and that Respondent did not have CURES access.

35. According to Respondent's records and the CURES database, Respondent continued to see Patient A and to issue prescriptions, from June 7, 2016 through at least March 2019, of combinations of benzodiazepines and psychostimulants which subjected Patient A to a high risk of harm and also raised concerns for monitoring because of the potential for medication misuse.

36. During the course of his treatment of Patient A, Respondent did not document that he discussed the risks and alternatives with the patient of the long-term controlled substances prescribed in order to obtain informed consent to the treatment from the patient.

37. During the course of his treatment of Patient A, Respondent failed to appropriately monitor the patient's compliance with the treatment regimen. Respondent never reviewed the et. CURES database regarding the controlled substances prescribed to the patient.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient B: Repeated Negligent Acts and/or Prescribing Without Appropriate Exam and Medical Indication and/or Excessive Prescribing)

38. Respondent Ulrich Berg, M.D. is subject to disciplinary action for unprofessional conduct through his acts and omissions regarding Patient B under Code section 2234 subd. (c) [repeated negligent acts] and/or section 2242 [furnishing dangerous drugs without appropriate examination and medical indication] and/or section 725 [excessive prescribing]. The circumstances are as follows:

39. In or about October 2012, Patient B, a female born in September 1982, was referred to Respondent by her psychiatrist who was retiring from practice. In a written Clinical Summary dated February 9, 2022, Respondent stated that Patient B was referred to him in October 2012 for "continued treatment of depression, anxiety, and chronic hip pain" and that the patient presented as "stabilized on Xanax 1 mg. bid and oxycodone 30 mg. bid." Respondent, however, obtained none of the records from the referring physician. It appears that Respondent did not document an appropriate examination with findings to support any of these diagnoses. Respondent noted that Patient B belonged to the Kaiser Health Plan (HMO) and paid in cash for her sessions with him. Respondent stated that he last saw the patient on February 18, 2018.

40. In his written Clinical Summary for Patient B dated February 9, 2022, Respondent listed two diagnoses for Patient B that he was treating: (1) Anxiety Disorder; and (2) chronic hip and knee pain. Respondent stated that he prescribed lorazepam 1 mg. bid for the patient's Anxiety Disorder and oxycodone 30 mg. qid for the chronic hip and knee pain. Respondent's records for Patient B, however, document no appropriate examinations or findings and no medical indications to support these diagnoses and his prescribing of the long-term combination of opioids and benzodiazepines.[3] His prescribing of both lorazepam and oxycodone was also often in higher doses than described in his Clinical Summary.

[3] Respondent produced to the Board records for Patient B with visit notes from 01/04/2016 through 2/21/2018. No billing records were produced for Patient B.

41. On or about January 4, 2016, Respondent saw Patient B and refilled prescriptions for #120 oxycodone 30 mg. and #60 lorazepam 1 mg. Respondent's records of the visit do not include any findings regarding the current status of the patient's pain, anxiety, or depression sufficient to support the prescriptions.

42. In his January 4, 2016 visit note, Respondent noted that Patient B was seeing a gastroenterologist and in October 2015 she had her gallbladder removed. According to Respondent's clinical summary dated February 9, 2022, Patient B continued to have ongoing gastrointestinal problems: bloating, nausea, vomiting.

43. During the course of treatment of Patient B, from January 2016 through February 2018, Respondent noted that the patient was having gastrointestinal problems but he did not consider that the patient's gastrointestinal complications might be related to her long-term use of opioids.

44. On or about March 1, 2017, Respondent saw Patient B and noted that the patient was relocating to the East Coast. Respondent noted that he gave the patient prescriptions for two months' supply of oxycodone 30 mg. #120 (two separate prescriptions of #60) and of #60 lorazepam.

45. According to the CURES database, on March 2, 2017, Patient B filled prescriptions from Respondent for #240 oxycodone 30 mg. and #60 lorazepam 1 mg.

46. Although he did not see Patient B again until August 1, 2017, Respondent has a brief note in the patient's records that, on April 13, 2017, "vacation supply sent." Respondent also has in Patient B's records a copy of a prescription dated April 4, 2017 for #120 lorazepam/Ativan with a note that the patient was "going to Iran for 2 months." Respondent's records, however, do not provide sufficient information about his prescribing. The CURES database does not indicate that Patient B filled any prescriptions for controlled substances in California in or about April 2017.

47. Respondent's records document that his next visit with Patient B (after March 2, 2017) was on or about August 1, 2017. Respondent's notes are partially illegible and do not

adequately document findings regarding the patient's condition, particularly regarding her anxiety and pain levels, while also not providing the details of any prescriptions issued.

48. According to the CURES database, Patient B did not fill any prescriptions in August 2017 but did fill prescriptions from Respondent on September 8, 2017 for the following controlled substances: #40 oxycodone 30 mg. and #30 lorazepam 1 mg.

49. On or about September 12, 2017, Respondent saw Patient B. His note of the visit is scant and partially illegible, with no mention of the patient's physical condition, pain and anxiety levels. The note also does not adequately document the current medications that the patient is taking and does not indicate that any prescriptions were issued. According to the CURES database, on September 21 and 27, 2017, Patient B filled two prescriptions from Respondent that totaled #80 oxycodone 30 mg. and #30 lorazepam 1 mg.

50. On or about October 9, 2017, Respondent saw Patient B and noted refilling prescriptions for #84 oxycodone 30 mg. and #60 lorazepam 1 mg. without documenting any information about the patient's medical conditions.

51. On or about November 10, 2017, Respondent saw Patient B. Respondent's notes of the visit, which are partially illegible, do not include any adequate findings about the patient's medical conditions and there is no indication that any prescriptions were issued. The CURES database reports that Respondent significantly increased the amount of oxycodone 30 mg. to #120 while also prescribing #60 lorazepam 1 mg. on that date.

52. On or about December 5, 2017, Respondent's notes of the visit, which are partially illegible, do not include any adequate findings about the patient's medical conditions. At this visit, Respondent again increased the dosage of oxycodone prescribed to Patient B, without any documented medical indication: #120 oxycodone 30 mg.; #120 oxycodone 15 mg; along with #60 lorazepam 1 mg.

53. On or about December 28, 2017, Respondent saw Patient B and noted that he increased the amount of lorazepam to #90 monthly, without any findings of the patient's medical conditions or reasonable medical indication for the increase. Respondent also issued a

prescription for #120 oxycodone 30 mg. without an appropriate examination with findings and documented medical indication.

54. On or about January 26, 2018, Respondent saw Patient B and prescribed #120 oxycodone 30 mg. and #90 lorazepam 1 mg. without documenting appropriate findings about the patient's medical conditions to support the prescribing.

55. On or about February 21, 2018, Respondent saw Patient B.[4] His visit notes, which are partially illegible do not include any adequate findings about the patient's medical conditions and do not document that any prescriptions were issued. Without explanation, there is a note that "She needs to get 2 month (sic) supply meds." According to the CURES database, Patient B filled, on February 21, 2018, the following prescriptions from Respondent: #240 oxycodone 30 mg. and #90 lorazepam 1 mg.

56. Respondent's prescribing of oxycodone and lorazepam to Patient B from December 2017 through February 2018 constitutes excessive prescribing of controlled substances with no documented medical indications to support the treatments.

57. During the course of his treatment of Patient B, from at least January 2016 through February 21, 2018, Respondent continued to prescribe oxycodone to the patient when she was being seen by an orthopedic surgeon for her hip problems. Respondent did not consult with the orthopedic surgeon to coordinate care and did not document a medical indication for his prescribing of opioids, on a chronic basis, to the patient.

58. During the course of his treatment of Patient B, from at least January 2016 through February 21, 2018, Respondent prescribed a combination of opioids and benzodiazepines on a long-term chronic basis without advising the patient of the risks, the benefits, and alternative treatments and/or without documenting that informed consent was obtained from the patient for the treatments.

59. During the course of his treatment of Patient B, from at least January 2016 through February 21, 2018, Respondent failed to appropriately monitor the patient's compliance with the

[4] The 02/21/2018 visit is the last (most recent) visit documented in the records that Respondent certified and produced to the Board on 02/23/2022.

prescribing regimen and to conduct periodic reviews of the efficacy of the treatments. Respondent never reviewed the CURES database regarding the controlled substances prescribed to the patient.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient C: Repeated Negligent Acts and/or Prescribing Without Appropriate Exam and Medical Indication and/or Excessive Prescribing)

60. Respondent Ulrich Berg, M.D. is subject to disciplinary action for unprofessional conduct through his acts and omissions regarding Patient C under Code section 2234 subd. (c) [repeated negligent acts] and/or section 2242 [furnishing dangerous drugs without appropriate examination and medical indication] and/or section 725 [excessive prescribing]. The circumstances are as follows:

61. On or about February 3, 2016, Respondent saw Patient C, a female born in October 1954, whom Respondent had been treating with psychotherapy and controlled substances for at least five years. Respondent was treating Patient C for chronic Post-Traumatic Stress Disorder arising from sexual harassment experienced in 2004 when the patient worked as an assistant cook and room steward on a container ship. Respondent's notes of the visit are scant and do not contain adequate findings regarding the patient's mental status or other medical conditions. The notes are partially illegible and provide incomplete information about the strength of the medications prescribed. Respondent notes that he issued prescriptions for: #90 Restoril (temazepam); #180 Xanax (alprazolam); and Nuvigil 250 mg.

Pharmacy prescribing records indicate that, in February 2016, Patient C filled prescriptions from Respondent for: #90 temazepam 30 mg. (Restoril) for: sleep/insomnia; #90 citalopram 20 mg. (Celexa) for depression/anxiety; #30 Nuvigil 250 mg. for sleep apnea; #180 alprazolam 0.5 mg. (Xanax) for panic attacks; and #60 clonazepam 1 mg. (Klonopin).

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62. On or about June 13, 2016, more than four months after the previous visit, Respondent next saw Patient C. Respondent's visit note is scant and contains no findings about the patient's mental and/or physical conditions. There are no details about the prescriptions issued, except for "meds refilled." According to the CURES database, on June 13, 2016, Patient C filled prescriptions from Respondent for the following controlled substances: #180 zolpidem tartrate 10 mg. (90 day supply); and #180 clonazepam 1 mg. (90 day supply).

63. Although Respondent has no record of seeing Patient C and/or issuing prescriptions to her in July through November 2016, the CURES database reports that Patient C filled prescriptions from Respondent, in August and November 2016, for the following controlled substances (in total): #180 zolpidem tartrate 10 mg.; #180 clonazepam 1 mg.; and #60 temazepam 30 mg. Pharmacy records also report that Patient C filled prescriptions from Respondent, including prescriptions for bupropion XL 300 mg. in June and July 2016.[5]

64. On or about December 8, 2016, Respondent saw Patient C, about six months after the previous visit. Respondent's notes are inadequate and contain no findings of the patient's mental and/or physical conditions, except the sentence "She has multiple physical symptoms." Respondent noted that the patient travels to the Philippines three times a year. There is no documentation of the patient's current medications. Respondent noted issuing prescriptions for: #180 clonazepam; #180 Ambien; and #90 citalopram 40 mg,, with a note that they were for one year.

65. According to the CURES database, however, Patient C did not fill any prescriptions from Respondent for controlled substances between November 23, 2016 and March 14, 2017, in California.

66. Although Respondent has no record of seeing Patient C and/or issuing prescriptions to her in March and July 2017, the CURES database reports that Patient C filled prescriptions from Respondent during those months for the following controlled substances (in total): #180 the zolpidem tartrate 10 mg. and #360 clonazepam 1 mg.

[5] Bupropion hydrochloride, known by trade names Wellbutrin XL and Zyban, is a prescription drug used to treat depression and may be used to prevent seasonal affective disorder or to assist with cessation of smoking.

67. On or about December 13, 2017, Respondent next saw Patient C, which was more than one year after the previous visit. Respondent's notes are scant and inadequate and contain no findings of the patient's mental and/or physical conditions. Respondent notes appear to record his issuing of prescriptions for #90 Celexa 40 mg., #90 Ambien 10 mg., and #270 citalopram 40 mg. (3 month supply). According to the CURES database, Patient C filled the prescription for #270 clonazepam 1 mg. on December 21, 2017 and, on January 12, 2018, filled the prescription for #90 Ambien 10 mg. Pharmacy records indicate that Patient C filled prescriptions for #90 citalopram on December 13, 2017 and on March 19, 2018.

68. Respondent's billing records indicate that he saw Patient C on March 23, 2018 for individual psychotherapy and medication evaluation. Respondent has no progress notes for March 23, 2018.

69. Respondent's billing records indicate that he saw Patient C for individual psychotherapy and medication evaluation visits on June 6, 2019, October 1, 2019, and on December 9, 2019. Respondent's notes of these three visits in 2019 are scant and mostly illegible. There are no findings to document the patient's mental status and/or physical condition and no list of the patient's current medications. Respondent's notes issuing prescriptions are partially illegible but prescribing records report that in June through December 2019, Patient C filled prescriptions from Respondent for Celexa, Klonopin, zolpidem/Ambien, ropinirole, and zaleplon.[6] Records indicate that, during that same time period, Patient C was also receiving prescription medications from other prescribers.

70. According to pharmacy prescribing records, on June 4, 2020, Patient C filled a prescription from Respondent for #60 zolpidem 10 mg. tablets (Ambien) with instructions to take 1 – 2 tablets at bedtime, as needed. A 20 mg. dose of zolpidem would constitute an excessive dose for Patient C.

71. According to Respondent's handwritten Clinical Summary in Patient C's records that were produced to the Board, Respondent treated her insomnia with Ambien, her anxiety and

[6] Ropinirole is a dopamine agonist prescription medicine used to control muscle movement, e.g. restless leg syndrome, symptoms of Parkinson's disease. Zaleplon is a hypnotic that is used for short-term treatment of insomnia. It is a Schedule IV controlled substance.

panic attacks with Klonopin, and her depressive symptoms with Celexa. Respondent stated that he gave the patient "adequate supplies to last her for her stays in the Philippines," where she would visit her aging parents at least two or three times a year, sometimes staying for six months. Respondent also stated that Patient C has other health issues: diabetes, obesity, chronic back pain and sciatica, restless leg syndrome, and hyperlipidemia. Respondent, however, never documented any examinations or evaluations of these health issues.

72. During the course of his treatment of Patient C, starting in February 2016, Respondent failed to document evaluations and findings regarding Patient's C mental and/or physical conditions to support his treatments.

73. During the course of his treatment of Patient C, starting in February 2016, Respondent did not document performing appropriate medical examinations and did not document findings to support medical indications for his prescribing a combination of opioids, benzodiazepines, and sedative-hypnotic drugs, along with medications for restless leg syndrome and sleep apnea.

74. During the course of his treatment of Patient C, starting in February 2016, Respondent saw the patient infrequently and did not adequately monitor Patient C and conduct appropriate periodic review of the treatments, given the types and quantities of medications being prescribed and the number of medical problems being treated. Respondent never reviewed the CURES database regarding the controlled substances prescribed to the patient.

75. Respondent demonstrated a lack of knowledge by prescribing of benzodiazepines and hypnotic sedative drugs on a chronic, yet infrequent, basis which put the patient at risk of potentially life-threatening complications. Respondent failed to make efforts to decrease the does, or find non-dependence producing and less dangerous medications for treatment.

76. During the course of his treatment of Patient C, starting in February 2016, Respondent prescribed to Patient C excessively high doses of a combination of benzodiazepines and sedative-hypnotic drugs while simultaneously treating the patient for sleep apnea, e.g. 10-20 mg. of zolpidem at bedtime, along with 3 mg. daily of clonazepam.

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FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient D: Repeated Negligent Acts and/or Prescribing Without Appropriate Examination and Medical Indication)

77. Respondent Ulrich Berg, M.D. is subject to disciplinary action for unprofessional conduct through his acts and omissions regarding Patient D under Code section 2234 subd. (c) [repeated negligent acts] and/or section 2242 [furnishing dangerous drugs without appropriate examination and medical indication]. The circumstances are as follows:

78. According to Respondent's handwritten Clinical Summary, he saw Patient D, a male born in November 1961, regularly for treatment of Post-Traumatic Stress Disorder, Panic Disorder, and for chronic lower back pain. Patient D was placed on permanent disability after a work-related accident in 1999, during which a deep excavation collapsed upon him and he narrowly escaped being buried alive. Respondent's Clinical Summary of Patient D reports that the patient is currently stabilized for his anxiety and panic attacks with one or two mg. daily of lorazepam (Ativan), as needed.

79. From at least October 27, 2015, Patient D saw Respondent about every six weeks for individual psychotherapy and medication management. Respondent has regularly prescribed to Patient D #60 lorazepam 1 mg. (30 days' supply).[7]

80. During the course of his treatment of Patient D, starting from October 27, 2015, Respondent's notes are scant and partially illegible and Respondent did not document an appropriate examination with findings regarding the patient's mental and/or physical condition to establish a medical indication that supports the long-term prescribing of lorazepam.

81. During the course of his treatment of Patient D, starting from October 27, 2015, Respondent did not document obtaining the patient's informed consent to the treatment by discussing with the patient the risks, benefits, and the alternatives to the long-term, chronic, use of lorazepam, and by advising the patient of the risk of dependency and/or potential complications of the treatment.

[7] The records for Patient D, which Respondent certified and produced to the Board on or about 02/02/2022, cover visits from 10/27/2015 through 03/23/2020 and billing records from 01/01/2016 to 01/01/2020.

82. During the course of his treatment of Patient D, starting from October 27, 2015, Respondent failed to conduct appropriate periodic reviews of the efficacy of the treatment.

83. During the course of his treatment of Patient D, starting from October 27, 2015, Respondent failed to properly monitor the patient's compliance with the treatment and/or failed to check the CURES database when prescribing controlled substances on a chronic basis.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patients A, B, C & D: Failure to Maintain Adequate and Accurate Medical Records)

84. Respondent Ulrich Berg, M.D. is subject to disciplinary action, jointly and severally, for unprofessional conduct under Code section 2266 for his failure to maintain adequate and accurate medical records regarding his treatment of Patient A and/or Patient B and/or Patient C and/or Patient D.

85. Paragraphs 25 through 83 are incorporated herein by reference, as if fully set forth.

SIXTH CAUSE FOR DISCIPLINE

Unprofessional Conduct: Failure to register with and review CURES database for Patients A, C, & D)

86. Respondent Ulrich Berg, M.D. is subject to disciplinary action for unprofessional conduct under section 2234 through violations of California Health and Safety Code section 11165.4, which sets forth requirements for health care practitioners to review the CURES database prior to issuing an initial prescription and also at least once every four months when prescribing controlled substances on a periodic basis. This requirement went into operative effect for all health care practitioners as of October 2, 2018.

87. Paragraphs 25 through 37 and Paragraphs 60 through 83 are incorporated herein by reference, as if fully set forth.

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88. During his interview with the Board's investigator in February 2022, Respondent stated that he is not registered with CURES and is unfamiliar with the regulations requiring the review of CURES reports when prescribing controlled substances on a chronic, periodic basis.

89. Respondent did not conduct appropriate periodic review of the CURES database, as required by statute on October 2, 2018, when prescribing controlled substances on an ongoing periodic basis to Patient A, Patient C, and Patient D.

DISCIPLINARY CONSIDERATIONS

90. To determine the degree of discipline, if any, to be imposed on Respondent Ulrich Berg, M.D., Complainant alleges that the Board issued a Decision and Order on December 18, 1996, in a prior disciplinary action titled *In the Matter of the Accusation Against Ulrich Berg, M.D.,* Medical Board of California Case Number 13-92-17952. The disciplinary matter was based on the allegations in both the Accusation filed on April 17, 1995 and the First Supplemental Accusation filed on July 6, 1995. Pursuant to this prior Decision, Respondent's license was revoked but the revocation was stayed and the license was placed on probation for three years with the following special terms and conditions: 15-days of suspension; a Prescribing Practices course; Maintain a Record of Controlled Drugs Prescribed; Education course(s), an additional 20 hours annually; and an Ethics course. That prior Decision is now final and is incorporated by reference, as if fully set forth herein.

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 A 26459, issued to Respondent Ulrich Berg, M.D.;

2. Revoking, suspending or denying approval of Respondent Ulrich Berg, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Ulrich Berg, M.D., to pay the Board the costs of the investigation and enforcement of this case and, if placed on probation, the costs of probation monitoring; and

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

DATED: MAR 24 2022

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

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