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

In the Matter of the Accusation Against:	)	
THOMAS NEUSCHATZ, M.D.	)	**Case No. 02-2009-199792**
Physician's and Surgeon's Certificate No. C 41964	)	
Respondent	)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on August 22, 2013 **.**

IT IS SO ORDERED July 23, 2013 **.**

MEDICAL BOARD OF CALIFORNIA

By: Kimberly Kirchmeyer

Kimberly Kirchmeyer
Interim Executive Director

KAMALA D. HARRIS
Attorney General of California
ROBERT MCKIM BELL
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **THOMAS NEUSCHATZ, M.D.** 8676 Marysville Rd. Oregon House, CA 95962 Physician's and Surgeon's Certificate No. C 41964 Respondent.	Case No. 02-2009-199792 OAH No. 2012061190 **STIPULATED SURRENDER OF LICENSE AND ORDER**

In the interest of a prompt and speedy resolution of this matter, consistent with the public interest and the responsibility of the Medical Board of California of the Department of Consumer Affairs the parties hereby agree to the following Stipulated Surrender of License and Order which will be submitted to the Board for approval and adoption as the final disposition of the Accusation.

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Interim Executive Officer of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Robert C. Miller, Deputy Attorney General.

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2. Thomas Neuschatz, M.D. (Respondent) is represented in this proceeding by attorney Lawrence S. Giardina, Esq., whose address is 400 University Ave., Sacramento, CA 95825-6502.

3. On or about August 1, 1985, the Medical Board of California issued Physician's and Surgeon's Certificate No. C 41964 to Thomas Neuschatz, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 02-2009-199792 and will expire on April 30, 2015, unless renewed.

JURISDICTION

4. Accusation No. 02-2009-199792 was filed before the Medical Board of California (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on May 23, 2012. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 02-2009-199792 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 02-2009-199792. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

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

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

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CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 02-2009-199792, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

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

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

RESERVATION

11. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

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

13. The parties understand and agree that facsimile copies of this Stipulated Surrender of License and Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

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

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. C 41964, issued to Respondent Thomas Neuschatz, M.D., is surrendered and accepted by the Medical Board of California. The effective date of this Decision and Order shall be thirty (30) days after the date the Decision and Order is signed by the Board.

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

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

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

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 02-2009-199792 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 02-2009-199792 shall

be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

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

DATED: 6/25/13

THOMAS NEUSCHATZ, M.D.
Respondent

I have read and fully discussed with Respondent Thomas Neuschatz, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 7/15/13

LAWRENCE S. GIARDINA, ESQ.
Attorney for Respondent

ENDORSEMENT

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

Dated: 6/26/2013

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

ROBERT C. MILLER
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 02-2009-199792

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

In the Matter of the Accusation Against: **THOMAS NEUSCHATZ, M.D.** P O Box 737 Oregon House, CA 95962 Physician's and Surgeon's Certificate No. C 41964, Respondent.	Case No. 02-2009-199792 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about August 1, 1985, the Medical Board of California issued Physician's and Surgeon's Certificate Number C 41964 to Thomas Neuschatz, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2013, unless renewed.

JURISDICTION

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

4. Section 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 division[1], may, in accordance with the provisions of this chapter:

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

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

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

(4) Be publicly reprimanded by the division.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the division 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 division 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 Division of Medical Quality 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:

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[1] California Business and Professions Code section 2002, as amended and effective January 1, 2008, provides that, unless otherwise expressly provided, the term "board" as used in the State Medical Practice Act (Cal. Bus. & Prof. Code, §§ 2000, et seq.) means the "Medical Board of California," and references to the "Division of Medical Quality" and "Division of Licensing" in the Act or any other provision of law shall be deemed to refer to the Board.

"(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 [Chapter 5, the Medical Practice Act].

"(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 which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

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

6. Section 2241 of the Code states:

"(a) A physician and surgeon may prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under his or her treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances.

"(b) A physician and surgeon may prescribe, dispense, or administer prescription drugs or prescription controlled substances to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances only as set forth in subdivision (c) or in Sections 11215, 11217, 11217.5, 11218, 11219, and 11220 of the Health and Safety Code. Nothing in this subdivision shall authorize a physician and surgeon to prescribe, dispense, or administer

dangerous drugs or controlled substances to a person he or she knows or reasonably believes is using or will use the drugs or substances for a nonmedical purpose.

"(c) Notwithstanding subdivision (a), prescription drugs or controlled substances may also be administered or applied by a physician and surgeon, or by a registered nurse acting under his or her instruction and supervision, under the following circumstances:

"(1) Emergency treatment of a patient whose addiction is complicated by the presence of incurable disease, acute accident, illness, or injury, or the infirmities attendant upon age.

"(2) Treatment of addicts in state-licensed institutions where the patient is kept under restraint and control, or in city or county jails or state prisons.

"(3) Treatment of addicts as provided for by Section 11217.5 of the Health and Safety Code.

"(d)(1) For purposes of this section and Section 2241.5, "addict" means a person whose actions are characterized by craving in combination with one or more of the following:

"(A) Impaired control over drug use.

"(B) Compulsive use.

"(C) Continued use despite harm.

"(2) Notwithstanding paragraph (1), a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict within the meaning of this section or Section 2241.5."

7. Section 2241.5 of the Code states:

"(a) A physician and surgeon may prescribe for, or dispense or administer to, a person under his or her treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing pain, including, but not limited to, intractable pain.

"(b) No physician and surgeon shall be subject to disciplinary action for prescribing, dispensing, or administering dangerous drugs or prescription controlled substances in accordance with this section.

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"(c) This section shall not affect the power of the board to take any action described in Section 2227 against a physician and surgeon who does any of the following:

"(1) Violates subdivision (b), (c), or (d) of Section 2234 regarding gross negligence, repeated negligent acts, or incompetence.

"(2) Violates Section 2241 regarding treatment of an addict.

"(3) Violates Section 2242 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs.

"(4) Violates Section 2242.1 regarding prescribing on the Internet.

"(5) Fails to keep complete and accurate records of purchases and disposals of substances listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) or controlled substances scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. Sec. 801 et seq.), or pursuant to the federal Comprehensive Drug Abuse Prevention and Control Act of 1970. A physician and surgeon shall keep records of his or her purchases and disposals of these controlled substances or dangerous drugs, including the date of purchase, the date and records of the sale or disposal of the drugs by the physician and surgeon, the name and address of the person receiving the drugs, and the reason for the disposal or the dispensing of the drugs to the person, and shall otherwise comply with all state recordkeeping requirements for controlled substances.

"(6) Writes false or fictitious prescriptions for controlled substances listed in the California Uniform Controlled Substances Act or scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970.

"(7) Prescribes, administers, or dispenses in violation of this chapter, or in violation of Chapter 4 (commencing with Section 11150) or Chapter 5 (commencing with Section 11210) of Division 10 of the Health and Safety Code.

"(d) A physician and surgeon shall exercise reasonable care in determining whether a particular patient or condition, or the complexity of a patient's treatment, including, but not limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a more qualified specialist.

"(e) Nothing in this section shall prohibit the governing body of a hospital from taking disciplinary actions against a physician and surgeon pursuant to Sections 809.05, 809.4, and 809.5."

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.

"(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 his or her 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."

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9. Section 2261 of the Code states: AKnowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct.@

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

11. 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."

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FIRST CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(b)]
(Gross Negligence)

Patient M.C.

12. Respondent is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient M.C. The circumstances are as follows:

13. Patient M.C. was a 19-year-old college student when his father filed a complaint with the California Medical Board in March, 2010, regarding his son's treatment by Respondent. Respondent treated M.C. from October 28, 2008 to February 16, 2010.

14. In January, 2010, while on holiday break from Chico State University, M.C. was staying with his family in San Diego. During that time, M.C. admitted to his family that he had a drug problem and needed help. This admission occurred after M.C. suffered a seizure which was attributed to Xanax withdrawal. M.C. subsequently underwent five days of inpatient detoxification from January 20 to 25, 2010.

15. Before M.C. returned to Chico, his father telephoned Respondent informing him of the seizure, and the inpatient detoxification of M.C. He pleaded with Respondent to stop prescribing more drugs to his son. Respondent did not document this conversation in the medical record.

16. When interviewed by Medical Board investigators, Respondent recalled the father telling him that his son was mentally unstable and seeing a psychiatrist.

17. M.C. made 17 visits to Respondent from October 28, 2008 through February 16, 2010. Respondent's treatment notes for M.C. are mostly illegible handwritten notes with corresponding typed transcription notes.

18. The patient chart contains forms for listing medications and medical problems on which there are no entries. The form for listing medications, refill amounts, number prescribed and directions for use are also blank. There are largely illegible entries corresponding to two patient care related telephone conversations. There is a request for medical records from Dr. McDonnell signed by patient, but incorrectly dated. There are no records from prior treating

physicians or any other providers in the patient chart. There are no lab reports, drug screens, or x-ray reports contained within the medical chart.

19. On October 28, 2008, the patient's first visit to Respondent, M.C. reported upper back and neck pain dating to a backpacking trip one year before. This pain had worsened after he was rear-ended in an automobile accident.

20. M.C. told Respondent that he was taking OxyContin (40 mg, three times daily) for his pain with incomplete relief. Respondent documented a physical exam appropriate to the complaint. Physical therapy was documented as having been prescribed and specific exercises were recommended.

21. Respondent doubled the dose of OxyContin that M.C. had reportedly been taking by prescribing 80 mg, three times daily. He authorized a one-month supply. There is no documentation that Respondent advised M.C. of the risks of OxyContin.

22. On the second visit, which took place 14 days later, M.C. reported that his medication had been stolen. A copy of the police report was provided to Respondent as evidence of the theft. Respondent provided M.C. another prescription for OxyContin with the warning that he would not fill them early in the future.

23. The third visit occurred 14 days later. M.C. reported new symptoms suggestive of nerve pain. Respondent did not prescribe any medications specific for the treatment of nerve pain. Instead, he provided an additional prescription for oxycodone which is a short acting opiate medication in the same class as OxyContin.

24. On the fourth visit, which occurring eight days later, M.C. reported another theft of his medication and again provided a police report to Respondent as evidence. On this visit, Respondent documented that M.C. had withdrawal symptoms. Respondent again documented that he advised M.C. he would not replace his medication again. However, Respondent prescribed a 50-day supply of OxyContin and oxycodone.

25. On visits six through sixteen, Respondent documents M.C.'s ongoing nerve pain symptoms for which the patient was never given a medication for the specific treatment of nerve pain. Instead, continued complaints of pain lead to prescriptions for increased amounts of

OxyContin and oxycodone, a trial of Soma, and the addition of Dilaudid. Respondent noted that M.C. actually asked for Dilaudid by name on April 27, 2009. M.C. told Respondent that the Dilaudid he had taken before worked better than the oxycodone and that he would like to go back to that. The starting dose of Dilaudid prescribed by Respondent was roughly twenty-five percent greater than the oxycodone Respondent had previously been prescribing for M.C. Although the Dilaudid was supposed to be used in place of oxycodone, the pharmacy prescription records show that M.C. continued to fill oxycodone prescriptions written by Respondent for another few months.

26. A similar duplication of similar medications occurred after M.C.'s tenth visit on June 22, 2009. There the patient requested a Fentanyl patch in place of OxyContin. Over the next several months, Respondent prescribed escalating doses of Fentanyl while he continued to also prescribe OxyContin to M.C.

27. On his seventh visit on March 26, 2009, M.C. complained of anxiety and he requested Xanax by name. Respondent did not thoroughly evaluate M.C. for this new complaint, nor did he prescribe any of the non-habituated medications recommended for patients with anxiety. Rather, Respondent prescribed Xanax at the 2 mg dose which is two to four 4 times greater than the recommended starting dosage. The number of Xanax tablets prescribed was then increased over the ensuing months without explanation in the medical chart.

28. On November 9, 2009, M.C. made his third report to Respondent that his medications had been stolen, and Respondent issued new prescriptions to replace the medications. This was approximately a year after his initial visit, and M.C. continued to receive from Respondent extremely high doses of controlled substances as follows: Xanax, 6 mg a day; Dilaudid, 96 mg a day; Duragesic (Fentanyl), 75 mcg a day; and OxyContin, 320 mg a day. The total dose of opiate medication prescribed by Respondent to patient M.C. roughly corresponds to approximately 1700 mg of oral morphine per day. By comparison, the average dose of oral morphine prescribed for patients with cancer pain is between 100 mg to 250 mg per day.

29. On December 10, 2009, M.C. reported for a fourth time that his medications had been stolen. According to Respondent's handwritten notes, he began a tapering dose of opiate

medications for M.C. to avoid withdrawal. Respondent did not decrease the dose or amount of Xanax, but, according to the pharmacy records, wrote a prescription for a 30 day supply of 2 mg Xanax. This amount would have lasted until January 10, 2010, and corresponds with the seizure M.C. suffered in mid January 2010, which was a week after he would have exhausted the Xanax prescription.

30. At M.C.'s seventeenth and last visit, Respondent did not document anything regarding the telephone conversation with M.C.'s father; nothing about the Xanax linked seizure; and, nothing about M.C.'s subsequent inpatient detoxification. Instead, Respondent noted that the patient continued to have chronic pain, ran out of his pain medications and is having mild withdrawal symptoms. Respondent also wrote that the patient has a history of psychiatric problems.

31. Respondent's care and treatment of M.C. was grossly negligent in the following respects:

1. Other than the questionnaire completed by M.C. himself, there is no documented inquiry into his substance abuse history nor was there any evaluation of his psychological status.

2. The patient reported that his pain began after a backpacking trip and was worsened after a car accident. The discomfort reported by M.C., a 19-year-old man, would be unlikely to persist several months to a year later. Respondent failed to recognize that a complaint of pain for such duration would either be a serious and previously unrecognized injury, or it would raise the possibility of drug seeking by the patient for nonmedical uses.

3. Respondent did not provide a limited amount of the same dose of pain medication that the patient claimed to have been taking until M.C.'s medical history could be confirmed. There is no evidence that Respondent confirmed prior OxyContin treatment for M.C., nor is there evidence that he tried to contact M.C.'s prior treating physician. Instead, Respondent increased by 100% the dose of OxyContin that the patient claimed to be taking.

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4. In the care and treatment of M.C., there are consistent documented recommendations regarding stretching exercises and sporadic references to physical therapy referrals. However, there is no documentation that M.C. actually took part in physical therapy. There is no documentation that he ever signed up for the yoga classes that Respondent recommended or verification that M.C. was complying with any exercise program.

5. At no point during M.C.'s treatment were any medications prescribed or recommended by Respondent other than controlled substances. There were multiple occasions during treatment when a prescription with non-opiate medication would have been appropriate.

6. Respondent's treatment plan for M.C. never specified functional objectives of treatment. At no point in his evaluation of M.C. were additional diagnostic tests such as laboratory studies, x-rays, or MRIs ordered by Respondent. At no point in his evaluation of M.C. was the veracity of his original story questioned nor were any prior treating physicians contacted.

7. Respondent failed to document informed consent by advising M.C. of the risks of dependency and other adverse effects of the various controlled substances prescribed.

8. Respondent failed to recognize or respond in a timely fashion to patient behaviors highly suggestive of drug misuse, such as requesting specific medications by name and reporting several thefts of his medications.

9. Respondent's chart for M.C. lacked a consistent accurate ongoing record of the dose, instructions for use, and quantity of medications prescribed. Except for the disorganized copies of prescriptions in the back of the patient chart, there was no way to accurately determine what medications M.C. was taking at any given time and when it was last prescribed. This lack of documentation may have contributed to various prescribing irregularities such as the months when the patient was prescribed both Dilaudid and oxycodone, and the later months when he was prescribed both OxyContin and Fentanyl. Respondent also failed to document the reasons for dosage increases.

32. Respondent's conduct as described above is gross negligence in the practice of medicine and constitutes unprofessional conduct in violation of section 2234(b) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

SECOND CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(c)]
(Repeated Negligent Acts)

33. Respondent is subject to disciplinary action under section 2234(c) of the Code in that he committed acts of repeated negligence and unprofessional conduct during the care and treatment of patient M.C. The circumstances are as follows:

34. Paragraphs 12 through 32 are repeated here as more fully set forth above.

35. Respondent's conduct as described above constitutes repeated negligent acts in the care and treatment of M.C., and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

THIRD CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 725]
(Excessive Prescribing)

36. Respondent is subject to disciplinary action under section 725 of the Code in that he prescribed excess quantities of controlled substances and dangerous drugs to M.C.

37. Paragraphs 12 through 32 are repeated here as more fully set forth above.

38. Respondent's conduct as described above constitutes excessive prescribing of controlled substances and dangerous drugs in the care and treatment of M.C. and is unprofessional conduct and grounds for discipline against Respondent's physician's and surgeon's certificate.

FOURTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2266]
(Inadequate Medical Records)

39. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate medical records for patient M.C. Specifically, Respondent failed to adequately record histories, physicals, accurate assessments of the patient's pain, and medications prescribed.

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40. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of M.C., and constitutes grounds for discipline against his physician's and surgeon's certificate.

FIFTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(b)]

(Gross Negligence)

Patient E.G.

41. Respondent is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient E.G. The circumstances are as follows:

42. On September 25, 2009, patient E.G.'s sister filed a complaint with the Medical Board of California, alleging that Respondent was prescribing multiple controlled substances to E.G., despite her lengthy history of substance abuse and her misuse and sale of the medications prescribed by Respondent. After Respondent surrendered his DEA license, E.G. experienced withdrawal symptoms for about two weeks. E.G. went to a new doctor who ordered x-rays and referred her to physical therapy and to a pain specialist. The pain specialist proposed a trial of epidural steroids and prescribed Neurontin and morphine.

43. E.G., a 42-year-old woman started seeing Respondent as her primary care physician at Chico Family Health Clinic. She followed Respondent when he opened his pain management private practice in Chico. E.G. was Respondent's patient for approximately ten years.

44. E.G.'s first visit to Respondent's private practice was on April 1, 2008. Respondent commented and documented that E.G. was well known to him from his other office. Respondent documented E.G's chronic lung disease and other medical problems including diabetes. The patient's was seeking relief of her chronic back and chest pain, and she requested Ativan for anxiety. Medications she was taking prior to this first visit were not listed but a physical examination was documented.

45. Respondent's treatment plan was for the reissuing of prescriptions for diabetes and an allergy condition. Respondent also provided prescriptions for six other medications, including Soma, Ativan and Vicodin ES, which E.G. was to take three times daily. She was given a

prescription for 200 tablets of Vicodin ES, which should have lasted for over two months if taken as directed.

46. At E.G's second visit two months later, the patient requested refills of Norco and Soma. There are no notes in the chart explaining how she came to be taking Norco instead of Vicodin ES. Respondent prescribed Norco, 8 tablets a day, which represented a 250 percent increase in her daily dose of hydrocodone. Respondent also prescribed Soma, 8 tablets a day, which is double the manufacturer's recommended dose of this medication. Respondent further prescribed Ambien for sleep which was in addition to the sedating antidepressant Amitryptiline E.G. was already taking.

47. At the third visit two months later, Respondent documented that E.G. was now taking OxyContin in addition to Norco, and again there is no explanation in the patient record regarding the addition of this opiate to the patient's already extensive medication list. The patient's pain is recorded as "50% better" and her function good. Respondent prescribed OxyContin, 20 mg a day "and occasionally more if she wants," Norco 10 mg 8 tablets daily as needed (a 25% increase), and a refill of Soma, 8 tablets daily or "whatever the pharmacy will give her."

48. At the fourth visit about six weeks later, E.G. allegedly reported inadequate pain relief and inadequate function. Respondent increased the dose of OxyContin to 40 to 80 mg per day. Soma and Ambien prescriptions were also refilled. The Norco was reduced back to the 7.5 mg formulation. Respondent had prescribed a two-month supply of all medications, yet E.G. returned about six weeks later on November 4, 2008. Respondent documented that E.G.'s back pain episodes had become more frequent, and "she would like to go up on the Norco and I said fine." In addition to resuming Norco 8 mg, 8 tablets daily, her OxyContin dose was increased 400% to 320 mg a day.

49. In the course of five visits, Respondent had increased E.G.'s opiate dose from Hydrocodone 22.5 mg a day to Hydrocodone 80 mg a day, plus oxycodone 320 mg a day. This represents a 600% to 700% increase in the dose of opiate medications over a seven-month period, roughly a 100% increase every month.

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50. The doses of opiates and other controlled substances prescribed for E.G. remained relatively stable for a little more than four months until April 9, 2009, when the patient reported a sudden increase in low back pain. For this an x-ray was purportedly ordered but does not appear in the patient record, and the dose of opiates started increasing again. First, Respondent increased Norco to the maximum dose possible and later generic oxycodone was added. The dose of oxycodone gradually increased from 90 mg a day; to 120 mg a day; then to 360 mg a day.

51. On January 14, 2010, Respondent dictated, "she seems to have overtaken her medication once again," and "I told her I would not be giving them early again." This is the first documentation in the medical record regarding misuse of medications by patient E.G. Although Respondent had been prescribing medications for conditions other than pain up until this visit, here he wrote, "follow-up with primary care physician for general medical and preventive care." This comment is repeated in the patient's chart at the visits two and four months later. Although Respondent continued to document no evidence for diversion, on April 29, 2010, he wrote, "we are going to do a urine drug screen." "I told her she had to have the results and current medications with bottles at the next appointment." A month later, Respondent ordered a pharmacy record regarding prescriptions filled by E.G.

52. The doses of opiates and other controlled substances remained stable for another six months until late 2010 or early 2011, when Respondent wrote E.G. a new prescription for Dilaudid (hydromorphone). Respondent apparently stopped prescribing OxyContin to E.G around this time, although there is no entry in the medical record regarding this medication change. The last entry in the medical record corresponds to an office visit on February 10, 2011, and it was around this time that E.G. was in jail. Although there are no documented visits, Respondent continued prescribing to E.G for several more months. Over a slightly greater than three month time period – between January 4, 2011 and April 16, 2011 – Respondent prescribed 2,560 tablets (20,480 mg) of Dilaudid to patient E.G.

53. Respondent's care and treatment of E.G. was grossly negligent in the following respects:

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1. Respondent failed to make a specific diagnosis regarding E.G's pain. There is no specific evaluation of her psychological status other than frequent notations about her anxious effect.

2. Respondent never followed up on x-rays that he ordered.

3. Respondent failed to establish or exclude a diagnosis of diabetes for E.G.

4. Respondent made multiple documented recommendations regarding exercise and stretching, but no documentation that E.G. complied with any of the stretching or exercise programs recommended to her.

5. The pain treatment plan for E.G. never specified the functional goals of treatment.

6. The reasons behind the increase in opiate medication were seldom clear from the record and never based on E.G.'s functional status.

7. According to her pain contract, E.G. was to bring her pain medication bottles to all appointments, but there is little documentation that she complied. At the October 21, 2010 appointment, she apparently did not bring her pain medication bottles, but there was no documented consequence for her failure to do so.

8. At one point in his evaluation of E.G., Respondent ordered an x-ray of her lumbar spine, but there were no x-ray reports in her chart, and no further reference to this x-ray was made by Respondent and his later progress notes. Sometimes diagnostic tests such as x-rays or CT scans were allegedly ordered by the many other physicians involved in the care of E.G., but there is no evidence that Respondent spoke with these other physicians or formally requested the results of these studies.

9. The only treatment Respondent employed for E.G. was opiate medications, the doses of which were increased with alarming rapidity. During the initial months of treatment Respondent doubled her opiate doses every month until at one point E.G. was receiving a mixture of opiate medications equal to 1,035 mg a day of oral morphine. By comparison, the average dose of oral morphine required by patients with cancer pain is between 100 mg to 200 mg per day.

10. Respondent failed to document that he informed E.G. about the risks of opiate medications.

11. Respondent failed to document that E.G. was ever referred to physical therapy or any physician specialist for evaluation or treatment of her chronic pain condition.

54. Respondent's conduct as described above is gross negligence in the practice of medicine and constitutes unprofessional conduct in violation of section 2234(b) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

SIXTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(c)]
(Repeated Negligent Acts)

55. Respondent is subject to disciplinary action under section 2234(c) of the Code in that he committed acts of repeated negligence and unprofessional conduct during the care and treatment of patient E.G. The circumstances are as follows:

56. Paragraphs 41 through 54 are repeated here as more fully set forth above.

57. Respondent's conduct as set described above constitutes repeated negligent acts in the care and treatment of E.G.

SEVENTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 725]
(Excessive Prescribing)

58. Respondent is subject to disciplinary action under section 725 of the Code in that he prescribed excess quantities of controlled substances and dangerous drugs to E.G.

59. Paragraphs 41 through 54 are repeated here as more fully set forth above.

60. Respondent's conduct as described above constitutes excessive prescribing of controlled substances and dangerous drugs in the care and treatment of E.G., and is unprofessional conduct and grounds for discipline against his physician's and surgeon's certificate.

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EIGHTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2266]
(Inadequate Medical Records)

61. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate medical records for patient E.G. Specifically, Respondent failed to adequately record histories, physicals, assessments of the patient's pain, and medications prescribed.

62. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of E.G. and constitutes grounds for discipline against his physician's and surgeon's certificate.

NINTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(b)]
(Gross Negligence)

Patient R.E.

63. Respondent is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient R.E. The circumstances are as follows:

64. In approximately February 2010, the Butte County Sheriff opened an investigation into the death of 19-year-old R.E., who was found dead in his apartment from an apparent drug overdose. At the patient's apartment were several prescriptions in his name that had been written by Respondent. The coroner determined that acute poisoning by multiple pharmaceuticals and illegal substances was the cause of R.E.'s death.

65. A pharmacy review for R.E. for June 8, 2008 through June 8, 2011, found that Respondent was the only physician prescribing controlled substances to R.E., which included methadone, hydromorphone, oxycodone and Xanax. The last prescription R.E. filled was on January 26, 2010, which was only a few days before his death. The only medications found in R.E.'s apartment in the hours after his death was a bottle of methadone tablets prescribed by Respondent.

66. R.E.'s mother reported that R.E. had a history of drug problems dating to age 15, when he was hospitalized after taking a hallucinogen. He spent 18 months in a residential

treatment program. He later resumed drug use and spent another six months in court-ordered residential treatment.

67. R.E. enrolled in college in 2008, but withdrew the second semester. In December 2009, he entered a medical detoxification program in San Diego. After completing the program he returned to Chico. There he shared an apartment with another of Respondent's patients.

68. R.E. made 11 visits to Respondent over 13 consecutive months from December 11, 2008 to January 26, 2010. At his first visit, R.E. completed a new patient intake form on which he recorded a 2004 hospitalization as drug-related. The suggested history of drug abuse was not commented upon by Respondent in any of R.E.'s 11 office visits, or on the "opiate risk tool" that Respondent used to evaluate his patient's risk of prescription misuse. At this first visit the patient claimed a chronic neck pain dating to a sports injury which was worsened by two subsequent motor vehicle accidents. R.E. reported prior treatment with prescription narcotics, most recently OxyContin 80 mg, three times daily. The patient provided no medical records, no prescription bottles, and was unable to recall the names of any prior treating doctors or location of the pharmacies he used.

69. Respondent performed a limited physical examination on R.E. Respondent documented, "I told him that before I gave him OxyContin, I would have to see previous records, doctor visits, etc." According to the office notes, R.E. was provided with a prescription for 45 tablets of oxycodone, 30 mg. However, according to a photocopy of the original prescription retained in the medical record, the prescribed amount was actually 240 tablets. There is a signed request for medical records for a "Dr. Phillips," dated December 11, 2008, but there is no address and no evidence that this request was ever sent.

70. At the second office visit approximately two months later, nothing was documented by Respondent regarding the lack of follow-up on the prior request for medical records. R.E. complained of neck pain interfering with sleep, and for this a prescription for 240 tablets of oxycodone was written and a new prescription for methadone 20 mg daily was provided. According to a pharmacy review, at some point before the third office visit, R.E. was provided a

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new prescription for 90 tablets of hydromorphone, 8 mg (Dilaudid). There is no documentation in the medical records regarding this prescription.

71. On the third visit, about six weeks later and about two weeks after the addition of hydromorphone to his medication regimen, R.E. reported that he was a fully functional full-time student. A physical examination was confined to his neck on which decreased range of motion was demonstrated. R.E. was instructed regarding a home exercise program. With no explanation in the records, increased doses of opiates were prescribed, specifically hydromorphone, 80 mg a day, and methadone, 50 mg a day. That dose represents more than twice as much methadone as had previously been prescribed.

72. On the fourth visit on April 23, 2009, approximately one month after the third visit, R.E. reported that he was working full-time. Respondent documented that the patient, "wants to get oxycodone and methadone." A limited physical examination showed slight improvement in neck range of motion. Despite R.E.'s occupational function and physical improvement, a muscle relaxant was added to his medication regimen. Oxycodone was either resumed or maintained and doses of methadone and hydromorphone were maintained.

73. Two weeks later on May 7, 2009, a theft of medication from R.E.'s dorm room was documented by a Chico police dispatcher. There is no corresponding note in the medical record except a May 7, 2009 handwritten note that said, "meds stolen." That same day Respondent prescribed oxycodone and methadone to R.E. The pharmacy review established the following prescriptions written for R.E. by Respondent: April 23, 2009, hydromorphone, 8 mg 300 tablets; April 23, methadone 10 mg 150 tablets; May 7, oxycodone 30 mg 128 tablets; May 7, methadone 10 mg 80 tablets.

74. At visit seven on July 23, 2009, Respondent documented, "he had been on Xanax 1 mg at night and he had less jerking in his legs . . . pain control is slightly decreased." The patient's dose of methadone was increased from 50 mg a day to 70 mg a day, "because his pain control is slightly down." His hydromorphone dose was maintained and Xanax 1 mg a day was added to his regimen.

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75. Modest increases in doses of Xanax and methadone occurred over the next three monthly visits. R.E. was supposed to return to the Respondent's office around November 20, 2009, but there was no documented visit until January 26, 2010. This interval includes the dates when the patient went home to San Diego and was in a detoxification program. Respondent continued to provide R.E. with prescriptions for controlled substances during this interval. Although there is no documentation in the office medical record of these prescriptions, the pharmacy review confirms that Respondent continued to prescribe to R.E. during this interval as follows: November 3, 2009 hydromorphone 8 mg # 150; November 30, 2009 Xanax 2 mg # 3; November 30, 2009 methadone 10 mg # 24; December 3, 2009 Xanax 2 mg # 51; December 3, 2009 methadone 10 mg # 510; December 3, 2009 hydromorphone 8 mg # 570.

76. R.E.'s final visit to Respondent was on January 26, 2010, five days prior to his death from overdose. On that last visit, Respondent makes no reference to R.E.'s recent inpatient treatment for drug detoxification. His physical exam of R.E. was largely unchanged and medications were refilled without dosage adjustment. Respondent prescribed medications for 45 days as follows: January 26, 2010 Alprazolam 2 mg #45; January 26, 2010 methadone 10 mg #450; January 26, 2010 hydromorphone 8 mg #450. The dose of opiate medications Respondent prescribed to R.E. corresponds to well over 740 mg of oral morphine every day. By comparison, the average dose of oral morphine required by patients with cancer pain is between 100 to 250 mg per day.

77. Respondent's care and treatment of R.E. was grossly negligent in the following respects:

1. Beyond a questionnaire completed by the patient himself, there is no documented inquiry into his substance abuse history nor was there an evaluation of his psychological status. Respondent never addressed R.E.'s history of drug-related hospitalization. Despite a history that spans many years, the patient claimed not to know the name of any of his treating physicians, the location of any pharmacies he used, nor was he able to produce any prescription bottles. Under those circumstances, Respondent should have suspected that R.E. was using the medications for a non-medical purpose. Respondent

should have provided a limited amount of pain medication until the patient's medical history could be verified. There is no evidence that Respondent ever confirmed the patient's prior opiate treatment even though this was documented as his intention at the first visit. Although there is a patient release of medical records from Dr. Phillips there is no evidence that this was ever sent.

2. Respondent never recorded the quality of R.E.'s social interactions beyond comments about the patient's sleep. There was never any documented inquiry into R.E.'s psychological status. Respondent's physical examination of the patient done at the initial visit was quite limited and became less thorough with every subsequent visit.

3. Respondent recorded no formal referral to physical therapy. There is no documentation that the patient actually enrolled in yoga classes as he claimed nor is there evidence that he complied with any of the stretching exercise programs Respondent recommended.

4. At no point during R.E.'s treatment were any medications prescribed or recommended other than controlled substances.

5. The treatment plans for the patient never specify the functional goals of treatment.

6. At no point in Respondent's evaluation of R.E. were traditional diagnostic tests such as laboratory studies, x-rays, or MRIs ordered by Respondent.

7. At no point in his evaluation of R.E. was the veracity of the original history questioned or prior treating physicians contacted by Respondent.

78. Respondent's conduct as described above is gross negligence in the practice of medicine and constitutes unprofessional conduct in violation of section 2234(b) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

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TENTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(c)]
(Repeated Negligent Acts)

79. Respondent is subject to disciplinary action under section 2234(c) of the Code in that he committed acts of repeated negligence and unprofessional conduct during the care and treatment of patient R.E. The circumstances are as follows:

80. Paragraphs 63 through 78 are repeated here as more fully set forth above.

81. Respondent's conduct as described above constitutes repeated negligent acts in the care and treatment of R.E.

ELEVENTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 725]
(Excessive Prescribing)

82. Respondent is subject to disciplinary action under section 725 of the Code in that he prescribed excess quantities of controlled substances and dangerous drugs to R.E.

83. Paragraphs 63 through 78 are repeated here as more fully set forth above.

84. Respondent's conduct as described above constitutes excessive prescribing of controlled substances and dangerous drugs in the care and treatment of R.E. and is unprofessional conduct and grounds for discipline against his physician's and surgeon's certificate.

TWELFTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2266]
(Inadequate Medical Records)

85. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate medical records for patient R.E. Specifically, Respondent failed to adequately record histories, physicals, assessments of patient pain, and medications prescribed.

86. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of R.E. and constitutes grounds for discipline against his physician's and surgeon's certificate.

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THIRTEENTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(b)]
(Gross Negligence)

Patient J.G.

87. Respondent is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient J.G. The circumstances are as follows:

88. Respondent's patient J.G. died on November 24, 2009. A consumer complaint was subsequently filed by J.G.'s live-in boyfriend and the father of their child. He alleged that Respondent prescribed methadone, Soma, Valium, and Klonopin that ultimately caused J.G.'s death. He alleged that Respondent was aware that J.G. was a drug addict.

89. According to her boyfriend, J.G. had tremors and difficulty breathing in the hours before her death. When he noticed she had stopped breathing, J.G.'s boyfriend called 911, and initiated CPR. By the time paramedics arrived, J.G. was pulseless, not breathing, and cool to the touch. Inside their home was a bottle of Soma prescribed by Respondent, and filled the previous day in which 25 of the 30 tablets remained. Also found was an empty bottle of Xanax prescribed by a different physician four days earlier. The toxicology report for J.G. was positive for methadone, carisprodolol, meprobamate (a metabolite of carisprodolol), benzodiazepines, Alprazolam, morphine, codeine and cannabinoids. The forensic autopsy report attributed J.G.'s death to acute poisoning by multiple pharmaceuticals.

90. Respondent provided care to J.G. dating back to March 15, 2007, while at the Chico Family Health Center. J.G. had nine separate visits with Respondent in Chico over an eleven month period.

91. At J.G.'s first visit Respondent prescribed Lexapro and diazepam (Valium) because J.G. had anxiety that had not improved when treated with Zoloft. At the second visit, Respondent documented concerns that, given her drug addiction, the patient could, "overuse . . . benzodiazepines." It is clear from the record that Respondent was aware that J.G. was also receiving methadone from a drug treatment clinic. On visits 3 through 9, Respondent provided her with prescriptions for the benzodiazepine, Klonopin and various non-controlled psychiatric

medications. The dose of Klonopin prescribed by Respondent to J.G. remained stable for over a year.

92. J.G. went to Chico Family Health Center on July 11, 2008, which was sometime after Respondent no longer worked there. She reported that her medications have been stolen and that she was in urgent need of refills. Her refill request was not accommodated and she became visibly upset and left the clinic.

93. J.G. then left Chico Family Health Clinic for Respondent's private office. Notably absent on the intake form are any checkmarks corresponding to her psychiatric history, psychiatric symptoms, or areas of pain. Respondent increased the doses of her psychiatric medications and doubled the dose of Klonopin. Around the time of this first visit, J.G. signed a generic pain management agreement. The only entries on her medication log were also made around this time.

94. According to a handwritten note on the communication sheet a few days after the first visit on July 24, 2008, a decision was made to stop Klonopin and start Valium. This documentation conflicts with the pharmacy review on which is listed dates corresponding to the following filled prescriptions: Clonazepam 2 mg, 60, filled on July 21, 2008; diazepam 5 mg, 98, filled July 24, 2008; Clonazepam 2 mg, 68, filled July 25, 2008.

At her second visit to Respondent's private practice on September 23, 2008, J.G. reported that she was taking Valium (diazepam) and it was helpful. She said that she had an appointment with a psychiatrist. Valium was prescribed 20 mg daily, and it appears that no more Klonopin was prescribed.

95. On the third visit about seven months later on April 30, 2009, Respondent dictated "patient has been going to Chico Family Health Clinic for general medical care and Aegis for chronic right shoulder pain and upper back pain. She does not want to go to Aegis anymore, but would rather come here. She takes Valium as a muscle relaxants and that helps. [Her physician at Chico Family Health Clinic] has been reluctant to give her that. "Records were provided by Aegis in advance of his visit. These records document the patient's stable dose of methadone 140 mg daily. Respondent conducted a minimal exam and prescriptions for methadone and Valium

20 mg a day were provided to J.G. She was also given a prescription for physical therapy. It also appears that a pharmacy review for the patient was requested by Respondent at this visit.

On visits five and six, stable doses of methadone and Valium were provided. At visit five Respondent documented increased shoulder pain for which shoulder exam was done and he recommended follow-up with her primary care physician to get a referral to an orthopedic doctor to see if something was internally wrong with her shoulder. On visit six, October 23, 2009, Respondent dictated patient, "urged to go to primary care physician to get a referral to an orthopedic doctor to see if . . . a specific treatment for her shoulder is available." The patient died of an overdose one month after this final visit.

96. There is nothing within the medical record documenting a prescription for the Soma that was found in the patient's home. According to the pharmacy review, J.G. was filling prescriptions for stable doses of controlled substances provided by both Respondent and her primary care physician in the weeks before her death. She was also having prescriptions filled at multiple pharmacies.

97. Respondent's care and treatment of J.G. was grossly negligent in the following respects:

1. Respondent did not order any diagnostic tests such as laboratory studies, x-rays, or MRIs for J.G.

2. Respondent failed to document any substance abuse history for J.G. although this was known to him from when he was her primary care physician at Chico Family Health Center, and also known to Respondent was J.G.'s ongoing treatment at a methadone maintenance clinic.

3. Respondent also erroneously documented that J.G. attended the Aegis methadone treatment clinic for chronic right shoulder pain and back pain, instead of for her addiction.

4. Respondent did not document whether J.G. ever followed through with the physical therapy referral or that she complied with any of the stretching or exercise program recommended to her by Respondent.

5. The pain treatment plan for J.G. never mentioned the functional goals of treatment. Treatment of J.G.'s anxiety with non-habituated medications such as antidepressants was replaced with narcotics soon after she came to Respondent's clinic for treatment.

6. Respondent assumed responsibility for treatment of J.G.'s known addiction, but inaccurately represented this as a treatment for a chronic pain condition. Respondent failed to document that he informed J.G. about the risks of benzodiazepines. Respondent adjusted J.G.'s diagnosis to correspond with his treatment of her for chronic pain. Her initial diagnosis and treatment for bipolar disorder with anxiety became a diagnosis and treatment for chronic back pain. Similarly, her treatment with methadone for opiate addiction became treatment for chronic right shoulder and back pain.

7. Respondent failed to discuss the care of J.G. with her primary care physician, coordinate orthopedic referrals directly with her primary care physician, or confirm ongoing treatment of her psychiatric condition. Respondent failed to discuss J.G.'s case with any of the addiction specialists at Aegis.

8. Respondent's assumed the methadone maintenance of a known opiate addict despite his lack of qualification and without the guidance of qualified addiction specialists.

9. Respondent failed to document all the medications the patient was taking.

98. Respondent's conduct as described above is gross negligence in the practice of medicine and constitutes unprofessional conduct in violation of section 2234(b) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

FOURTEENTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(c)]
(Repeated Negligent Acts)

99. Respondent is subject to disciplinary action under section 2234(c) of the Code in that he committed acts of repeated negligence and unprofessional conduct during the care and treatment of patient J.G. The circumstances are as follows:

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100. Paragraphs 87 through 98 are repeated here as more fully set forth above.

101. Respondent's conduct as described above constitutes repeated negligent acts in the care and treatment of J.G.

FIFTEENTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 725]
(Excessive Prescribing)

102. Respondent is subject to disciplinary action under section 725 of the Code in that he prescribed excess quantities of controlled substances and dangerous drugs to R.E.

103. Paragraphs 87 through 98 are repeated here as more fully set forth above.

104. Respondent's conduct as described above constitutes excessive prescribing of controlled substances and dangerous drugs in the care and treatment of J.G., and is unprofessional conduct and grounds for discipline against his physician's and surgeon's certificate.

SIXTEENTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2266]
(Inadequate Medical Records)

105. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate medical records for patient J.G. Specifically, Respondent failed to adequately record histories, physicals, assessments of patient pain, and medications prescribed.

106. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of J.G. and constitutes grounds for discipline against his physician's and surgeon's certificate.

SEVENTEENTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(b)]
(Gross Negligence)

Patient W.G.

107. Respondent is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient W.G. The circumstances are as follows:

108. On June 1, 2009, a complaint was received from a Nevada County physician who provided care to W.G. on May 29, 2009. He stated that W.G. was receiving multiple prescriptions for hydrocodone from Respondent. According to the complaint, Respondent

advised the patient to fill prescriptions at different pharmacies to avoid suspicion. Ultimately the patient was taking 40 tablets per day of Norco (which is 400 mg a day of hydrocodone and 13 gm a day of acetaminophen). The complaining physician cited a, "remote history of wrist fracture" as the patient's only source of pain and also that the patient had a history of alcohol abuse thus increasing his risk for addiction.

109. W.G. was interviewed and said that he had gone to see Respondent because he heard it was easy to get medication from him. He had no pre-existing medical conditions, but told Respondent that his back was sore. There was no medication agreement and he denies ever having been examined by Respondent. He paid $50-$60 cash for a five minute visit with Respondent and got prescriptions for Soma and Norco. The available treatment notes indicate that Respondent treated W.G. from approximately April, 2008 to May, 2009.

110. After starting the Norco, he found he liked it and started requesting more from Respondent. W.G. admitted calling Respondent's office requesting a replacement for prescriptions he had "lost." These replacement prescriptions were called into the pharmacy without question. This continued for about two years. Toward the end of his treatment with Respondent, W.G. was being prescribed Percocet which he was taking in large quantities, about eight pills every two hours.

111. W.G. did not realize that taking that much acetaminophen would cause problems. He said that he overdosed on the Percocet and awoke in the hospital two days later. W.G. stated that his addiction to prescription drugs cost him his marriage, his house, and his job.

The only medical records available for W.G. were certified copies from the Oregon House Clinic. These incomplete records span April 16, 2008 through May 2, 2009. There is a handwritten telephone log, an incomplete medication list in which quantities prescribed are not recorded, and two x-ray reports.

112. The April 16, 2008 visit referenced a history of low back pain. At none of the visits was documentation provided regarding how long the back pain had been present, the extent of the pain, or how the pain impacted the patient's function. There is no evidence that the pain had been evaluated by any prior treating physicians. There is no evidence that Respondent made an

attempt to diagnose the underlying causes of pain as no x-rays of the back or other studies were ordered. The patient's psychological status and social function were never documented as having been assessed by Respondent, even when the patient presented in his office in tears after his wife left him because of his use of prescription pain medications.

113. A diagnosis of depression and anxiety was eventually rendered by the nurse practitioner, but there is no evidence that Respondent ever followed- up on this diagnosis to refill the antidepressants that were prescribed.

114. Respondent's care and treatment of W.G. was grossly negligent in the following respects:

1. Respondent made limited documentation or assessment of W.G.'s occupational and personal function.

2. Respondent failed to request the patient's past medical records.

3. Respondent failed to determine the source of the patient's unrelenting low back pain.

4. Respondent failed to document a treatment plan for the care of the patient's claimed low back pain, nor were there any notes regarding the functional objectives of treatment.

5. Respondent failed to conduct any trials of non-prescription medication, used no common medications for the treatment of neuropathic pain, and made no formal referral for physical therapy to treat W.G.'s pain.

6. Respondent failed to adequately inform W.G. of the toxicity of acetaminophen and risks of opiate medication.

7. Respondent failed to periodically review the progress of W.G.'s treatment and make adjustments to treatment accordingly. Instead, Respondent simply increased dosages of opiate medications in spite of the evidence that W.G. was becoming socially and psychologically impaired due to the abuse of the medications.

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115. Respondent's conduct as described above is gross negligence in the practice of medicine and constitutes unprofessional conduct in violation of section 2234(b) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

EIGHTEENTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(c)]
(Repeated Negligent Acts)

116. Respondent is subject to disciplinary action under section 2234(c) of the Code in that he committed acts of repeated negligence and unprofessional conduct during the care and treatment of patient W.G. The circumstances are as follows:

117. Paragraphs 107 through 115 are repeated here as more fully set forth above.

118. Respondent's conduct as described above constitutes repeated negligent acts in the care and treatment of W.G.

NINETEENTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 725]
(Excessive Prescribing)

119. Respondent is subject to disciplinary action under section 725 of the Code in that he prescribed excess quantities of controlled substances and dangerous drugs to W.G.

120. Paragraphs 107 through 115 are repeated here as more fully set forth above.

121. Respondent's conduct as described above constitutes excessive prescribing of controlled substances and dangerous drugs in the care and treatment of W.G., and is unprofessional conduct and grounds for discipline against his physician's and surgeon's certificate.

TWENTIETH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2266]
(Inadequate Medical Records)

122. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate medical records for patient W.G. Specifically, Respondent failed to adequately record histories, physicals, assessments of patient pain, and medications prescribed.

123. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of W.G., and constitutes grounds for discipline against his physician's and surgeon's certificate.

TWENTY-FIRST CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(b)]
(Gross Negligence)

Patient C.C.

124. Respondent is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient C.C. The circumstances are as follows:

125. Patient C.C., a woman in her mid-40s, began treatment with Respondent in March 2007, and continued to receive primary care from Respondent until the day before her death in October, 2010.

126. C.C.'s main medical problems were obesity, chronic pain in her back and joints, insomnia, anxiety, elevated blood pressure, and asthma. Respondent saw her every 2 to 4 weeks. On many of these visits Respondent encouraged her to lose weight, but the patient gained almost 100 pounds over the three-and-one-half years of her treatment by Respondent.

127. At every visit Respondent prescribed psychiatric and pain medications to C.C. Her pain was treated by Respondent with different kinds of opiate medications until she achieved acceptably effective pain relief on a high dose of extended release morphine and hydromorphone. Her anxiety, insomnia, and depression symptoms were treated with various medications representing multiple psychiatric pharmaceutical classes. For her pain and anxiety complaints, Respondent treated C.C. with several medications with a significant potential for abuse and addiction.

128. On October 22, 2010, C.C. went to her monthly appointment with Respondent. The documentation does not suggest that anything was out of the ordinary at that visit. Her extended release morphine was not refilled but she received refills for hydromorphone and presumably continued to take her seven other chronic medications including Valium.

129. On October 23, 2010, C.C.'s husband awakened to find her cool to the touch and he later noticed her to be unresponsive. By the time paramedics arrived, lividity and rigor mortis had already set in.

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130. Respondent appeared to have been the primary care physician for this patient. The standard of practice among primary care providers caring for women in their 40s, is to perform or offer annual clinical breast examinations, mammography and pelvic examination.

131. Respondent's care and treatment of C.C. was grossly negligent in the following respects:

1. Respondent did not perform any breast or pelvic examination, nor did he refer C.C. out for any such exams.

2. The x-rays of C.C. that were purportedly ordered were not commented upon by Respondent in subsequent visits and no reports of x-rays ordered by Respondent are contained within the medical chart.

3. Respondent recorded C.C.'s vital signs in only about half of the office visits.

4. Respondent recorded little history that pertains specifically to C.C.'s psychological status or function except for ongoing complaints of anxiety, intermittent complaints of insomnia, and later comments by Respondent including, "moods are good." There is no documentation regarding C.C.'s compliance with Respondent's recommendation that she go to the county mental health clinic. No systematic psychological examination is documented in any of her many visits with Respondent.

5. Respondent's evaluation of her chronic pain complaints was cursory at most visits. There was no follow-up by Respondent on previously ordered x-rays.

6. Respondent did not develop a working diagnosis of C.C.'s psychological complaints. There is no indication that C.C. had been formally diagnosed with either bipolar disease or schizophrenia, and no evidence within this record that she met the diagnostic criteria for either of these conditions. However, Respondent proscribed treatment for these conditions for C.C. by prescribing Zyprexa and Seroquel.

7. Respondent does not document the nature of C.C.'s anxiety. Her anxiety may have represented adverse effects to multiple medications. There is no evidence in the record that C.C. was receiving counseling nor is there any evidence that she had seen a psychiatrist or psychologist.

8. Respondent did not thoroughly evaluate C.C.'s back pain. There is no documentation of a complete spinal and neurological evaluation in the patient record. There are no records of any x-rays or scans such as CT or MRI. Respondent's treatment consisted primarily of increasing the dosage of opiate analgesia until a dosage plateau was reached in January 2010. That dose persisted for several months, during which C.C. complained of an array of symptoms that could have represented drug toxicity. At the time of her death, C.C. was taking a daily dose of opiates equivalent to 650 mg of oral morphine daily. For comparison, the average dose of oral morphine required by patients with cancer pain is between 100 to 250 mg per day.

9. Respondent failed to advise C.C. about the risks associated with the many medications that he prescribed to her.

10. Treatment goals for C.C. were never defined by Respondent.

11. Respondent employed no objective pain scales for C.C. Respondent often dictated, "takes medications as directed without side effects," but there is no evidence that C.C. was ever specifically asked about potential medication adverse effects. When C.C. did present with complaints of dizziness, vomiting and weight gain, all of which could represent dedication side effects, Respondent wrote, "no side effects from medication."

12. Respondent failed to request consultation with a spine or pain specialist, and failed to consult with a mental health professional to establish psychiatric diagnosis and treatment recommendations.

132. Respondent's conduct as described above is gross negligence in the practice of medicine and constitutes unprofessional conduct in violation of section 2234(b) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

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TWENTY-SECOND CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(c)]
(Repeated Negligent Acts)

133. Respondent is subject to disciplinary action under section 2234(c) of the Code in that he committed acts of repeated negligence and unprofessional conduct during the care and treatment of patient C.C. as follows:

134. Paragraphs 124 through 132 are repeated here as more fully set forth above.

135. Respondent's conduct as described above constitutes repeated negligent acts in the care and treatment of patient C.C.

TWENTY-THIRD CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 725]
(Excessive Prescribing)

136. Respondent is subject to disciplinary action under section 725 of the Code in that he prescribed excess quantities of controlled substances and dangerous drugs to C.C.

137. Paragraphs 124 through 132 are repeated here as more fully set forth above.

138. Respondent's conduct as described above constitutes excessive prescribing of controlled substances and dangerous drugs in the care and treatment of C.C. and is unprofessional conduct and grounds for discipline against his physician's and surgeon's certificate.

TWENTY-FOURTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2266]
(Inadequate Medical Records)

139. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate medical records for patient C.C. Specifically, Respondent failed to adequately record histories, physicals, assessment of patient pain, and medications prescribed.

140. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of C.C. and constitutes grounds for discipline against his physician's and surgeon's certificate.

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TWENTY-FIFTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(b)]
(Gross Negligence)

Patient C.R.

141. Respondent is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient C.R. The circumstances are as follows:

142. On March 22, 2010, patient C.R., a 61-year-old woman, was found dead on the floor of her bedroom. On her bedside table were nearly full bottles of opiate pharmaceuticals: methadone and hydromorphone (Dilaudid), a two-thirds full bottle of Soma, and other medications prescribed by Respondent. In addition, there were bottles of tranquilizers (benzodiazepines) prescribed by a different physician. The Butte County Sheriff's coroner determined that the cause of C.R.'s death was acute poisoning caused by multiple pharmaceuticals. According to C.R.'s daughter, a Walgreens pharmacist called C.R. several times with advice regarding the risk of toxic interactions between many of the medications that were being prescribed to her.

143. Respondent's medical records for C.R. are from March 10, 2008, through March 19, 2010, consisting of 28 separate office visits. The last visit was made three days prior to C.R.'s death.

144. C.R.'s first visit to Respondent was on March 10, 2008, a few weeks prior to C.R.'s scheduled low back surgery. There is no new patient questionnaire in the records. Respondent did a limited physical examination and an assessment plan are documented. C.R. reported adequate pain control with hydromorphone (Dilaudid 4 mg, 10 to 12 pills daily), and methadone (60 mg daily). It is unclear who had been prescribing these high doses of opiate medications. In addition to seeing the orthopedic surgeon, C.R. also saw a general physician for care of hypertension and her non-pain linked medical conditions. Beyond requesting medical records, Responded made no effort to confirm the accuracy of C.R.'s opiate doses, nor did he communicate directly with the orthopedist. There also is no evidence that Respondent communicated with the general physician who was also treating C.R.

145. C.R. signed a medication agreement as her initial visit with Respondent, which included the statement, "I will not get pain medication from another medical practitioner without consultation with [Respondent] or unless admitted to a hospital."

146. Respondent wrote a prescription for a month supply of Dilaudid and methadone in the dosages that C.R. indicated that she had already been taking. Respondent began a medication list for C.R., but it was only maintained through September 2008.

147. On April 4, 2008, Respondent saw C.R. for the second time. She had undergone back surgery a few weeks earlier on March 18. She reported pain at 6-7, out of 10. Her blood pressure was elevated at 174/100. Respondent performed a nominal physical examination. Respondent then doubled the doses of methadone and hydromorphone previously prescribed to C.R. to methadone 120 mg a day and hydromorphone 8 mg, as needed. The plan was for her to, "taper slowly as surgery pain wears off." Other medications were recorded as refills including diazepam (Valium), Soma (carisprodolol), and Restoril (a sleep medication). There is no evidence that Respondent spoke with C.R.'s orthopedist about her significant postoperative pain, although this would have been the usual practice.

148. On C.R.'s third visit on May 1, 2008, her prescriptions for opiate medications were refilled. A blood test was ordered to evaluate her history of anemia. Although her blood pressure had been quite elevated at the previous visit, it was not checked at this visit nor was any other vital sign recorded.

149. On May 6, 2008, C.R. called into Respondent's office to report losing about 50 tablets of Dilaudid. Respondent authorized a prescription for Dilaudid to cover the loss.

150. Visit four was on June 5, 2008. C.R. reported to Respondent that she did not have a primary care physician. Again, her blood pressure was not checked nor other vital signs recorded. The previously ordered blood test was not commented upon in Respondent's notes. C.R.'s methadone dose was decreased back to 90 mg daily. Neurontin was added to her regimen. Thyroid supplements were ordered for unconfirmed history of thyroid disease. No blood tests were ordered regarding either anemia or thyroid function.

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151. Visit five was on July 7, 2008. No vital signs were recorded, but there is a documented history and brief exam. C.R. reported, "good" or "75%" pain control. Despite her improvement, all her pain medications were refilled without dosage adjustment.

152. Two weeks later on July 18, 2008, C.R. returned for her sixth visit complaining that, "pain control is not doing well. She wants to increase the methadone to 4 times daily." Respondent accommodated C.R.'s request by increasing her methadone dosage to 120 mg daily. Respondent further prescribed 6 tablets of Soma daily, which exceeded the maximum recommended dosage of 4 tablets per day. The quantity of all medications dispensed was intended to last through August 31, 2008. However, on August 12, 2008, C.R. returned requesting early refills because she planned to be out-of-town. She was given a one-month supply of medications with plans to return in late September. Instead, C.R. returned on August 18, 2008, reporting that she did not have much medication left, "and . . . starting to get withdrawal symptoms." Her blood pressure was not recorded, but Responded dictated that her "vital signs were normal." No examination was done. Respondent prescribed Dilaudid and methadone.

153. On October 16, 2008, C.R. told Respondent that she had overtaken some of her medicines while tending to her dying father. Medications were refilled without dosage adjustment.

154. There was a progressive increase in the amount of Dilaudid 8 mg (hydromorphone) provided to C.R. in the fall of 2008. By December 23, 2008, her monthly dosage of Dilaudid had increased to 450 tablets. That represented a 25% increase over roughly four months.

155. On January 22, 2009, Respondent failed to make any reference in the patient chart regarding C.R.'s recent hospitalization during which she was weaned off methadone and Dilaudid. She indicated a desire to remain off these drugs, but said she wanted to continue Soma and begin treatment with Norco. Respondent accommodated this request. Although it is unclear whether or not C.R. was still seeing her orthopedist or any other physician, Respondent dictated, "follow-up with orthopedic doctor and follow up with primary care physician."

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156. Three weeks later on February 13, 2009, C.R. returned to Respondent's office and said she wanted to resume Dilaudid and methadone. She reported knee pain for which she was seeing an orthopedic doctor who said that she might need a knee replacement. The name of this doctor is not documented and no records were requested. Respondent prescribed the same doses of methadone and Dilaudid that C.R. was taking prior to her January hospitalization.

157. Thirteen days later on February 26, 2009, C.R. returned reporting dizziness and having vomited, "a lot of her pills." Respondent wrote, "patient takes the medications as directed without side effects." Respondent prescribed methadone, Dilaudid, and Soma along with an additional prescription for Valium (diazepam), 8 mg daily. Photocopies of prescriptions retained within the medical records indicate that according to the pharmacy records, only a subset of these prescriptions was actually dispensed to C.R.

158. The orders on February 26, 2009, for Dilaudid 8 mg and Dilaudid 2 mg, were written on separate prescriptions. Similarly, there were two separate prescriptions written on February 26 for Soma, one for the 160 tablets and the other for 100 tablets. The reason for writing these prescriptions separately is not indicated.

159. When C.R. returned six weeks later on April 13, 2009, she reported that she now had a primary care physician named Dr. Logan. She also reported dizziness and vomiting. There is no indication that Respondent linked these symptoms to the medications he was prescribing. No vital signs were taken at this visit. C.R.'s knee pain was reportedly, "worse and worse. She could barely walk on it." Respondent increased her methadone dose to 160 mg daily, which was a 25% increase. Respondent further prescribed 500 tablets of Dilaudid 8 mg, which was a 100% increase as compared with the amount prescribed in January 2009. There is no indication that Respondent spoke with C.R.'s orthopedist or referred her for physical therapy or a knee injection. Respondent recommended, but did not prescribe a knee brace.

160. Approximately four weeks later on May 7, 2009, C.R. reported that she had an appointment with an orthopedic doctor, but this physician is not identified in the patient chart. Her knee pain was worse and an examination suggested worsening findings in both knees. There is no evidence that Respondent conferred with either the primary care physician or the

orthopedist. Respondent increased the Methadone dosage for C.R. again to 240 mg daily, a 33% increase. Dilaudid was refilled and Soma was increased to 8 tablets daily, which is twice the recommended maximum daily dose.

161. Since C.R.'s development of knee pain in February, 2009, C.R.'s functioning became progressively impaired. By June 29, 2009, she was confined to a wheelchair. Again, reference is made in the patient chart to, "an appointment with an orthopedic surgeon," but this doctor is neither identified nor contacted by Respondent. Respondent refilled prescriptions for Soma and opiate medications.

162. On July 28, 2009, C.R. reported falling because her knees gave out. Again, reference is made to, "an appointment with an orthopedic surgeon," but this doctor is not identified or contacted by Respondent. Respondent refilled C.R.'s medications, the dose of methadone being decreased by about a third, and Soma decreased by 25%. Around this time Respondent requested a pharmacy review for C.R. covering the dates April 28 to July 23, 2009. This report confirmed that except for Valium and sleep medications prescribed by her primary care physician, Respondent was the only prescriber of controlled substances to C.R.

163. One month later on August 7, 2009, C.R. reported to Respondent that she had dizziness, vomiting, and had sustained several falls. There is no evidence that Respondent considered that these symptoms could be manifestations of medication toxicity. In fact, Respondent wrote in the patient chart, "no side effects from medications." Although he wrote, "she does not want to take any more medications," Respondent increased her Dilaudid dose to 20 tablets per day, a 17% increase. The methadone and Soma doses were maintained.

164. On September 28, 2009, C.R. reported improvement and prescriptions for medications were rewritten with a downward dose adjustment for the Dilaudid.

165. A month later on October 26, 2009, C.R. reported continued falls and worsening pain. She was so frail that Respondent wrote, "I did not even ask her to bend (her back). I did not want her to fall over." Respondent increased the Methadone dose to 210 mg a day, a 15% increase. All of the other medication dosages were maintained.

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166. The dose of all medications was maintained through the visits of December 3, 2009 through March 19, 2010. There is nothing within Respondent's records of the patient's March 19, 2010 visit that explains C.R.'s death three days later. However, the pharmacy review indicates that C.R. was taking gradually increasing doses of benzodiazepines (primarily Valium), prescribed to her by her primary care physician. At the autopsy for C.R., the level of hydromorphone in her blood was well above toxic levels.

167. Respondent's care and treatment of C.R. was grossly negligent in the following respects:

1. Respondent did not contact the patient's primary care physician, other treating physician, or the orthopedist regarding the patient's significant postoperative pain.

2. Respondent failed to document anything about C.R.'s social functioning.

3. Respondent's physical examinations of C.R. were limited and there was no follow-up by Respondent to ensure that C.R.'s primary care physician was examining the patient more thoroughly.

4. Respondent failed to take the patient's vital signs, which was especially negligent after C.R.'s elevated blood pressure recorded on April 4, 2008.

5. Respondent failed to followed-up on C.R.'s hospitalization that she reported to him on her office visit of January 22, 2009. She reported being weaned off the opiate medication previously prescribed by Respondent during that hospitalization. Respondent did not order any records from that hospital visit. From February 2009 to July 2009, progressive knee pain was C.R.'s dominant complaint. Respondent failed to request medical records from the orthopedist that C.R. was seeing.

6. The medication list started on C.R.'s initial entry to Respondent's practice was abandoned six months later. Respondent also failed to document any of the medications that C.R. had prescribed to her by other physicians and failed to document her use of over-the-counter medications.

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7. Respondent failed to order an EKG for a 61-year-old woman who was being treated with methadone, which he should have done at least once at some point during his two-year treatment of C.R.

8. Respondent should have been weaning C.R. off opiate medications after she recovered from spinal surgery. Functional goals to achieve this tapering of opiates were never established. Instead, Respondent complied with whatever the patient requested. He increased dosages and added medications at the patient's request.

9. Respondent failed to inform the patient about the potential risks of addiction and other side effects associated with the medications he was prescribing for her.

168. Respondent's conduct as described above is gross negligence in the practice of medicine and constitutes unprofessional conduct in violation of section 2234(b) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

TWENTY-SIXTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(c)]
(Repeated Negligent Acts)

169. Respondent is subject to disciplinary action under section 2234(c) of the Code in that he committed acts of repeated negligence and unprofessional conduct during the care and treatment of patient C.R. as follows:

170. Paragraphs 141 through 167 are repeated here as more fully set forth above.

171. Respondent's conduct as set described above constitutes repeated negligent acts in the care and treatment of C.R.

TWENTY-SEVENTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 725]
(Excessive Prescribing)

172. Respondent is subject to disciplinary action under section 725 of the Code in that he prescribed excess quantities of controlled substances and dangerous drugs to C.R.

173. Paragraphs 141 through 167 are repeated here as more fully set forth above.

174. Respondent's conduct as described above constitutes excessive prescribing of controlled substances and dangerous drugs in the care and treatment of C.R. and is unprofessional conduct and grounds for discipline against his physician's and surgeon's certificate.

TWENTY-EIGHTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2266]
(Inadequate Medical Records)

175. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate medical records for patient C.R. Specifically, Respondent failed to adequately record histories, physicals, assessment of patient pain, and medications prescribed.

176. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of C.R. and constitutes grounds for discipline against his physician's and surgeon's certificate.

TWENTY-NINTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(b)]
(Gross Negligence)

Patient C.H.

177. Respondent is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient C.H. The circumstances are as follows:

178. Patient C.H. was a 42-year-old special education teacher when she died on December 7, 2010. She had been suffering with chronic pain in the back and shoulder area. She saw Respondent in his office about every month from June, 2008 to December, 2010. For each of these 28 visits she paid $65 cash.

179. She was referred to Respondent when she asked for more pain medication from her primary care physician. When she first consulted with Respondent, C.H. was taking a modest amount of hydrocodone and Soma, along with appropriate doses of the non-controlled pain medications gabapentin and ibuprofen. Respondent continued these non-controlled medications for only a couple of months after starting his treatment of C.H.

180. Over time, Respondent increased the dose of Hydrocodone and oxycodone was added, as was hydromorphone. The oxycodone was eventually replaced by methadone and an extended release formulation of morphine sulfate.

181. Over the course of the first 6 to 12 months of treatment with Respondent, C.H. became less functional. She was unable to continue working as a teacher, she lost her home, and

later she was unable to complete household tasks. After one year, she started complaining of sedation and impaired cognition.

182. Concerned about her mother's functional and mental deterioration, C.H.'s daughter telephoned Respondent twice during the summer of 2010. Respondent reportedly did not take responsibility for C.H's worsening condition, but suggested that the daughter discuss her concerns with her mother's primary care physician. There is no evidence that Respondent ever spoke with the patient's primary care physician or her tribal health physician. There were no laboratory test results, or EKG tracings in the chart. There is no record of conversations or correspondence between Respondent and any of the physician specialists also treating C.H. There is no indication that Respondent was aware that the patient was receiving anti-anxiety and insomnia medications from her other physicians.

183. On December 9, 2010, C.H.'s housekeeper found C.H. dead in her home. The postmortem analysis revealed potentially toxic levels of morphine and methadone in the patient's blood. The cause of death was ruled a non-suicidal case of acute poisoning from multiple pharmaceuticals. The only pharmaceuticals found with the patient at the time of her death were those that had been prescribed by Respondent.

184. Respondent's care and treatment of C.H. was grossly negligent in the following respects:

1. Respondent performed no real inquiry into the patient's level of social function nor was there anything in the medical records suggesting that her psychological state was systematically evaluated by Respondent. Respondent's failure to address her mental status and psychological function was especially negligent in the summer of 2010, when the patient started complaining of memory loss, slow cognition, and sedation.

2. Although Respondent referred the patient for physical therapy, there is no documentation of follow up regarding her compliance.

3. Respondent failed to follow up on the EKG that he ordered at the thirteenth office visit, and he failed to reorder an EKG on this patient at any of the subsequent 13 visits she made to his office.

4. Respondent failed to obtain the patient's vital signs at any of the 27 follow-up visits.

5. Respondent's treatment plan for C.H. did not specifically address the functional goals of treatment. There is no treatment plan and the notes by Respondent in the medical record imply that the patient's reported level of pain relief was the principal treatment objective. Beyond the first few months of treatment, there is no evidence that Respondent considered using any medications for the treatment of the patient's pain other than opiates.

6. Respondent relied on the semi-exclusive use of opiate medication, the dosage of which appeared exclusively predicated on the patient's self-reported pain control.

7. Respondent failed to consult with other treating physicians and/or decrease the dose of opiate medications when the patient's condition deteriorated. Respondent failed to recognize that her deterioration was likely caused by drug toxicity. Respondent failed to order an EKG for C.H. during the course of her treatment to assess the effect the high levels of opiates were having on the patient's heart function.

8. Respondent never referred C.H. to a specialist for chronic pain.

9. Respondent failed to maintain an accurate list of the medications that C.H. was taking, and failed to accurately document her mental health history.

185. Respondent's conduct as described above is gross negligence in the practice of medicine and constitutes unprofessional conduct in violation of section 2234(b) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

THIRTIETH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(c)]
(Repeated Negligent Acts)

186. Respondent is subject to disciplinary action under section 2234(c) of the Code in that he committed acts of repeated negligence and unprofessional conduct during the care and treatment of patient C.H. follows:

187. Paragraphs 177 through 184 are repeated here as more fully set forth above.

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188. Respondent's conduct as described above constitutes repeated negligent acts in the care and treatment of C.H.

THIRTY-FIRST CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 725]
(Excessive Prescribing)

189. Respondent is subject to disciplinary action under section 725 of the Code in that he prescribed excess quantities of controlled substances and dangerous drugs to C.H.

190. Paragraphs 177 through 184 are repeated here as more fully set forth above.

191. Respondent's conduct as described above constitutes excessive prescribing of controlled substances and dangerous drugs in the care and treatment of C.H. and is unprofessional conduct and grounds for discipline against his physician's and surgeon's certificate.

THIRTY-SECOND CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2266]
(Inadequate Medical Records)

192. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate medical records for patient C.H. Specifically, Respondent failed to adequately record histories, physicals, assessments of patient pain, and medications prescribed.

193. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of C.H., and constitutes grounds for discipline against his physician's and surgeon's certificate.

THIRTY-THIRD CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(b)]
(Gross Negligence)

Patient D.S.

194. Respondent is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient D.S. The circumstances are as follows:

195. Patient D.S. was a 48-year-old man who died on July 31, 2010, from oxycodone toxicity complicating hypertensive cardiomyopathy. Respondent had been the treating physician for D.S. for many years. Respondent treated D.S. in his private practice from July 8, 2008, until

at least July 2010. At a later point, Respondent became the treating physician for D.S.'s chronic pain while D.S. had another physician for his primary care.

196. Respondent's initial assessment of D.S. included allergies, asthma, COPD, tobacco abuse, chronic back pain, and anxiety. No mention is made of hypertension.

197. The pharmacy records for D.S. reveal that Respondent was prescribing hydrocodone, and oxycodone. Respondent was also aware that another physician was prescribing lorazepam, zolpidem, and carisoprodol for D.S. D.S. was also receiving overlapping prescriptions for hydrocodone from his primary care physician.

198. Respondent noted that D.S. was being treated for heart failure by his primary care physician, and a note is made to, "follow up with primary care physician," but there is no record of follow-up and no record that Respondent did any assessment of the patient's cardiac and respiratory issues.

199. Respondent's care and treatment of D.S. was grossly negligent in the following respects:

1. Patient's with compromised respiratory function and congestive heart failure are especially susceptible to the depressive effects of narcotics. Respondent made no objective assessment of the patient's respiratory function, or the patient's cardiac status.

2. D.S. was receiving multiple sedative prescriptions, including carisoprodol, lorazepam, and zolpidem. The prescription doses for these medications exceeded the manufacturer's recommended maximum dosages. Prescribing sedative medications to patients also receiving high doses of narcotics, especially in a patient such as D.S. with compromised respiratory function, must be closely monitored. Respondent failed to document the need for these sedative drugs given the danger they presented to the patient, and he took no steps to find less harmful therapeutic alternatives.

3. Respondent failed to consult with and coordinate the treatment of D.S. with his primary care physician.

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4. Respondent failed to obtain a drug and alcohol abuse history from D.S. even though the records indicate that D.S. had such a history.

200. Respondent's conduct as described above is gross negligence in the practice of medicine and constitutes unprofessional conduct in violation of section 2234(b) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

THIRTY-FOURTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(c)]
(Repeated Negligent Acts)

201. Respondent is subject to disciplinary action under section 2234(c) of the Code in that he committed acts of repeated negligence and unprofessional conduct during the care and treatment of patient D.S. The circumstances are as follows:

202. Paragraphs 194 through 200 are repeated here as more fully set forth above.

203. Respondent's conduct as described above constitutes repeated negligent acts in the care and treatment of D.S.

THIRTY-FIFTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 725]
(Excessive Prescribing)

204. Respondent is subject to disciplinary action under section 725 of the Code in that he prescribed excess quantities of controlled substances and dangerous drugs to D.S.

205. Paragraphs 194 through 200 are repeated here as more fully set forth above.

206. Respondent's conduct as described above constitutes excessive prescribing of controlled substances and dangerous drugs in the care and treatment of D.S. and is unprofessional conduct and grounds for discipline against his physician's and surgeon's certificate.

THIRTY-SIXTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2266]
(Inadequate Medical Records)

207. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate medical records for patient D.S. Specifically, Respondent failed to adequately record histories, physicals, assessments of patient pain, and medications prescribed.

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208. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of D.S. and constitutes grounds for discipline against his physician's and surgeon's certificate.

THIRTY-SEVENTH CAUSE FOR DISCIPLINE
[Bus. & Prof. Code § 2234(b)]
(Gross Negligence)
Patient J.T.

209. Respondent is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient J.T. The circumstances are as follows:

210. J.T. died on May 11, 2011, from what the Butte County Coroner determined was polydrug overdose. J.T. also had alcohol related chronic sever liver disease. J.T. was Respondent's patient from September 5, 2008 to March 25, 2011.

211. Respondent's chart notes from his initial visit with J.T. on September 5, indicate that Respondent knew J.T. from, "the distant past." J.T. had pain from a fractured back in 1986. He reported that Norco and Soma reduced the pain. Respondent did not note the medications J.T. was then currently taking. Respondent did not take an alcohol or substance use history from J.T.

212. Respondent's stated plan for J.T. was to follow up with primary care physician for regular care, but that physician is not identified in the note nor is any request for records made from that primary care physician. Respondent prescribed Norco 10 mg, up to 5 daily, Soma 2-3 times a day and the patient was to return in 1 to 2 months.

213. J.T. returned for his second visit only 20 days later with what Respondent noted was an acute increase in pain due to an automobile accident. Respondent prescribed methadone 30 mg daily and oxycodone 60 mg daily. Respondent remarked in the chart that "this is a definite increase in his medications."

214. At J.T.'s next visit on October 21, 2008, Respondent doubled the patient's dose of oxycodone to 120 mg daily.

215. On March 20, Respondent increases J.T.'s dosage of methadone from 20 to 30 mg daily and increases oxycodone from 120 to 225 mg daily.

216. On at least two occasions, Respondent treats J.T. for non-pain related issues. J.T. complained of low libido, and Respondent ran a test of J.T.'s testosterone level and later starts him on testosterone injections. Respondent also refilled the patient's asthma inhaler.

217. On December 18, 2009, Respondent increased J.T.'s dosage of oxycodone to 315 mg daily, because the patient said he had fallen and hurt his hip.

218. On March 23, 2010, Respondent wrote in the patient chart, "we are going to do a drug screen." On May 7, 2010, Respondent told J.T. that he would only be getting a 10 day supply of his medications until the drug screen results come in. The lab received the test specimen on May 10, 2010, and it tested positive for cannabinoids, hydrocodone, hydromorphone, oxycodone, oxymorphone, and methadone. When J.T. returned for his next visit on June 3, there is no mention in the notes of any discussion of the drug test results.

219. Respondent's final treatment note for J.T. was on February 11, 2011.

220. Mixed in at several places in patient J.T. medical chart are notes for a different patient with a similar name.

221. Respondent's care and treatment of J.T. was grossly negligent in the following respects:

1. Respondent failed to employ a record keeping system that had a unique identifier for each patient. This failure led to patient charts and notes being misfiled.

2. Respondent failed to request the patient's past medical records or document an adequate past medical history for the patient.

3. Respondent ran a drug screen and received the lab results which showed that the patient was taking drugs not prescribed by Respondent. However, Respondent failed to address these results, discuss them with the patient, or act on them in any way.

222. Respondent's conduct as described above is gross negligence in the practice of medicine and constitutes unprofessional conduct in violation of section 2234(b) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

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THIRTY-EIGHTH CAUSE FOR DISCIPLINE
[Bus. & Prof. Code § 2234(c)]
(Repeated Negligent Acts)

223. Respondent is subject to disciplinary action under section 2234(c) of the Code in that he committed acts of repeated negligence and unprofessional conduct during the care and treatment of patient J.T. The circumstances are as follows:

224. Paragraphs 209 through 222 are repeated here as more fully set forth above.

225. Respondent's conduct as described above constitutes repeated negligent acts in the care and treatment of J.T.

THIRTY-NINTH CAUSE FOR DISCIPLINE
[Bus. & Prof. Code § 725]
(Excessive Prescribing)

226. Respondent is subject to disciplinary action under section 725 of the Code in that he prescribed excess quantities of controlled substances and dangerous drugs to J.T.

227. Paragraphs 209 through 222 are repeated here as more fully set forth above.

228. Respondent's conduct as described above constitutes excessive prescribing of controlled substances and dangerous drugs in the care and treatment of J.T., and is unprofessional conduct and grounds for discipline against his physician's and surgeon's certificate.

FORTIETH CAUSE FOR DISCIPLINE
[Bus. & Prof. Code § 2266]
(Inadequate Medical Records)

229. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate medical records for patient J.T. Specifically, Respondent failed to adequately record histories, physicals, assessments of patient pain, and medications prescribed. He also confused and misfiled patient records.

230. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of J.T., and constitutes grounds for discipline against his physician's and surgeon's certificate.

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FORTY-FIRST CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(b)]
(Gross Negligence)

Patient M.R.

231. Respondent is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient M.R. The circumstances are as follows:

232. Respondent treated M.R. sporadically from approximately November 2001 to June 2010. M.R. died on June 6, 2010. The available records indicate that M.R. was being treated for COPD, diabetes, chest pain, peripheral neuropathy, hypertension, mild obesity, and tobacco abuse. Respondent starts the patient's medications at Norco 12 pills daily, and diazepam 10 mg 4 times daily.

233. On September 24, 2008, Respondent adds hydromorphone 8 mg 4 pills daily to the patient's regimen, which represented a 50 % increase in total narcotic dose being prescribed to M.R. The patient was also being treated for bronchitis at that time.

234. On November 19, 2008, the patient returns with coughing and coarse breath sounds. Respondent notes intent to send the patient to a pulmonary specialist because he is getting progressively short of breath. Soma four times daily is added to the drug regimen.

235. M.R. next visits on December 17, 2008, and states that he cannot afford his medications, but "wants Dilaudid, Norco, and Valium which he cannot live without." A diagnosis of depression and anxiety is made by Respondent, but he does no assessment, history or mental status examination about these conditions.

236. On May 13, 2009, the patient is seen by Respondent, does not indicate any increase in pain, but Respondent increases his Dilaudid by 100 % from 8 mg 4 pills a day, to 8 pills a day. On June 10, 2009, the patient complains of foot and chest wall pain and Respondent wrote in the chart, "He would like to go up on Dilaudid. I said fine." Respondent increased the patient's Dilaudid dosage 50 % from 8 to 12 pills daily.

237. By August 8, 2009, the patient's lung volume was at 50 %. In September the patient complains of shortness of breath with exertion, pain and greater depression. Respondent adds

Cymbalta as an antidepressant. The patient's Dilaudid is increased from 12 pills a day to 16. In only four month, Respondent had increased M.R.'s Dilaudid dose over 400 %. In November, the patient returned complaining of trouble sleeping. Respondent added extended release morphine 60 mg at bedtime and urged the patient to see a psychiatrist.

238. On March 13, 2010, M.R. is noted to have increased fatigue and low blood pressure and he continued to lose weight. Respondent noted concern about renal failure or cancer. Pain medication was continued as before.

239. In the April and May visits, the patient continued to have worsening shortness of breath and appeared gray. Nighttime oxygen is ordered and M.R. is told to see a pulmonologist. Respondent also noted that he was going to order a drug screen. The patient reports being suicidal. He is given a prescription for morphine at bedtime and it is noted, "discontinue Prozac and start him on Cymbalta," even though a prior treatment note had stated that Cymbalta had already been prescribed. The patient is advised to go immediately to the county mental health services and follow up with a pulmonologist.

240. M.R. returned on June 2, 2010, reporting that he had been in the hospital with pneumonia. His medications were renewed and an antibiotic was prescribed. The patient returned three days later on June 5, and the notes from that visit read as if the June 2 visit had not occurred. Respondent's notes indicated that, "Vitals are normal," but only blood pressure was recorded.

241. Respondent's care and treatment of M.R. was grossly negligent in the following respects:

1. Respondent did not document any consideration of the adverse effects the narcotics he was prescribing M.R. were having on the patient's pulmonary function.

2. Respondent failed to assess the effects of his combined administration of both Valium and Soma in a patient with deteriorating pulmonary function.

242. Respondent's conduct as described above is gross negligence in the practice of medicine and constitutes unprofessional conduct in violation of section 2234(b) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

FORTY-SECOND CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(c)]
(Repeated Negligent Acts)

243. Respondent is subject to disciplinary action under section 2234(c) of the Code in that he committed acts of repeated negligence and unprofessional conduct during the care and treatment of patient M.R. The circumstances are as follows:

244. Paragraphs 231 through 242 are repeated here as more fully set forth above.

245. Respondent's conduct as described above constitutes repeated negligent acts in the care and treatment of M.R.

FORTY-THIRD CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 725]
(Excessive Prescribing)

246. Respondent is subject to disciplinary action under section 725 of the Code in that he prescribed excess quantities of controlled substances and dangerous drugs to M.R.

247. Paragraphs 231 through 242 are repeated here as more fully set forth above.

248. Respondent's conduct as described above constitutes excessive prescribing of controlled substances and dangerous drugs in the care and treatment of M.R. and is unprofessional conduct and grounds for discipline against his physician's and surgeon's certificate.

FORTY-FOURTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2266]
(Inadequate Medical Records)

249. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate medical records for patient M.R. Specifically, Respondent failed to adequately record histories, physicals, assessments of patient pain, and medications prescribed.

250. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of M.R. and constitutes grounds for discipline against his physician's and surgeon's certificate.

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FORTY-FIFTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(b)]
(Gross Negligence)

Patient J.B.

251. Respondent is subject to disciplinary action under section 2234(b) of the Code in that he committed acts of gross negligence and unprofessional conduct during the care and treatment of patient J.B. The circumstances are as follows:

252. J.B. died on January 2, 2011, from a drug overdose and pneumonia ten days after seeing Respondent for a refill of the medications he was being prescribed, which included morphine, oxycodone, Soma, and Klonopin.

253. Respondent began treating J.B. on October 27, 2009, after the patient had been in a car accident. The medical records from the patient's treatment after the accident were not available to Respondent during that first visit. Respondent did not obtain any significant medical history from J.B., but prescribed methadone 10 mg at night, oxycodone 15 mg every 4 hours, and Soma three times daily. J .B. was told to return in a month.

254. At J.B.'s next visit in November, 2009, Respondent noted that the patient's pain control was moderately good and the patient asked for Ambien. Respondent performed a cursory physical exam, found the patient had a little bit of tenderness across the upper back. Respondent increased the prescription of methadone to 40 mg daily, the oxycodone was doubled to 30 mg every 4 hours, and he added Ambien 10 mg for sleep. In late November the patient was hospitalized for altered mental state and on a visit to Respondent on December 14, 2009, he switched J.B. from Ambien to Ativan because the Ambien caused the patient "hallucinations."

255. On February 8, 2010, the patient indicated that some days his neck was worse, and Respondent's examination showed some muscle tenderness. Respondent increased the patient's methodone to 60 mg daily, the oxycodone was increased from every 4 hours to every 3, and Klonopin 1 mg at night is added to the Ativan 1 mg that had begun in December.

256. On April 30, 2010, the notes for J.B.'s visit indicate that he is a truck driver and may continue in that occupation. However, the treatment notes are contradictory when in one place Respondent notes, "Pain is not well controlled...," but later he notes, "Everything is relatively

well controlled." Respondent increased J.B. methadone to 80 mg daily, and oxycodone and Soma are continued.

257. On May 27, 2010, it is noted that the patient, "wants to try something else," the "Methadone did not seem to help his pain at all." Respondent prescribed extended release morphine at 200 mg daily. In the next visit in June, Respondent notes that the patient said, "the Morphine does not last long enough." Respondent increased the morphine dose to 300 mg daily.

258. On October 21, 2010, the patient reported that the morphine made his drowsy even though he broke the pills in half. Respondent advised him to take precautions while driving. The patient noted increased knee pain. Respondent did not order any diagnostic tests, but increased the oxycodone to 60 mg every 4 hours.

259. J.B.'s final visit with Respondent was on December 23, 2010. This visit is recorded in a handwritten note that is barely legible. Respondent did not record any of the patient's vital signs. J.B. died on January 2, 2011, and the bottles of the prescription drugs issued by Respondent at the December 23 office visit were found in J.B.'s room. In that ten day period, 83 pills of oxycodone 15 mg were missing; 52 pills of oxycodone 30 mg were missing; 14 pills of Klonopin were missing; 57 pills of morphine were missing; and 57 pills of Soma were missing.

260. Respondent's care and treatment of J.B. was grossly negligent in the following respects:

1. Respondent began the patient on methadone immediately even though the patient had not been on any pain medication previously.

2. Respondent failed to request the patient's past medical records or attempt to contact any prior or current treating physicians. Pharmacy records for J.B. showed that he was receiving narcotic prescriptions from several different physicians, but Respondent never acknowledged that in the patient chart.

3. Respondent increased the dosage of narcotic medications without noting adequate justification for the increases. No meaningful assessment of the patient's pain was ever conducted.

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4. Respondent failed to order or conduct any diagnostic testing to assist in evaluating the patient's pain and any health impact from the large doses of narcotic medications being prescribed.

5. Respondent abruptly changed the patient's medication from methadone to morphine simply because the patient said the methadone did not seem to help. Respondent then increased the morphine dosage by 50 % in one month because the patient reported it did not last long enough. Respondent tried no alternative dosing strategies prior to merely increasing the dose.

6. J.B. died just over a week after having an office visit with Respondent, and the autopsy revealed that the patient was suffering from pneumonia at the time of his death. Respondent did not note any indication of the patient's respiratory impairment at that last office visit, and Respondent did not record the patient's pulmonary function at any visit even though the narcotics he was prescribing the patient have a strong respiratory suppressant effect.

261. Respondent's conduct as described above is gross negligence in the practice of medicine and constitutes unprofessional conduct in violation of section 2234(b) of the Code, and thereby provides cause for discipline to Respondent's physician's and surgeon's certificate.

FORTY-SIXTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(c)]
(Repeated Negligent Acts)

262. Respondent is subject to disciplinary action under section 2234(c) of the Code in that he committed acts of repeated negligence and unprofessional conduct during the care and treatment of patient J.B. The circumstances are as follows:

263. Paragraphs 251 through 261 are repeated here as more fully set forth above.

264. Respondent's conduct as described above constitutes repeated negligent acts in the care and treatment of J.B.

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FORTY-SEVENTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 725]
(Excessive Prescribing)

265. Respondent is subject to disciplinary action under section 725 of the Code in that he prescribed excess quantities of controlled substances and dangerous drugs to J.B.

266. Paragraphs 251 through 261 are repeated here as more fully set forth above.

267. Respondent's conduct as described above constitutes excessive prescribing of controlled substances and dangerous drugs in the care and treatment of J.B., and is unprofessional conduct and grounds for discipline against his physician's and surgeon's certificate.

FORTY-EIGHTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2266]
(Inadequate Medical Records)

268. Respondent is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate medical records for patient J.B. Specifically, Respondent failed to adequately record histories, physicals, assessments of patient pain, and medications prescribed.

269. Respondent's conduct as described above constitutes unprofessional conduct in the care and treatment of J.B., and constitutes grounds for discipline against his physician's and surgeon's certificate.

FORTY-NINTH CAUSE FOR DISCIPLINE

[Bus. & Prof. Code § 2234(c)]
(Repeated Negligent Acts)

Patients M.C., E.G., R.E., J.G., W.G., C.C., C.R., C.H., D.S, J.T., M.R., and J.B.

270. Respondent is subject to disciplinary action under section 2234(c) of the Code in that he committed acts of repeated negligence and unprofessional conduct during the care and treatment of patients: M.C., E.G., R.E., J.G., W.G., C.C., C.R., C.H., D.S., J.T., M.R., and J.B. follows:

271. Paragraphs 12 through 269 are repeated here as more fully set forth above.

272. Respondent's conduct as described above, as to acts of negligence in the treatment of any or all of the patients all alleged, constitutes repeated negligent acts in the practice of medicine and provides cause for discipline to Respondent's physician's and surgeon's certificate.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number C 41964, issued to Thomas Neuschatz, M.D.;

2. Revoking, suspending or denying approval of Thomas Neuschatz, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Thomas Neuschatz, M.D., if placed on probation, to pay the Medical Board of California the costs of probation monitoring;

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

DATED: May 23, 2012

LINDA K. WHITNEY
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant