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BEFORE THE BOARD OF MEDICAL EXAMINERS
STATE OF MONTANA

In the Matter of **KENNETH OLSON**, Medical Examiners, License No. 7183.	Case Nos. 2020-MED-404; 2022-MED-03877 **FINAL ORDER**

The Montana Board of Medical Examiners, giving primary consideration to sanctions necessary to protect and compensate the public and secondary consideration to sanctions designed to rehabilitate Dr. Kenneth Olson, approves, adopts, and incorporates all terms and conditions of the fully executed Stipulation as its Findings of Fact, Conclusions of Law, and Final Order.

DATED 5/19/2023 | 12:23:10 PM MDT .

DocuSigned by:
Ana Diaz
D9B77163C79F449...

Presiding Officer, Adjudication Panel
Montana Board of Medical Examiners

CERTIFICATE OF SERVICE

I certify I served a true and accurate copy of the foregoing ***Stipulation and Final Order*** by placing it in the United States Postal Service mail, first-class postage prepaid, addressed to the following:

Kenneth Olson
c/o Elizabeth Hausbeck
Hall Booth Smith
1001 East Front Street, Suite 402
Missoula MT 59802

DATED 5/19/2023 | 12:59:59 PM MDT .

DocuSigned by:
Jennifer Lane
DC7E52710660478...

Department of Labor and Industry

BEFORE THE BOARD OF MEDICAL EXAMINERS
STATE OF MONTANA

In the Matter of **KENNETH OLSON,** Medical Examiners, License No. 7183.	Case Nos. 2020-MED-404; 2022-MED-03877 **STIPULATION**

The Department of Labor and Industry (Department), through its legal counsel and Kenneth Olson (Dr. Olson or Respondent), enter this Stipulation and agree as follows:

A. AGREED FACTS

1. On or about September 19, 1992, the Montana Board of Medical Examiners (Board) issued Kenneth Olson a physician license, number 7183. Dr. Olson's license is renewed through March 31, 2025.

History

2. Dr. Olson is a psychiatrist whose training focused on issues of psychoanalytic psychotherapy, chemical dependency, and psychopharmacology.

3. On January 18, 2019, the Board adopted a stipulation and entered a final order in a prior disciplinary action against Dr. Olson, Case No. 2017-MED-597.

4. In the stipulation, Dr. Olson agreed he committed unprofessional conduct by failing to review medical records, perform a physical examination, coordinate care of previous providers, review the Montana Prescription Drug Registry, and collect a urine drug screen for a patient (Patient 1).

5. Pursuant to the final order, the Board required Dr. Olson to complete a course on prescribing controlled substances.

Case No. 2020-MED-404

6. In February 2017, Dr. Olson began seeing another patient (Patient 2) to address concerns with Patient 2's body falling asleep, her management of attention, and lapses of awareness.

7. Dr. Olson previously treated Patient 2 approximately 5-10 years earlier, but Patient 2 was terminated from his practice. In the interval, Patient 2 received treatment from a sleep specialist, Virginia Pascual, MD.[5]

8. Patient 2 had a history of abusing substances, including opiates, benzodiazepines, and sedative-hypnotics.

9. Upon re-establishing care with Dr. Olson, Patient 2 reported that Dr. Pascual diagnosed her with narcolepsy, and that she had attempted numerous medications to treat her narcolepsy.

10. Dr. Olson did not perform tests or evaluations to confirm Patient 2's self-reported diagnoses for narcolepsy.

11. Dr. Olson prescribed dosages of stimulants[6] higher than generally recommended dosages to treat Patient 2's self-reported narcolepsy, as well as her diagnosis of attention deficit/hyperactivity disorder (ADHD).

12. Patient 2's medical records demonstrate the following:

a. Dr. Olson did not review the medical records for Patient 2 for the interval period when she was not under his care and, in the absence of available records, he did

[5] Dr. Olson provided treatment records to the Board from when he started treating Patient 2 again in February 2017. Dr. Olson did not provide treatment records from the time he previously provided care to Patient 2, nor information about when or why he discharged Patient 2. Dr. Olson asserts that he had requested Dr. Pascual's records for Patient 2 when he started treating her again in 2017, but Dr. Pascual did not respond to his request.

[6] Each stimulant at issue in this complaint is listed as a controlled substance.

not perform adequate testing and examination to confirm her self-reported narcolepsy diagnoses.[7]

b. Patient 2 was diagnosed with Ehlers Danlos Syndrome (EDS). Patients with EDS have a higher risk of cardiac complications. Patients taking stimulants also have a higher risk of cardiac complications. Even though Patient 2 was diagnosed with EDS, and was prescribed high dosages of stimulants, Dr. Olson did not document that he considered possible risks of cardiac complications to Patient 2, and he did not adequately monitor Patient 2 for those possible negative cardiac complications.

c. Dr. Olson did not document that he considered other symptoms that could cause Patient 2's narcolepsy or ADHD symptoms, even when Patient 2's symptoms did not respond as anticipated to the prescribed medication.

d. Dr. Olson did not coordinate with Patient 2's primary care provider to investigate and treat other physical illnesses that Dr. Olson noted (including low blood pressure and chest pain), or how those illnesses may be connected to Patient 2's sleep disorder symptoms.

e. Dr. Olson did not adequately monitor Patient 2's use of controlled substances. Specifically, before this complaint was filed, Dr. Olson did not conduct any drug screening to confirm Patient 2 was using the substances as prescribed or that she was refraining from using other substances that could negatively react with the prescribed stimulants. Dr. Olson also failed to document any evaluation he performed of Patient 2 that would reveal adverse effects from using prescribed stimulants, including cardiac complications.

---

[7] Dr. Olson also provided to the Board a sleep study Dr. Pascual performed in 2009, but there is no indication that he considered the results of the sleep study in determining appropriate care for Patient 2.

Case No. 2022-MED-03877

13. In November 2013, Dr. Olson began providing care to another patient (Patient 3) at Bridger Psychiatric Services. Patient 3 was 7 years old at the time.

14. During her initial appointment, Dr. Olson diagnosed Patient 3 with ADHD and prescribed stimulants to treat this diagnosis.

15. Dr. Olson also diagnosed Patient 3 with obsessive compulsive disorder (OCD) within the first few visits.

16. By August 2015, Dr. Olson had diagnosed Patient 3 with partial seizure disorder and started prescribing Depakote (sodium valproate) to treat this diagnosis.

17. Sodium valproate is a known teratogenic drug.

18. In January 2017, Patient 3 was admitted to the Shodair Child and Adolescent Psychiatric Program (Shodair) due to concerns about increasing aggression and escalating dangerous behavior.

19. One day after admission to Shodair, Patient 3 discontinued using psychostimulant medication. Patient 3's mood improved, and she appeared to be doing well off the medication.

20. While at Shodair, Patient 3 was monitored for signs of seizures based on Dr. Olson's prior diagnosis. Shodair records note that Patient 3 showed no sign of seizures during her stay, and her providers did not endorse a diagnosis of partial seizures.

21. As part of her treatment at Shodair, Patient 3 underwent a psychological evaluation by James Maxson, PsyD. Dr. Maxson considered but rejected Patient 3's ADHD diagnosis, noting that any attention deficiency was more likely caused by anxiety. Dr. Maxson determined Patient 3 had Oppositional Defiant Disorder (ODD), and he confirmed the diagnosis for OCD.

22. Patient 3 started taking Seroquel (quetiapine) to treat OCD symptoms.

23. Weight gain is a known side effect of quetiapine.

24. Patient 3 appeared to stabilize on the quetiapine, and Shodair discharged her on February 8, 2017.

25. Dr. Olson received copies of Patient 3's records from Shodair.

26. Following Patient 3's discharge, Dr. Olson continued prescribing quetiapine.

27. By the end of 2017, Dr. Olson again diagnosed Patient 3 with ADHD and partial seizure disorder, and he prescribed medication to treat those diagnoses.

28. By August 2017, Dr. Olson diagnosed Patient 3 with bipolar disorder.

29. ADHD medications can exacerbate symptoms of bipolar disorder.

30. In December 2017, Dr. Olson started prescribing Wellbutrin (bupropion).

31. Bupropion is known to exacerbate symptoms in patients with seizure disorder.

32. Dr. Olson's notes before April 1, 2021, do not contain documentation of Patient 3's vital signs, including her height, weight, pulse, and blood pressure.

33. Dr. Olson's notes from April 1, 2021, through March 28, 2022, show identical measurements for Patient 3's height and weight, and no measurements for other vital signs.

34. Patient 3's medical records demonstrate the following:

a. Dr. Olson did not adequately document his analysis, testing, objective findings, or other investigation he performed to determine Patient 3's diagnoses, even when his diagnoses were contradicted by findings from other treatment providers.

b. Dr. Olson did not adequately document that he counseled Patient 3 regarding the risks of adverse effects of the medications he prescribed Patient 3.

c. Dr. Olson did not adequately monitor Patient 3 for adverse effects from the medications he prescribed. This failure to monitor includes his failure to document Patient 3's vital signs over the nine years he provided care to Patient 3.

B. AGREED CONCLUSIONS OF LAW

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

2. The Department serves notice on the licensee following a Screening Panel's reasonable cause finding pursuant to Mont. Code Ann. § 37-1-309.

3. A licensee may request a hearing pursuant to Mont. Code Ann. § 37-1-309 or enter a Stipulation with the Department pursuant to Mont. Code Ann. § 2-4-603(1).

4. Dr. Olson's failure to meet generally accepted standards of practice in treating Patients 2 and 3 constitutes unprofessional conduct under Mont. Code Ann. § 37-1-316(18)

5. Dr. Olson's failure to accurately document Patient 3's vital signs, or at least note that the vital signs were inaccurate, constitutes unprofessional conduct under Admin. R. Mont. 24.156.625(1)(e).

6. Upon a decision a licensee has violated Title 37 of the Mont. Code Ann. or is unable to practice with reasonable skill and safety due to a physical or mental condition or upon stipulation of the parties, the Board may issue an order entering sanctions authorized by Mont. Code Ann. § 37-1-312.

C. AGREED SANCTIONS

1. License Suspension *Stayed*. Dr. Olson's physician license is INDEFINITELY SUSPENDED. Mont. Code Ann § 37-1-312(1)(b). The suspension of Dr. Olson's license is ***stayed*** provided he meets all conditions below.

a. If Dr. Olson fails to meet any of the conditions of Paragraph 2, his license will be suspended and satisfaction of the conditions of Paragraphs 2 shall become conditions precedent to any application or petition for reinstatement of his license. *See* Mont. Code Ann. § 37-1-314.

b. If Dr. Olson's license is suspended, he must surrender any physical copy of the license in his possession to the Board office immediately upon being notified that the stay has been lifted and his license is suspended:

Montana Board of Medical Examiners
301 South Park Avenue
P.O. Box 200514
Helena, MT 59620-0514.

c. Dr. Olson must renew his license, even while suspended, or it will lapse, expire, and terminate. Mont. Code Ann. § 37-1-141. Should Dr. Olson's license terminate, he would not be eligible for license reinstatement and would have to apply for a license as a new applicant.

2. Clinical Skills Assessment. Within six (6) months of entry of a Final Order in this matter, Dr. Olson shall arrange and complete, at his cost, a Clinical Skills Assessment conducted by the Center for Personalized Education for Professionals (CPEP).

a. Dr. Olson must authorize CPEP to share with the Department all information related to his assessment.

b. Dr. Olson shall cause a final report by CPEP detailing the results from his Clinical Skills Assessment to be forwarded to the Department.

c. Dr. Olson must immediately inform the Department when he receives a copy of the assessment results and forward a copy to the Board Office if the Board has not already received the results.

d. If CPEP recommends Dr. Olson retrain in a residency or residency-like setting, Dr. Olson's license shall be SUSPENDED until he completes all the recommendations from CPEP to ensure he is safe return to practice and submits proof of completion to the Department.

e. Dr. Olson shall, during his term of probation stated under Paragraph 3, successfully complete all recommendations by CPEP based on the Clinical Skills Assessment, including but not limited to, enrollment in and successful completion of all recommended programs and courses, chart reviews, and supervision requirements. Proof of completion shall be submitted to the Board Office.

3. Probation. Upon entry of the Final Order in this matter, Dr. Olson's physician license is placed on probation for a period of three (3) years. The term of probation is tolled if he is not practicing medicine, including while his license is suspended because he fails to comply with the conditions under Paragraph 2 above. During the term of probation, Dr. Olson shall:

a. Review and obey the provisions of Mont. Code Ann. Title 37, chapters 1 and 3, and Admin. R. Mont. Title 24, chapter 156.

b. Submit quarterly updates to the Department regarding whether he is working as physician.

b. Immediately inform the Department if he ceases practicing in Montana, at which time, his probation shall be tolled until he begins practicing in Montana again.

c. If practicing as a physician, undergo monthly chart audits completed by a peer reviewer. Mont. Code Ann. § 37-1-312(1)(e). The peer reviewer must hold an active and unencumbered Montana physician license and must be approved by the Department before the first chart audit is completed. Dr. Olson shall bear the cost of the peer-reviews, if any. Information provided in the peer-review reports that may constitute unprofessional conduct may result in additional complaints against Dr. Olson's license. The peer-review requirements of this Stipulation shall remain in effect regardless of whether CPEP recommends peer or chart review. The peer-reviewer shall do the following monthly:

i. Randomly select and review ten (10) patient records, including Dr. Olson's patient record, any prescribing records for the patient, and any relevant and available collateral information related to the patient; and

ii. Submit a report detailing the peer reviewer's evaluation of Dr. Olson's records, including addressing Dr. Olson's (1) compliance with the terms of this Stipulation, (2) compliance with all recommendations from the Clinical Skills Assessment, and (3) adherence to standards of practice, including record keeping standards.

4. Possible Early Termination of Probation. Dr. Olson may request to terminate his probation after two (2) years, not including any time during which the term is tolled, if he has been fully compliant with the terms of this Stipulation, his peer reviewer supports early

termination of probation, and he has otherwise successfully completed all conditions of Paragraphs 2 and 3 above.

8. Submission. Dr. Olson shall submit, or cause to be submitted, all required reports and/or documents to the following addresses either by postal or electronic mail:

Department of Labor and Industry
Compliance Monitoring Specialist
301 South Park Avenue
PO Box 200514
Helena, MT 59620-0514
DLIBSDCOMPLAINTS@MT.GOV

D. ADDITIONAL PROVISIONS

1. Waiver of Rights. Respondent has read and understands each term of the *Notice of Proposed Board Action and Opportunity for Hearing* (Notice) and this Stipulation, and understands the various rights provided, including the right to: a hearing before an impartial hearing examiner; present evidence, testify, and confront and cross-examine witnesses at the hearing; be represented by legal counsel; subpoena witnesses; request judicial review and appeal; and all other rights under Mont. Code Ann. Title 2, ch. 4, pt. 6 (Montana Administrative Procedure Act), Title 37, ch. 1 and 3, and other applicable law. Respondent desires to avoid unnecessary expenditure of time and other valuable resources to resolve this matter. Therefore, Respondent voluntarily and knowingly waives the rights listed above and elects to resolve this matter on the terms and conditions of this Stipulation and acknowledges that no promise, other than those contained in this Stipulation, and no threat or improper assertion has been made by the Board or Department or by any member, officer, agent, or representative of the Board or Department to induce Respondent to enter into this Stipulation.

2. Release. This Stipulation is a final compromise and settlement of this contested case proceeding. Respondent, and assigns, agents, and representatives of Respondent, release

the Board, its members, officers, agents, or representatives from any and all liability, claim, and cause of action, whether now known or contemplated, including but not limited to, any claims under Mont. Code Ann. Title 2, ch. 9, pt. 3 (Montana Tort Claims Act), as amended, or any claim arising under 42 U.S.C. § 1983, which now or in the future may be based upon, arise out of, or relate to any of the matters raised in this case, its processing, investigation, litigation, or from the negotiation or execution of this Stipulation.

3. Entire Agreement. This Stipulation contains the entire agreement of the parties. All prior discussions and writings are superseded by this Stipulation, and no discussion by the Board prior to the approval of this Stipulation may be used to interpret or modify it. Any modification requires a written amendment signed by both parties and final Board approval.

4. Severability. If a court or administrative tribunal declares any term or condition contained in this Stipulation to be unenforceable for any reason, the unenforceable term or condition shall be severed from the remainder of this Stipulation, and the remainder of this Stipulation shall be interpreted and enforced according to its original intent.

5. Reservation. This Stipulation does not restrict the Board from initiating disciplinary action concerning allegations of unprofessional conduct that occur after the date Respondent signs this Stipulation or concerning allegations of conduct not specifically mentioned in this Stipulation that are now known to the Board or yet to be discovered.

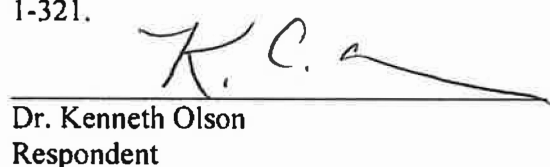
6. Stipulation Subject to Final Approval. This Stipulation is subject to final approval by the Board.

7. Renewed Right to Hearing – Inadmissibility of Stipulation. If the Board considers and does not approve this Stipulation, it is withdrawn and may not be considered as evidence for any purpose. Respondent will have a renewed 20 days from the date of the publicly

noticed Board meeting to submit a written request for a hearing in this matter. Failure by Respondent to request a hearing constitutes a default and allows the Board to enter a Final Order of discipline against Respondent. If, instead, this case proceeds to hearing, Respondent will assert no claim that the Board was prejudiced by its review and discussion of this Stipulation or of any record relating to this Stipulation.

8. Public Documents. The Notice and this Stipulation and Final Order issued by the Board are public documents that the Department, at minimum, must make publicly available on the Department's website and professional databases, and may otherwise distribute to other interested persons or entities.

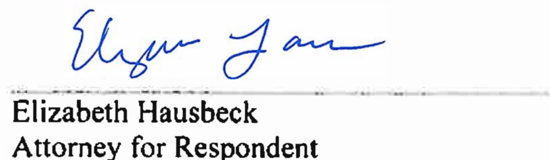
9. Complying with the Terms of the Stipulation. Respondent's failure to strictly abide by the terms of the Stipulation shall constitute a violation of the Final Order of the Board and may result in a separate disciplinary action against Respondent's license. Mont. Code Ann. § 37-1-316(8). Alternatively, Respondent's failure to strictly abide by the terms of the Stipulation may result in administrative suspension of Respondent's license until Respondent complies with the terms of the Stipulation and pays a reinstatement fee. Mont. Code Ann. § 37-1-321.



4-28-23

Dr. Kenneth Olson
Respondent

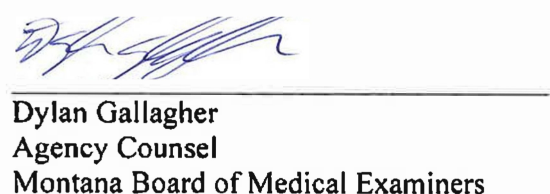
DATE



4/28/2023

Elizabeth Hausbeck
Attorney for Respondent

DATE



5/01/2023

Dylan Gallagher
Agency Counsel
Montana Board of Medical Examiners

DATE

Kevin G. Maki
Dylan Gallagher
Agency Counsel
DEPARTMENT OF LABOR AND INDUSTRY
Office of Legal Services
1315 Lockey Avenue
P.O. Box 1728
Helena, MT 59624-1728
Telephone: (406) 444-5466
E-mail: *laborlegal@mt.gov*

BEFORE THE BOARD OF MEDICAL EXAMINERS
STATE OF MONTANA

In the Matter of **KENNETH OLSON**, Physician License, License No. 7183.	Case Nos. 2020-MED-404; 2022-MED-03877 **NOTICE OF PROPOSED BOARD ACTION AND OPPORTUNITY FOR HEARING**

On April 9, 2021, and September 30, 2022, the Screening Panel of the Montana Board of Medical Examiners considered information presented by the Montana Department of Labor and Industry (Department) and directed issuance of this *Notice of Proposed Board Action and Opportunity for Hearing* (Notice), to Kenneth Olson, MD.

A. FACT ASSERTIONS

1. On or about September 19, 1992, the Montana Board of Medical Examiners (Board) issued Kenneth Olson a physician license, number 7183. Dr. Olson's license is renewed through March 31, 2025.

History

2. Dr. Olson is a psychiatrist whose training focused on issues of psychoanalytic psychotherapy, chemical dependency, and psychopharmacology.

3. On January 18, 2019, the Board adopted a stipulation and entered a final order in a prior disciplinary action against Dr. Olson, Case No. 2017-MED-597.

4. In the stipulation, Dr. Olson agreed he committed unprofessional conduct by failing to review medical records, perform a physical examination, coordinate care of previous providers, review the Montana Prescription Drug Registry, and collect a urine drug screen for a patient (Patient 1).

5. Pursuant to the final order, the Board required Dr. Olson to complete a course on prescribing controlled substances.

Case No. 2020-MED-404

6. In February 2017, Dr. Olson began seeing another patient (Patient 2) to address concerns with Patient 2's body falling asleep, her management of attention, and lapses of awareness.

7. Dr. Olson previously treated Patient 2 approximately 5-10 years earlier, but Patient 2 was terminated from his practice. In the interval, Patient 2 received treatment from a sleep specialist, Virginia Pascual, MD.[1]

8. Patient 2 had a history of abusing substances, including opiates, benzodiazepines, and sedative-hypnotics.

9. Upon re-establishing care with Dr. Olson, Patient 2 reported that Dr. Pascual diagnosed her with narcolepsy, and that she had attempted numerous medications to treat her narcolepsy.

[1] Dr. Olson provided treatment records to the Board from when he started treating Patient 2 again in February 2017. Dr. Olson did not provide treatment records from the time he previously provided care to Patient 2, nor information about when or why he discharged Patient 2. Dr. Olson asserts that he had requested Dr. Pascual's records for Patient 2 when he started treating her again in 2017, but Dr. Pascual did not respond to his request.

10. Dr. Olson did not perform tests or evaluations to confirm Patient 2's self-reported diagnoses for narcolepsy.

11. Dr. Olson prescribed dosages of stimulants[2] higher than generally recommended dosages to treat Patient 2's self-reported narcolepsy, as well as her diagnosis of attention deficit/hyperactivity disorder (ADHD).

12. Patient 2's medical records demonstrate the following:

a. Dr. Olson did not review the medical records for Patient 2 for the interval period when she was not under his care and, in the absence of available records, he did not perform adequate testing and examination to confirm her self-reported narcolepsy diagnoses.[3]

b. Patient 2 was diagnosed with Ehlers Danlos Syndrome (EDS). Patients with EDS have a higher risk of cardiac complications. Patients taking stimulants also have a higher risk of cardiac complications. Even though Patient 2 was diagnosed with EDS, and was prescribed high dosages of stimulants, Dr. Olson did not document that he considered possible risks of cardiac complications to Patient 2, and he did not adequately monitor Patient 2 for those possible negative cardiac complications.

c. Dr. Olson did not document that he considered other symptoms that could cause Patient 2's narcolepsy or ADHD symptoms, even when Patient 2's symptoms did not respond as anticipated to the prescribed medication.

d. Dr. Olson did not coordinate with Patient 2's primary care provider to investigate and treat other physical illnesses that Dr. Olson noted (including low blood

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[2] Each stimulant at issue in this complaint is listed as a controlled substance.
[3] Dr. Olson also provided to the Board a sleep study Dr. Pascual performed in 2009, but there is no indication that he considered the results of the sleep study in determining appropriate care for Patient 2.

pressure and chest pain), or how those illnesses may be connected to Patient 2's sleep disorder symptoms.

e. Dr. Olson did not adequately monitor Patient 2's use of controlled substances. Specifically, before this complaint was filed, Dr. Olson did not conduct any drug screening to confirm Patient 2 was using the substances as prescribed or that she was refraining from using other substances that could negatively react with the prescribed stimulants. Dr. Olson also failed to document any evaluation he performed of Patient 2 that would reveal adverse effects from using prescribed stimulants, including cardiac complications.

Case No. 2022-MED-03877

13. In November 2013, Dr. Olson began providing care to another patient (Patient 3) at Bridger Psychiatric Services. Patient 3 was 7 years old at the time.

14. During her initial appointment, Dr. Olson diagnosed Patient 3 with ADHD and prescribed stimulants to treat this diagnosis.

15. Dr. Olson also diagnosed Patient 3 with obsessive compulsive disorder (OCD) within the first few visits.

16. By August 2015, Dr. Olson had diagnosed Patient 3 with partial seizure disorder and started prescribing Depakote (sodium valproate) to treat this diagnosis.

17. Sodium valproate is a known teratogenic drug.

18. In January 2017, Patient 3 was admitted to the Shodair Child and Adolescent Psychiatric Program (Shodair) due to concerns about increasing aggression and escalating dangerous behavior.

19. One day after admission to Shodair, Patient 3 discontinued using psychostimulant medication. Patient 3's mood improved, and she appeared to be doing well off the medication.

20. While at Shodair, Patient 3 was monitored for signs of seizures based on Dr. Olson's prior diagnosis. Shodair records note that Patient 3 showed no sign of seizures during her stay, and her providers did not endorse a diagnosis of partial seizures.

21. As part of her treatment at Shodair, Patient 3 underwent a psychological evaluation by James Maxson, PsyD. Dr. Maxson considered but rejected Patient 3's ADHD diagnosis, noting that any attention deficiency was more likely caused by anxiety. Dr. Maxson determined Patient 3 had Oppositional Defiant Disorder (ODD), and he confirmed the diagnosis for OCD.

22. Patient 3 started taking Seroquel (quetiapine) to treat OCD symptoms.

23. Weight gain is a known side effect of quetiapine.

24. Patient 3 appeared to stabilize on the quetiapine, and Shodair discharged her on February 8, 2017.

25. Dr. Olson received copies of Patient 3's records from Shodair.

26. Following Patient 3's discharge, Dr. Olson continued prescribing quetiapine.

27. By the end of 2017, Dr. Olson again diagnosed Patient 3 with ADHD and partial seizure disorder, and he prescribed medication to treat those diagnoses.

28. By August 2017, Dr. Olson diagnosed Patient 3 with bipolar disorder.

29. ADHD medications can exacerbate symptoms of bipolar disorder.

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31. Bupropion is known to exacerbate symptoms in patients with seizure disorder.

32. Dr. Olson's notes before April 1, 2021, do not contain documentation of Patient 3's vital signs, including her height, weight, pulse, and blood pressure.

33. Dr. Olson's notes from April 1, 2021, through March 28, 2022, show identical measurements for Patient 3's height and weight, and no measurements for other vital signs.

34. Patient 3's medical records demonstrate the following:

a. Dr. Olson did not adequately document his analysis, testing, objective findings, or other investigation he performed to determine Patient 3's diagnoses, even when his diagnoses were contradicted by findings from other treatment providers.

b. Dr. Olson did not adequately document that he counseled Patient 3 regarding the risks of adverse effects of the medications he prescribed Patient 3.

c. Dr. Olson did not adequately monitor Patient 3 for adverse effects from the medications he prescribed. This failure to monitor includes his failure to document Patient 3's vital signs over the nine years he provided care to Patient 3.

B. ASSERTIONS OF LAW

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

2. Based on the fact assertions above, the Board found reasonable cause to believe Dr. Olson violated the following statutes, rules, or standards, justifying disciplinary proceedings:

Montana Code Annotated

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

. . .

(18) conduct that does not meet the generally accepted standards of practice.

Administrative Rules of Montana[4]

24.156.625 Unprofessional Conduct.
(1) In addition to those forms of unprofessional conduct defined in 37-1-316, MCA, the following is unprofessional conduct for a licensee or license applicant under Title 37, chapter 3, MCA:

. . .

(e) resorting to fraud, misrepresentation, or deception in the examination or treatment of a person; or in billing, giving, or receiving a fee related to professional services; or reporting to a person, company, institution, or organization, including fraud, misrepresentation, or deception with regard to a claim for benefits under Title 39, chapter 71 or 72, MCA;

C. STATEMENT OF RIGHTS AND PROCEDURES

1. You may request a hearing to contest these charges. To exercise the right to a hearing, you must send a written request within 20 days of receipt of this Notice, addressed as follows:

Department of Labor and Industry
Office of Legal Services
1315 Lockey Avenue
P.O. Box 1728
Helena, MT 59624-1728

2. Failure to request a hearing within 20 days of the receipt of this Notice constitutes a default and allows the Board to enter a Final Order of discipline against you based on the facts available to it.

3. If you request a hearing within 20 days, the Commissioner of Labor and Industry will appoint an impartial hearing examiner to conduct the hearing. The hearing examiner will notify you and the Department of the time and place of the hearing. You have the right to appear in person or by or with counsel.

[4] The rules cited in this Notice were in effect when the conduct at issue occurred. Unprofessional conduct provisions related to all licensees under the jurisdiction of this Board are now consolidated in Admin. R. Mont. 24.156.405, as amended by MAR Notice No. 24-156-93.

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

5. After a proposed decision of a hearing examiner, a default, or a stipulated agreement, the Board will issue a Final Order and may impose one or any combination of sanctions under Mont. Code Ann. § 37-1-312 or rules adopted by the Board, including:

a. revocation of the license;
b. suspension of the license for a fixed or indefinite term;
c. restriction or limitation of the practice;
d. satisfactory completion of a specific program of remedial education or treatment;
e. monitoring of the practice by a supervisor approved by the disciplining authority;
f. censure or reprimand, either public or private;
g. compliance with conditions of probation for a designated period of time;
h. payment of a fine not to exceed $1,000.00 for each violation (deposited in the state general fund); and
i. refund of costs and fees billed to and collected from a customer.

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

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

DATED this 20th day of March 2023.

Dylan Gallagher
Agency Counsel
DEPARTMENT OF LABOR AND INDUSTRY

CERTIFICATE OF SERVICE

I certify I served a true and accurate copy of the foregoing ***Notice of Proposed Board Action and Opportunity for Hearing*** by placing it in the United States Postal Service mail, certified with return receipt requested and postage prepaid, addressed to the following:

DATED this 20th day of March 2023.

Kenneth Olson
c/o Elizabeth Hausbeck
Hall Booth Smith
1001 East Front Street, Suite 402
Missoula MT 59802

Department of Labor and Industry