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

In the Matter of the Accusation Against:	)	
	)	
	)	
BILLY ZACHERY EARLEY, P.A.	)	**Case No. 1E-2011-220507**
	)	
Physician Assistant	)	
License No. PA 15350	)	
	)	
Respondent	)	
	)	

DECISION AND ORDER

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

This Decision shall become effective at 5:00 p.m. on April 21, 2016.

IT IS SO ORDERED April 14, 2016.

PHYSICIAN ASSISTANT BOARD

By: _____
Glenn L. Mitchell, Jr.
Executive Officer

KAMALA D. HARRIS
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
JOSEPH F. MCKENNA III
Deputy Attorney General
State Bar No. 231195
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-2997
Facsimile: (619) 645-2061

Attorneys for Complainant

BEFORE THE
PHYSICIAN ASSISTANT BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **BILLY ZACHERY EARLEY, P.A.** **2144 Wembley Lane** **Corona, CA 92881** **Physician Assistant License No. PA 15350,** Respondent.	Case No. 1E-2011-220507 OAH No. 2015-030386 **STIPULATED SURRENDER OF LICENSE AND DISCIPLINARY ORDER**

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

PARTIES

1. Glenn L. Mitchell, Jr. (Complainant) is the Executive Officer of the Physician Assistant Board. He brought this action solely in his official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Joseph F. McKenna III, Deputy Attorney General.

2. Respondent Billy Zachery Earley, P.A. (respondent) is represented in this proceeding by attorney Yves-Georges Joseph, Esq., whose address is: 555 Park Center Drive, Suite 225, Santa Ana, California, 92705.

3. On or about May 10, 2000, the Physician Assistant Board issued Physician Assistant License No. PA 15350 to respondent. Respondent's Physician Assistant License No. PA 15350 was in full force and effect at all times relevant to the charges and allegations brought herein and will expire on January 31, 2018, unless renewed.

JURISDICTION

4. On December 19, 2014, Accusation No. 1E-2011-220507 was filed before the Physician Assistant Board (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 December 19, 2014. Respondent timely filed his Notice of Defense contesting the Accusation. A true and correct copy of Accusation No. 1E-2011-220507 is attached hereto as Exhibit A and incorporated herein by reference as if fully set forth herein.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with his counsel, and fully understands the charges and allegations in Accusation No. 1E-2011-220507. Respondent has also carefully read, fully discussed with his counsel, and fully understands the effects of this Stipulated Surrender of License and Disciplinary 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 Accusation No. 1E-2011-220507; 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, having been fully advised of same by his attorney of record, Yves-Georges Joseph, Esq.

7. Having the benefit of counsel, respondent hereby voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

////

////

CULPABILITY

8. Respondent admits the truth of each and every charge and allegation in Accusation No. 1E-2011-220507, agrees that cause exists for discipline and hereby surrenders his Physician Assistant License No. PA 15350 for the Board's formal acceptance.

9. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician Assistant License No. PA 15350 without further notice to, or opportunity to be heard by, respondent.

10. Respondent understands that by signing this stipulation he enables the Executive Officer of the Physician Assistant Board to issue an order accepting the surrender of his Physician Assistant License No. PA 15350 on behalf of the Board without notice to, or opportunity to be heard by, respondent.

CONTINGENCY

11. The Physician Assistant Practice Act, in Business and professions Code section 3527, subdivision (a), provides, in pertinent part, that "[t]he board may order the denial of an application for, or the issuance subject to terms and conditions of, or the suspension or revocation of a physician assistant license ... for unprofessional conduct that includes, but is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a violation of the regulations adopted by the board or the Medical Board of California."

12. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a ... stipulation for surrender of a license." This authority is also delegated to the Executive Officer of the Physician Assistant Board through Business and Professions Code section 3527, subdivision (a).

13. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Officer for his consideration in the above-entitled matter and, further, that the Executive Officer shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, respondent fully understands and agrees that he may not withdraw his agreement

or seek to rescind this stipulation prior to the time that the Executive Officer considers and acts upon it.

14. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Officer, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Officer may receive oral and written communications from its staff and/or the Attorney General's office. Communications pursuant to this paragraph shall not disqualify the Executive Officer and/or any other person from future participation in this or any other matter affecting or involving respondent. In the event that the Executive Officer, in his discretion, does not approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should the Executive Officer reject this Stipulated Surrender of License and Disciplinary Order for any reason, respondent will assert no claim that Executive Officer was prejudiced by his review, discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

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

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

17. In consideration of the foregoing admissions and stipulations, the parties agree the Executive Officer of the Physician Assistant Board may, without further notice to or opportunity to be heard by respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician Assistant License No. PA 15350, issued to respondent Billy Zachery Earley, P.A., is surrendered and accepted by the Executive Officer of the Physician Assistant Board.

1. The surrender of respondent's Physician Assistant License No. PA 15350 and the acceptance of the surrendered license by the Executive Officer 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 Physician Assistant Board.

2. Respondent shall lose all rights and privileges as a physician assistant in California as of the effective date of the Board's Decision and Disciplinary 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 Disciplinary 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. 1E-2011-220507 shall be deemed to be true, correct and fully admitted by respondent when the Executive Officer 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. 1E-2011-220507 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.

6. Before respondent files an application for licensure or petition for reinstatement with the Physician Assistant Board, respondent must first fully reimburse the Board its costs of investigation and prosecution in Accusation No. 1E-2011-220507, pursuant to Business and Professions Code section 125.3, in the amount of $61,400.00.

////

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Disciplinary Order and have fully discussed it with my attorney, Yves-Georges Joseph, Esq. I understand the stipulation and the effect it will have on my Physician Assistant License No. PA 15350. I enter into this Stipulated Surrender of License and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Disciplinary Order of the Executive Officer of the Board.

DATED: 4-13-16

BILLY ZACHERY EARLEY , P.A.
Respondent

I have read and fully discussed with respondent Billy Zachery Earley, P.A.., the terms and conditions and other matters contained in the above Stipulated Surrender of License and Disciplinary Order. I approve its form and content.

DATED: 4/13/2016

YVES-GEORGES JOSEPH, ESQ.
Attorney for Respondent

ENDORSEMENT

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

Dated: 4/13/2016

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

JOSEPH F. MCKENNA III
Deputy Attorney General
Attorneys for Complainant

SD2014708189 / Doc.No.81318515

Exhibit A

Accusation No. 1E-2011-220507

KAMALA D. HARRIS
Attorney General of California
THOMAS S. LAZAR
Supervising Deputy Attorney General
JOSEPH F. MCKENNA III
Deputy Attorney General
State Bar No. 231195
110 West "A" Street, Suite 1100
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-2997
Facsimile: (619) 645-2061

Attorneys for Complainant

BEFORE THE
PHYSICIAN ASSISTANT BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **BILLY ZACHERY EARLEY, P.A.** **2144 Wembley Lane** **Corona, CA 92881** **Physician Assistant License No. PA 15350,** Respondent.	Case No. 1E-2011-220507 **ACCUSATION**

Complainant alleges:

PARTIES

1. Glenn L. Mitchell, Jr. (Complainant) brings this Accusation solely in his official capacity as the Executive Officer of the Physician Assistant Board of California (Board), Department of Consumer Affairs.

2. On or about May 10, 2000, the Physician Assistant Board of California issued Physician Assistant License No. PA 15350 to Billy Zachery Early, P.A. (respondent). The Physician Assistant License was in full force and effect at all times relevant to the charges and allegations brought herein and will expire on January 31, 2016, unless renewed.

///

JURISDICTION

3. This Accusation is brought before the Physician Assistant 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 (Code) unless otherwise indicated.

4. Section 3527 of the Code states:

"(a) The board may order the denial of an application for, or the issuance subject to terms and conditions of, or the suspension or revocation of, or the imposition of probationary conditions upon a physician assistant license after a hearing as required in Section 3528 for unprofessional conduct that includes, but is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a violation of the regulations adopted by the board or the Medical Board of California.

"(b) The board may order the denial of an application for, or the suspension or revocation of, or the imposition of probationary conditions upon, an approved program after a hearing as required in Section 3528 for a violation of this chapter or the regulations adopted pursuant thereto.

"(c) The Medical Board of California may order the denial of an application for, or the issuance subject to terms and conditions of, or the suspension or revocation of, or the imposition of probationary conditions upon, an approval to supervise a physician assistant, after a hearing as required in Section 3528, for unprofessional conduct, which includes, but is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a violation of the regulations adopted by the board or the Medical Board of California.

" ...

"(f) The board may order the licensee to pay the costs of monitoring the probationary conditions imposed on the license.

"(g) The expiration, cancellation, forfeiture, or suspension of a physician assistant license by operation of law or by order or decision of the board or a court

of law, the placement of a license on a retired status, or the voluntary surrender of a license by a licensee shall not deprive the board of jurisdiction to commence or proceed with any investigation of, or action or disciplinary proceeding against, the licensee or to render a decision suspending or revoking the license."

5. Section 3502 of the Code states:

"(a) Notwithstanding any other provision of law, a physician assistant may perform those medical services as set forth by the regulations of the board when the services are rendered under the supervision of a licensed physician and surgeon or of physicians and surgeons approved by the board, except as provided in Section 3502.5.

"(b) . . .

"(c)(1) A physician assistant and his or her supervising physician and surgeon shall establish written guidelines for the adequate supervision of the physician assistant. This requirement may be satisfied by the supervising physician and surgeon adopting protocols for some or all of the tasks performed by the physician assistant. The protocols adopted pursuant to this subdivision shall comply with the following requirements:

"(A) A protocol governing diagnosis and management shall, at a minimum, include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be provided to the patient.

"(B) A protocol governing procedures shall set forth the information to be provided to the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow-up care.

"(C) Protocols shall be developed by the supervising physician and surgeon or adopted from, or referenced to, texts or other sources.

"(D) Protocols shall be signed and dated by the supervising physician

and surgeon and the physician assistant.

"(2) The supervising physician and surgeon shall review, countersign, and date a sample consisting of, at a minimum, 5 percent of the medical records of patients treated by the physician assistant functioning under the protocols within 30 days of the date of treatment by the physician assistant. The physician and surgeon shall select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

"(3) Notwithstanding any other provision of law, the Medical Board of California or board may establish other alternative mechanisms for the adequate supervision of the physician assistant.

"..."

6. Section 3502.1 of the Code states:

"(a) In addition to the services authorized in the regulations adopted by the board, and except as prohibited by Section 3502, while under the supervision of a licensed physician and surgeon or physicians and surgeons authorized by law to supervise a physician assistant, a physician assistant may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device pursuant to subdivisions (c) and (d).

"(1) A supervising physician and surgeon who delegates authority to issue a drug order to a physician assistant may limit this authority by specifying the manner in which the physician assistant may issue delegated prescriptions.

"(2) Each supervising physician and surgeon who delegates the authority to issue a drug order to a physician assistant shall first prepare or adopt a written, practice specific, formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. The drugs listed shall constitute the formulary and shall include only drugs that are

appropriate for use in the type of practice engaged in by the supervising physician and surgeon. When issuing a drug order, the physician assistant is acting on behalf of and as an agent for a supervising physician and surgeon.

"(b) 'Drug order' for purposes of this section means an order for medication which is dispensed to or for a patient, issued and signed by a physician assistant acting as an individual practitioner within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription or order of the supervising physician, (2) all references to 'prescription' in this code and the Health and Safety Code shall include drug orders issued by physician assistants pursuant to authority granted by their supervising physicians, and (3) the signature of a physician assistant on a drug order shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

"(c) A drug order for any patient cared for by the physician assistant that is issued by the physician assistant shall either be based on the protocols described in subdivision (a) or shall be approved by the supervising physician before it is filled or carried out.

"(1) A physician assistant shall not administer or provide a drug or issue a drug order for a drug other than for a drug listed in the formulary without advance approval from a supervising physician and surgeon for the particular patient. At the direction and under the supervision of a physician and surgeon, a physician assistant may hand to a patient of the supervising physician and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon, manufacturer as defined in the Pharmacy Law, or a pharmacist.

"(2) A physician assistant may not administer, provide or issue a drug order for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for the particular patient.

"(3) Any drug order issued by a physician assistant shall be subject to a reasonable quantitative limitation consistent with customary medical practice in the supervising physician and surgeon's practice.

"(d) A written drug order issued pursuant to subdivision (a), except a written drug order in a patient's medical record in a health facility or medical practice, shall contain the printed name, address, and phone number of the supervising physician and surgeon, the printed or stamped name and license number of the physician assistant, and the signature of the physician assistant. Further, a written drug order for a controlled substance, except a written drug order in a patient's medical record in a health facility or a medical practice, shall include the federal controlled substances registration number of the physician assistant. The requirements of this subdivision may be met through stamping or otherwise imprinting on the supervising physician and surgeon's prescription blank to show the name, license number, and if applicable, the federal controlled substances number of the physician assistant, and shall be signed by the physician assistant. When using a drug order, the physician assistant is acting on behalf of and as the agent of a supervising physician and surgeon.

"(e) The medical record of any patient cared for by a physician assistant for whom the supervising physician and surgeon's drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven days.

"(f) All physician assistants who are authorized by their supervising physicians to issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration (DEA)."

7. California Code of Regulations, title 16, section 1399.521 states:

"In addition to the grounds set forth in section 3527, subdivision (a), of the Code, the board may deny, issue subject to terms and conditions, suspend, revoke or place on probation a physician assistant for the following causes:

"(a) Any violation of the State Medical Practice Act which would constitute unprofessional conduct for a physician and surgeon.

". . .

"(d) Performing medical tasks which exceed the scope of practice of a physician assistant as prescribed in these regulations."

8. California Code of Regulations, title 16, section 1399.540, states:

"(a) A physician assistant may only provide those medical services which he or she is competent to perform and which are consistent with the physician assistant's education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant.

"(b) The writing which delegates the medical services shall be known as a delegation of services agreement. A delegation of services agreement shall be signed and dated by the physician assistant and each supervising physician. A delegation of services agreement may be signed by more than one supervising physician only if the same medical services have been delegated by each supervising physician. A physician assistant may provide medical services pursuant to more than one delegation of services agreement.

"(c) The board or Medical Board of California or their representative may require proof or demonstration of competence from any physician assistant for any tasks, procedures or management he or she is performing.

"(d) A physician assistant shall consult with a physician regarding any task, procedure or diagnostic problem which the physician assistant determines exceeds his or her level of competence or shall refer such cases to a physician."

9. California Code of Regulations, title 16, section 1399.545, states:

"(a) A supervising physician shall be available in person or by electronic communication at all times when the physician assistant is caring for patients.

"(b) A supervising physician shall delegate to a physician assistant only those

tasks and procedures consistent with the supervising physician's specialty or usual and customary practice and with the patient's health and condition.

"(c) A supervising physician shall observe or review evidence of the physician assistant's performance of all tasks and procedures to be delegated to the physician assistant until assured of competency.

"(d) The physician assistant and the supervising physician shall establish in writing transport and back-up procedures for the immediate care of patients who are in need of emergency care beyond the physician assistant's scope of practice for such times when a supervising physician is not on the premises.

"(e) A physician assistant and his or her supervising physician shall establish in writing guidelines for the adequate supervision of the physician assistant which shall include one or more of the following mechanisms:

"(1) Examination of the patient by a supervising physician the same day as care is given by the physician assistant;

"(2) Countersignature and dating of all medical records written by the physician assistant within thirty (30) days that the care was given by the physician assistant;

"(3) The supervising physician may adopt protocols to govern the performance of a physician assistant for some or all tasks. The minimum content for a protocol governing diagnosis and management as referred to in this section shall include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be given the patient. For protocols governing procedures, the protocol shall state the information to be given the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow-up care. Protocols shall be developed by the physician, adopted from, or referenced to, texts or other sources. Protocols shall be signed and dated by the supervising physician and the

physician assistant. The supervising physician shall review, countersign, and date a minimum of 5% sample of medical records of patients treated by the physician assistant functioning under these protocols within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent, in his or her judgment, the most significant risk to the patient;

"(4) Other mechanisms approved in advance by the board.

"(f) The supervising physician has continuing responsibility to follow the progress of the patient and to make sure that the physician assistant does not function autonomously. The supervising physician shall be responsible for all medical services provided by a physician assistant under his or her supervision."

10. Section 2052 of the Code, states:

"(a) Notwithstanding Section 146, any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of so doing a valid, unrevoked, or unsuspended certificate as provided in this chapter or without being authorized to perform the act pursuant to a certificate obtained in accordance with some other provision of law is guilty of a public offense, punishable by a fine not exceeding ten thousand dollars ($10,000), by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, by imprisonment in a county jail not exceeding one year, or by both the fine and either imprisonment.

"(b) Any person who conspires with or aids or abets another to commit any act described in subdivision (a) is guilty of a public offense, subject to the punishment described in that subdivision.

"(c) The remedy provided in this section shall not preclude any other remedy provided by law."

11. Section 2069 of the Code, states:

"(a)(1) Notwithstanding any other law, a medical assistant may administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical supportive services upon the specific authorization and supervision of a licensed physician and surgeon or a licensed podiatrist. A medical assistant may also perform all these tasks and services upon the specific authorization of a physician assistant, a nurse practitioner, or a certified nurse-midwife.

"(2) The supervising physician and surgeon may, at his or her discretion, in consultation with the nurse practitioner, certified nurse-midwife, or physician assistant, provide written instructions to be followed by a medical assistant in the performance of tasks or supportive services. These written instructions may provide that the supervisory function for the medical assistant for these tasks or supportive services may be delegated to the nurse practitioner, certified nurse-midwife, or physician assistant within the standardized procedures or protocol, and that tasks may be performed when the supervising physician and surgeon is not onsite, if either of the following apply:

"...

"(B) The physician assistant is functioning pursuant to regulated services defined in Section 3502, including instructions for specific authorizations, and is approved to do so by the supervising physician and surgeon.

"(b) As used in this section and Sections 2070 and 2071, the following definitions apply:

"(1) 'Medical assistant' means a person who may be unlicensed, who performs basic administrative, clerical, and technical supportive services in compliance with this section and Section 2070 for a licensed physician and surgeon or a licensed podiatrist, or group thereof, for a medical or podiatry corporation, for a physician assistant, a nurse practitioner, or a certified nurse-

midwife as provided in subdivision (a), or for a health care service plan, who is at least 18 years of age, and who has had at least the minimum amount of hours of appropriate training pursuant to standards established by the board. The medical assistant shall be issued a certificate by the training institution or instructor indicating satisfactory completion of the required training. A copy of the certificate shall be retained as a record by each employer of the medical assistant.

"(2) 'Specific authorization' means a specific written order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the certified nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed on a patient, which shall be placed in the patient's medical record, or a standing order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the certified nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed, the duration of which shall be consistent with accepted medical practice. A notation of the standing order shall be placed on the patient's medical record.

"(3) 'Supervision' means the supervision of procedures authorized by this section by the following practitioners, within the scope of their respective practices, who shall be physically present in the treatment facility during the performance of those procedures:

"(A) A licensed physician and surgeon.

" ...

"(C) A physician assistant, nurse practitioner, or certified nurse-midwife as provided in subdivision (a).

"(4) 'Technical supportive services' means simple routine medical tasks and procedures that may be safely performed by a medical assistant who has limited training and who functions under the supervision of a licensed physician and surgeon or a licensed podiatrist, or a physician assistant, a nurse practitioner, or a

certified nurse-midwife as provided in subdivision (a).

"(c) Nothing in this section shall be construed as authorizing any of the following:

"(1) The licensure of medical assistants.

"(2) The administration of local anesthetic agents by a medical assistant.

" ...

"(4) A medical assistant to perform any clinical laboratory test or examination for which he or she is not authorized by Chapter 3 (commencing with Section 1200).

"(5) A nurse practitioner, certified nurse-midwife, or physician assistant to be a laboratory director of a clinical laboratory, as those terms are defined in paragraph (8) of subdivision (a) of Section 1206 and subdivision (a) of Section 1209.

"(d) A nurse practitioner, certified nurse-midwife, or physician assistant shall not authorize a medical assistant to perform any clinical laboratory test or examination for which the medical assistant is not authorized by Chapter 3 (commencing with Section 1200). A violation of this subdivision constitutes unprofessional conduct.

"..."

12. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a

separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

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

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

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption 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.

"..."

13. Section 2238 of the Code states:

"A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

14. 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.

"..."

15. Section 2264 of the Code states:

"The employing, directly or indirectly, the aiding, or the abetting of any

unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct."

16. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

17. Section 2285 of the Code states:

"The use of any fictitious, false, or assumed name, or any name other than his or her own by a licensee either alone, in conjunction with a partnership or group, or as the name of a professional corporation, in any public communication, advertisement, sign, or announcement of his or her practice without a fictitious-name permit obtained pursuant to Section 2415 constitutes unprofessional conduct. This section shall not apply to the following:

"(a) Licensees who are employed by a partnership, a group, or a professional corporation that holds a fictitious name permit.

"(b) Licensees who contract with, are employed by, or are on the staff of, any clinic licensed by the State Department of Health Services under Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code.

"(c) An outpatient surgery setting granted a certificate of accreditation from an accreditation agency approved by the medical board.

"(d) Any medical school approved by the division or a faculty practice plan connected with the medical school."

18. Section 2286 of the Code states:

"It shall constitute unprofessional conduct for any licensee to violate, to attempt to violate, directly or indirectly, to assist in or abet the violation of, or to conspire to violate any provision or term of Article 18 (commencing with Section 2400), of the Moscone-Knox Professional Corporation Act (Part 4 (commencing

with Section 13400) of Division 3 of Title 1 of the Corporations Code), or of any rules and regulations duly adopted under those laws."

19. Section 2400 of the Code states:

"Corporations and other artificial legal entities shall have no professional rights, privileges, or powers. However, the Division of Licensing may in its discretion, after such investigation and review of such documentary evidence as it may require, and under regulations adopted by it, grant approval of the employment of licensees on a salary basis by licensed charitable institutions, foundations, or clinics, if no charge for professional services rendered patients is made by any such institution, foundation, or clinic."

20. Section 2406 of the Code states:

"A medical corporation or podiatry corporation is a corporation that is authorized to render professional services, as defined in Section 13401 of the Corporations Code, so long as that corporation and its shareholders, officers, directors, and employees rendering professional services who are physicians and surgeons, psychologists, registered nurses, optometrists, podiatrists, chiropractors, acupuncturists, naturopathic doctors, physical therapists, occupational therapists, or, in the case of a medical corporation only, physician assistants, marriage and family therapists, clinical counselors, or clinical social workers, are in compliance with the Moscone-Knox Professional Corporation Act, the provisions of this article, and all other statutes and regulations now or hereafter enacted or adopted pertaining to the corporation and the conduct of its affairs.

"With respect to a medical corporation or podiatry corporation, the governmental agency referred to in the Moscone-Knox Professional Corporation Act is the board."

21. Section 2415 of the Code states:

"(a) Any physician and surgeon or any doctor of podiatric medicine, as the case may be, who as a sole proprietor, or in a partnership, group, or professional

corporation, desires to practice under any name that would otherwise be a violation of Section 2285 may practice under that name if the proprietor, partnership, group, or corporation obtains and maintains in current status a fictitious-name permit issued by the Division of Licensing, or, in the case of doctors of podiatric medicine, the California Board of Podiatric Medicine, under the provisions of this section.

"(b) The division or the board shall issue a fictitious-name permit authorizing the holder thereof to use the name specified in the permit in connection with his, her, or its practice if the division or the board finds to its satisfaction that:

"(1) The applicant or applicants or shareholders of the professional corporation hold valid and current licenses as physicians and surgeons or doctors of podiatric medicine, as the case may be.

"(2) The professional practice of the applicant or applicants is wholly owned and entirely controlled by the applicant or applicants.

"(3) The name under which the applicant or applicants propose to practice is not deceptive, misleading, or confusing.

"(c) Each permit shall be accompanied by a notice that shall be displayed in a location readily visible to patients and staff. The notice shall be displayed at each place of business identified in the permit.

"(d) This section shall not apply to licensees who contract with, are employed by, or are on the staff of, any clinic licensed by the State Department of Health Services under Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code or any medical school approved by the division or a faculty practice plan connected with that medical school.

"(e) Fictitious-name permits issued under this section shall be subject to Article 19 (commencing with Section 2420) pertaining to renewal of licenses, except the division shall establish procedures for the renewal of fictitious-name permits every two years on an anniversary basis. For the purpose of the

conversion of existing permits to this schedule the division may fix prorated renewal fees.

"(f) The division or the board may revoke or suspend any permit issued if it finds that the holder or holders of the permit are not in compliance with the provisions of this section or any regulations adopted pursuant to this section. A proceeding to revoke or suspend a fictitious-name permit shall be conducted in accordance with Section 2230.

"(g) A fictitious-name permit issued to any licensee in a sole practice is automatically revoked in the event the licensee's certificate to practice medicine or podiatric medicine is revoked.

"(h) The division or the board may delegate to the executive director, or to another official of the board, its authority to review and approve applications for fictitious-name permits and to issue those permits.

"(i) The California Board of Podiatric Medicine shall administer and enforce this section as to doctors of podiatric medicine and shall adopt and administer regulations specifying appropriate podiatric medical name designations.

22. Unprofessional conduct under California Business and Professions Code section 2234 is conduct which breaches the rules of ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine.[1]

COST RECOVERY

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

[1] *Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575

included in a stipulated settlement.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

24. Respondent is subject to disciplinary action under sections 3527 and 2234, as defined by section 2234, subdivision (b), of the Code, and California Code of Regulations, Title 16, section 1399.521, subdivision (a), in that he committed acts of gross negligence in his care and treatment of patients T.T., P.H., P.P., L.A., W.J., and K.M., as more particularly alleged hereinafter:

Patient T.T.

(a) On or about December 7, 2012, T.M., a Medical Board of California investigator, posing as patient T.T., conducted an undercover visit at First Choice Clinica Familiar (FCCF), which is owned by respondent. Patient T.T. was seen for one (1) visit and initially met with FCCF's weight-loss coordinator to discuss the different weight-loss options offered at FCCF. Respondent then met with patient T.T. and further discussed with her the different weight-loss options offered at FCCF. Respondent briefly discussed diet and the importance of exercise with patient T.T. Respondent then prescribed phentermine[2] to be taken weekly by patient T.T. Significantly, respondent never asked patient T.T. about her medical history including, among other things, what, if any, medications she was currently taking; whether she smoked cigarettes or drank alcohol; whether she had any past or present addiction problems; whether she had any past or present mental health

[2] Phentermine is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a stimulant and an appetite suppressant that is prescribed to patients for the management of exogenous obesity. Phentermine is a sympathomimetic amine and can increase blood pressure and pulse of patients. Therefore, caution is to be exercised in prescribing phentermine for patients with even mild hypertension and, dosage should be individualized to obtain an adequate response with the lowest effective dose. Lastly, phentermine is related chemically and pharmacologically to amphetamines, a drug of extensive abuse; therefore, the possibility of abuse should be monitored when phentermine is prescribed as part of a weight reduction program.

issues; or whether she had any past attempts with weight loss through use of controlled substances.

(b) Respondent committed gross negligence in his care and treatment of patient T.T., which included, but was not limited to, the following:

(1) Respondent failed to perform and document an adequate history prior to prescribing Phentermine, a controlled substance;

(2) Respondent performed no physical examination of patient T.T. other than recording her blood pressure and weight;

(3) Respondent failed to discuss the major potential risks of using a controlled substance for weight loss treatment; and

(4) Respondent failed to get approval from a supervising physician before prescribing a controlled substance for weight loss treatment.

Patient P.H.

(c) Respondent treated patient P.H. for knee pain. Respondent saw patient P.H. at FCCF approximately seven (7) times between on or about August 1, 2011, and on or about July 9, 2012. Respondent wrote a prescription for Norco[3] and Xanax[4] for patient P.H. that was filled on or about July 7, 2011, however, the first clinic note for patient P.H. is not until on or about August 1, 2011. On patient P.H.'s first documented visit at FCCF on or about August 1, 2011, a urine drug screen was performed that tested "positive" for methamphetamine,[5] but "negative" for opioids or benzodiazepines. Patient P.H. told respondent that he used

[3] Norco is a brand name for acetaminophen and hydrocodone bitartrate, a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. Norco is an opioid pain medication that is used to relieve moderate to severe pain.

[4] Xanax is a brand name for alprazolam (a benzodiazepine), a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

[5] Methamphetamine is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d).

methamphetamine only "once in awhile" and, that he used it for social use only. Notwithstanding patient P.H.'s admitted illegal drug use during his initial documented visit with respondent, he prescribed patient P.H. Norco and Xanax. A second urine drug screen for patient P.H. was taken on or about October 13, 2011, and every drug tested for was documented as negative. On or about February 27, 2012, an x-ray of patient P.H.'s knee was ordered but there was no record provided of any results. At no time in respondent's care and treatment of patient P.H. did he conduct a mental status examination. Most of patient P.H.'s medical records made by respondent are partially illegible.

(d) Respondent committed gross negligence in his care and treatment of patient P.H., which included, but was not limited to, the following:

(1) Respondent failed to document any discussion with patient P.H. regarding the fact that, notwithstanding prescriptions for Norco and Xanax, patient P.H.'s urine drug screens were negative for these controlled substances;

(2) Respondent failed to adequately document patient P.H.'s medical history and/or social history;

(3) Respondent failed to adequately document patient P.H.'s pain history;

(4) Respondent failed to seek a referral for appropriate consultation for pain management; and

(5) Respondent prescribed opioids and benzodiazepines to patient P.H., notwithstanding patient P.H.'s admitted recent illegal use of methamphetamines.

Patient P.P.

(e) Respondent treated patient P.P. for back pain due to surgery. Respondent saw patient P.P. at FCCF approximately seventeen (17) times between on or about July 20, 2011, and on or about October 10, 2012. Although respondent's first documented visit with patient P.P. occurred on or about July 20, 2011, the Controlled Substances Utilization Review and Evaluation System

///

(CURES)[6] reports indicated that respondent had been prescribing controlled substances to patient P.P. since in or around May, 2010. Between on or about May 5, 2010, respondent issued forty-three (43) prescriptions to patient P.P. for Oxycontin, Oxycodone, Alprazolam, and Opana ER. However, no documentation exists in patient P.P.'s medical records that respondent ever saw patient P.P. in connection with the issuance of these prescriptions. During this timeframe that respondent documented his treatment for patient P.P., the medical records are largely filled with illegible notations and lack a complete history taken of patient P.P. prior to respondent prescribing him controlled substances for pain and anxiety. On or about July 20, 2011, respondent conducted a cursory physical examination of patient P.P.; however, he did not document patient P.P.'s past medical history, social history, or review of systems. Respondent also recorded a cursory history of patient P.P.'s pain history but he did not conduct a mental status examination, drug or alcohol history, or psychiatric history of patient P.P. In fact, on or about July 20, 2011, respondent prescribed Xanax for patient P.P. without any diagnosis or documentation of any discussion with patient P.P regarding his anxiety. On that same date, respondent also noted that patient P.P. disclosed he was "opioid dependent" and, that he wanted to start taking methadone[7] to decrease his opioid dependence. Without having reviewed patient P.P.'s past medical records or taken an adequate history on his past opioid use, and without any discussion of his history

[6] The CURES is a program operated by the California Department of Justice (DOJ) to assist health care practitioners in their efforts to ensure appropriate prescribing of controlled substances, and law enforcement and regulatory agencies in their efforts to control diversion and abuse of controlled substances. (Health & Saf. Code, § 11165.) California law requires dispensing pharmacies to report to the DOJ the dispensing of Schedule II, III and IV controlled substances as soon as reasonably possible after the prescriptions are filled. (Health & Saf. Code, § 11165, subd. (d).) The history of controlled substances dispensed to a specific patient based on the data contained in the CURES is available to a health care practitioner who is treating that patient. (Health & Saf. Code, § 11165.1, subd. (a).)

[7] Methadone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

of any drug and/or alcohol use, respondent prescribed methadone, 60 mg, to patient P.P. Respondent re-filled the methadone prescription multiple times over the course of his care and treatment of patient P.P. Under federal law, practitioners wishing to administer and dispense approved Schedule II controlled substances, namely, methadone, for maintenance and detoxification treatment must obtain a separate DEA registration as a Narcotic Treatment Program. In addition to obtaining this separate DEA registration, this type of activity also requires the approval and registration of the Center for Substance Abuse Treatment within the Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services, as well as the applicable state methadone authority. Prior to prescribing methadone to patient P.P., respondent did not possess a separate DEA registration for maintenance and detoxification treatment. Furthermore, respondent did not adequately document or establish a treatment plan, with stated objectives for converting patient P.P. from opioids to methadone, in order to decrease patient P.P.'s dependency on opiates. Respondent prescribed methadone in high dosages to patient P.P. without informing him about any increased risks associated with overdose or death. On or about October 28, 2011, a notation was recorded in patient P.P.'s progress notes that indicated he was "*having more pain and anxiety*," however, there was no documentation of discussion or additional history and examination of patient P.P. taken to justify the diagnosis of anxiety. Notwithstanding the need for more information prior to diagnosing patient P.P. with anxiety, respondent again prescribed Xanax without an adequate medical indication. During the course of respondent's treatment of patient P.P., only two (2) urine drug screens were obtained. The results from the urine drug screen performed on August 20, 2011, were "negative" for all drugs prescribed to him by respondent. A second urine drug screen was ordered on October, 10, 2012, however, there is no notation in patient P.P.'s medical records reporting the test results. Significantly, respondent did not document any discussion with patient P.P. in progress notes as to why his

test results were negative for opiates, benzodiazepines, and methadone, despite being prescribed these controlled substances by respondent. On or about September 30, 2011, a partially legible notation was made in patient P.P.'s progress notes that indicated his wife took his medications away from him because she does not want him taking Oxycontin. Respondent did not document any further discussion of the circumstances involving patient P.P.'s wife taking his medications but, instead, he again prescribed methadone and Xanax to patient P.P. On or about March 12, 2012, a partially legible notation was made in patient P.P.'s progress notes that indicated he had reported losing his methadone medication to respondent. Respondent made a partially legible notation under plan that indicated patient P.P. was "*admonished not to lose his meds.*" Notwithstanding clear indications of possible diversion and/or abuse, including patient P.P.'s negative urine drug screen for controlled substances, alleged loss of his methadone, and report that his wife previously had taken his medications away from him, respondent re-filled prescriptions for Oxycodone, Xanax, and methadone for patient P.P.

(f) Respondent committed gross negligence in his care and treatment of patient P.P., which included, but was not limited to, the following:

(1) Respondent failed to document a diagnosis or treatment plan for anxiety prior to prescribing Xanax to patient P.P.;

(2) Respondent failed to adequately document or establish a treatment plan, with stated objectives for converting patient P.P. from opioids to methadone;

(3) Respondent failed to obtain the proper licensing for methadone maintenance therapy;

(4) Respondent failed to obtain a comprehensive social history and/or a complete substance abuse history for patient P.P.;

(5) Respondent failed to follow up on the "negative" urine drug screen with patient P.P.; and

(6) Respondent failed to follow up on the issue of patient P.P.'s wife taking

his medications away from him.

Patient L.A.

(g) Respondent treated patient L.A. for knee pain. Respondent saw patient L.A. at FCCF approximately thirteen (13) times between on or about July 15, 2011, and on or about February 5, 2013. Although respondent's first documented visit with patient L.A. occurred on or about July 15, 2011, the CURES reports in his medical records indicated that respondent had already written three (3) prescriptions for controlled substances to patient L.A. in or around May, 2011, and June, 2011. On or about July 15, 2011, respondent documented that patient L.A. had been on pain management medication for five (5) years. Some of the examination notations are illegible. Respondent did not document patient L.A.'s social history, past medical history and/or review of systems. In addition, respondent did not document a mental status exam and/or psychiatric history for patient L.A. On or about September 15, 2012, a progress note for patient L.A. contained no recorded history, examination or vital signs; however, it included two (2) partially legible notations indicating, "*Pt has police report meds stolen in jail*" and "*Incident report/police report filed.*" The only documentation in patient L.A.'s medical records of this alleged police report is a business card from the City of Riverside Police Records Division, dated September 4, 2012, containing the name of a records specialist and a file number. A handwritten note from patient L.A. on FCCF letterhead, dated September 4, 2012, also indicated that he had been admitted to a mental health facility on August 15, 2012, and that when he was discharged six (6) days later, he was missing an unspecified number of Norco tablets from his bottle. There is a handwritten and unsigned notation on a CURES report in medical records for patient L.A., dated August 23, 2012, which stated "*No more Norcos, wing* [sic] *down, 170 N/V.*" And again, on or about February 5, 2013, there is an additional notation in a progress note indicating that patient L.A. reported "*a doctor at the hospital soled* [sic] *his meds or some of them on several*

visits," and that police reports had been filed. There are no police reports found in patient L.A.'s medical records in connection with this or any other alleged incident. Despite a pattern of reporting "stolen" medications on the part of patient L.A., respondent again prescribed Norco and Xanax to patient L.A. following the February 5, 2013, clinical visit. Significantly, between on or about July 15, 2011, and on or about February 5, 2013, over the course of thirteen (13) patient visits, there are five (5) notations either in patient L.A.'s clinic notes or on billing slips indicating a plan, "next time," for a urine drug screen. However, there is no record of a urine drug screen ever being performed for patient L.A.

(h) Respondent committed gross negligence in his care and treatment of patient L.A., which included, but was not limited to, the following:

(1) Respondent failed to seek appropriate consultation and/or referral for complex pain problems in light of aberrant drug seeking behavior on the part of patient L.A.;

(2) Respondent failed to seek appropriate consultation and/or referral for substance abuse issues in light of aberrant drug seeking behavior on the part of patient L.A.; and

(3) Respondent failed to obtain test results for any of the five (5) urine drug screens.

Patient W.J.

(i) Respondent treated patient W.J. for foot pain. Respondent saw patient W.J. at FCCF approximately fifteen (15) times between on or about July 16, 2011, and on or about November 29, 2012. On or about July 16, 2011, at the initial visit, respondent documented that patient W.J. had diabetes and was taking insulin. The assessment/diagnosis section in the progress note listed diabetic neuropathy, skin structure disease, social anxiety disorder, and panic attacks. However, respondent did not document any information regarding patient W.J.'s social history, review of systems, psychiatric history, and/or mental status exam. On or about August 7,

2011, a progress note indicated that patient W.J.'s chief complaint was pain management of his legs. The examination section was mostly illegible. The medications section included "Xanax" and "Norco," but it did not indicate dosages or amounts for these controlled substances. The assessment section indicated "severe diabetic neuropathy" and "anxiety." The treatment/plan section indicated "*urine drug* [illegible word] *next visit.*" On or about February 14, 2012, a progress note indicated that respondent's medications had been confiscated by the police. The progress note also included the handwritten notation "*No Refills*," which was circled and next to the examination notes section. A handwritten note and signed by patient W.J., dated February 14, 2012, and prepared on FCCF letterhead, indicated that he was arrested by "*Aladdin Bail Company*" on January 24, 2012, and "*the bounty men took my medication: Norco, Xanax, Soma* [illegible]." Patient W.J.'s letter requested a refill prescription. Respondent received a refill authorization request for Norco faxed from Target pharmacy, dated February 22, 2012, on which respondent signed and authorized a quantity of one hundred eighty (180) Norco, and also made a handwritten notation indicating patient W.J. was given the additional prescription "*because he lost partial meds.*" A CURES report included in patient W.J.'s chart was run on February 14, 2012, which showed that, on or about January 31, 2012, patient W.J. filled a prescription for Norco (180 quantity) and Xanax (70 quantity), which was seven (7) days after the alleged confiscation of his medication on January 24, 2012. On or about March 6, 2012, a progress note indicated that patient W.J.'s medications were again taken away from him and, that the "*police dept. verified that they took his meds.*"[8] A partially typed and partially handwritten note signed by patient W.J., dated March 6, 2012, alleged that a police officer arrested him on March 1, 2012, and then confiscated

[8] Under the examination notes section, a handwritten notation indicated that "*patient says that the police is* [sic] *after him and they have arrested him 2 times for nothing.*"

his prescription medications, including, Norco, Soma, and Xanax. The letter fails to explain the circumstances under which patient W.J. was arrested. Patient W.J.'s letter requested a refill prescription. A CURES report included in patient W.J.'s chart was run on March 6, 2012, which showed that, on or about February 14, 2012, patient W.J. filled a prescription for Norco (180 quantity) and Xanax (60 quantity), and on February 23, 2012, he obtained an additional refill for Norco (180 quantity). On or about April 10, 2012, at patient W.J.'s next visit, under the treatment/plan section is a handwritten notation indicating that "*Pt says that he did not get the 180 tabs on 3-13-12.*" An additional handwritten notation indicated "*Pt* [down arrow] *meds ASAP.*" A CURES report included in patient W.J.'s chart was run on April 10, 2012, which showed that, on or about March 7, 2012, W.J. refilled his Norco prescriptions (180 quantity); and again, on or about March 12, 2012, he refilled his Norco prescriptions (180 quantity). Also reflected in the CURES report were patient W.J.'s previously noted refills for Norco on January 31, 2012; February 14, 2012; and February 23, 2012. All of these refills were written by respondent. Between on or about January 1, 2012, and on or about April 10, 2012, the CURES data revealed one thousand eighty (1,080) tablets of Norco were filled under prescription for patient W.J., and all had been written by respondent.[9] Nowhere in patient W.J.'s medical records or progress notes did respondent ever document any discussion or indicate a treatment plan for decreasing patient W.J.'s use of opioids or benzodiazepines; apparent issues with medication compliance and requests for refill under suspicious circumstances; and/or potential concerns over substance abuse. In addition, patient W.J.'s medical records do not include any police reports that would substantiate some or all of his claims with regards to separate incidents involving confiscation of his medications by police. Finally, at no time during respondent's care and treatment

[9] At this rate, patient W.J. would have been averaging approximately eleven (11) tablets of Norco every day.

of patient W.J. was a urine drug screen ever performed.

(j) Respondent committed gross negligence in his care and treatment of patient W.J., which included, but was not limited to, the following:

(1) Respondent failed to develop a clear plan to manage misuse of the prescribed opioids by, and then continued to prescribe controlled substances to, patient W.J. without a documented plan or rationale;

(2) Respondent failed to assess and document patient W.J.'s progress and/or lack of progress with opioid therapy, any adverse effects of opioid therapy, and/or any positive responses to opioid therapy; and

(3) Respondent failed to stop prescribing controlled substances and refer patient W.J. to a substance abuse program, in light of the contradictions between his self-reporting, lack of documentation, and CURES data.

Patient K.M.

(k) Respondent treated patient K.M. for jaw pain. Respondent saw patient K.M. at FCCF approximately eighteen (18) times between on or about July 16, 2011, and on or about December 14, 2012. On or about July 16, 2011, at patient K.M.'s initial visit, she reported constant severe pain to respondent and rated her pain "ten" (10) on a scale of one to ten (1 to 10). Patient K.M. reported that she had a history of pain management for her jaw and respondent noted in the progress note that "*it took her 4 years to get rid of pain.*" Respondent also documented in the progress note that patient K.M. had a morphine pump and that she was seeing Dr. I for management of the morphine pump. However, respondent did not document any discussion with patient K.M. as to whether the morphine pump was for her ongoing therapy, what the current dose was, or whether she had received any recent refills. Respondent also did not document any discussion about any prior oral opioid prescribing, or whether Dr. I was aware that she was being prescribed oral opioids in addition to the morphine pump. In fact, respondent never once during the entire period of his care and treatment of patient K.M.

documented a report or correspondence from, or any conversation with, Dr. I, regarding his treatment of patient K.M. via the morphine pump.[10] On the initial intake visit, on or about July 16, 2011, respondent did not document any discussion about the description of the pain quality, onset of pain, duration of prior therapies, past medical history, social history, psychiatric history, or review of systems. Respondent documented in the pain diagram bilateral facial pain only. Respondent's physical exam of patient K.M. was devoid of any head and/or facial examination, with the exception of Pupils Equal, Round, Reactive to Light and Accommodation (PERRLA), which indicated that only a cursory eye exam was performed. Respondent did not conduct and/or document a mental status examination of patient K.M. The progress note contained a diagnosis of fibromyalgia but there was no documented examination of the musculoskeletal system. The treatment/plan section indicated "*urine drug screen*" and, prescriptions for methadone, Norco and Xanax were issued. On or about August 12, 2011, a progress note again noted that patient K.M. was using a morphine pump and that she had seen several pain management providers. Respondent did not document any discussion on whether the pump was functional and delivering morphine to patient K.M. Under the treatment/plan section, it indicated, "*needs drug screen NV.*" On or about August 19, 2011, patient K.M. reported that her car had been towed which resulted in the confiscation of her medication. The progress note contained a notation that patient K.M. had eighteen (18) surgeries to her face and that she had a morphine pump for eleven (11) years. The progress note also contained a notation for the prescription of Norco and Xanax, but no indication of the number of tablets. A CURES report showed that patient K.M. subsequently filled her prescription for the Norco (180 quantity), Xanax (90 quantity), and Valium (90 quantity). Under the treatment/plan section, the only notation is "*HTN*

[10] A CURES report confirmed the dispensing of morphine powder, 500 mg, by Dr. I on or about June 9, 2011.

therapy." On or about September 14, 2011, a progress note included a handwritten notation indicating that patient K.M. told respondent that her "*daughter got put in prison for stealing her meds*." Under the treatment/plan section, the only notation is "*HTN therapy*." A billing slip for this visit indicated "*Urine next time*." A CURES report showed that patient K.M. subsequently filled her prescription from respondent for Norco (180 quantity), methadone (300 quantity), and Valium (90 quantity). On or about October 7, 2011, a progress note included a handwritten notation indicating that "*Pt is very depressed. She is out of her morphine pump and Dr.* [I] *didn't refill it.*" Respondent made no notation under the treatment/plan section. There was no follow up comment on the urine drug screen that had been planned from the prior visit. A CURES report in patient K.M.'s medical records indicated that morphine powder had been prescribed by Dr. I, and was dispensed on or about October 7, 2011. A CURES report showed that patient K.M. subsequently filled her prescription from respondent for Norco (180 quantity), methadone (300 quantity), and Valium (90 quantity). On or about October 22, 2011, a progress note that was mostly illegible, included a notation regarding the morphine pump that was also illegible. Under the treatment/plan section, a handwritten notation indicated only "*urine drug screen next visit*." However, respondent did not document any plan for treatment. A CURES report showed that patient K.M. subsequently filled a prescription from for Norco (180 quantity), methadone (300 quantity), and Valium (90 quantity). On or about November 25, 2011, a progress note included a handwritten notation that indicated "*Pt has been on these meds for too long*." However, respondent's notation did not specify which medications he was referring to. Respondent added another notation indicating that "*Pt says 'I can't lower any meds now please!'*" Under the treatment/plan section, a handwritten notation indicated that "*pt has seen hundreds of doctors for pain management*." However, again, respondent did not document any plan for treatment. A CURES report showed that patient K.M. subsequently

filled her prescription from respondent on or about November 29, 2011, for Norco (180 quantity), methadone (300 quantity), and Valium (90 quantity). A urine drug screen dated November 25, 2011, indicated that patient K.M.'s urine had tested "negative" for all prescribed drugs. On or about January 27, 2012, a progress note documented patient K.M.'s chief complaint was "TMJ." However, the progress note did not document a face and head examination. The other examination notations were mostly illegible. The notations for assessment were illegible, and there was no treatment or plan documented in the progress note for this visit. On or about March 10, 2012, a progress note again documented patient K.M.'s chief complaint was "TMJ." Again, respondent's examination notes are illegible. Respondent's assessment indicated "*1) severe TMJ; 2) Maxillary* [illegible]; *3) morphine pump*." However, respondent did not document a treatment plan in the progress notes. A handwritten notation in the margin of the progress note for this visit indicated, "*call in script for norco & valium.*" On or about May 16, 2012, a partially legible progress note documented patient K.M.'s clinical visit. The handwritten notations under examination were partially legible and, a mostly illegible notation regarding history indicated something about "Valium." No treatment plan was documented for this visit. In or around June 2012, patient K.M. drafted two (2) separate letters and submitted them to the FCCF clinic on FCCF letterhead, which described two (2) separate incidents of how she recently lost her medication, including a theft of her medication from her car trunk and losing her medications in the toilet at Walgreens. There is an undated FCCF clinic note indicating "*Pt 5 days early*" and "*police report reviewed.*" No additional comment or notation was included in the clinic note. A CURES report in patient K.M.'s chart showed that on or about May 21, 2012, she filled her prescription for Norco (126 quantity), Xanax (60 quantity), and methadone (300 quantity); and again, on or about June 13, 2012, she filled her prescription for methadone (300 quantity), Xanax (60 quantity), and Norco (165 quantity). On or about July 11,

2012, a progress note again documented patient K.M.'s chief complaint was "TMJ." Again, respondent did not document a description of pain location and/or patient K.M.'s response to therapy. The examination notations are illegible. Respondent's assessment only indicated "*1) severe TMJ; 2) Anxiety 3) fibromyalgia.*" Under the treatment/plan section, it only indicated "*Pt has too much pain.*" A handwritten notation in the margin of the progress note for this visit indicated, "*No refills.*" A CURES report in patient K.M.'s chart showed that on or about July 11, 2012, she filled her prescription from respondent for Norco (165 quantity), Xanax (60 quantity), and methadone (300 quantity). On or about July 13, 2012, a prescription refill request was faxed by Walgreen's for diazepam to FCCF. A handwritten notation made by respondent in patient K.M.'s medical records denied the refill, with the notation "*No valium pt is on high quantity of Xanax. too dangerous.*" On or about August 3, 2012, a progress note documented patient K.M.'s chief complaint was "TMJ." Respondent's assessment indicated "*1) severe TMJ; 2) Anxiety.*" The examination notes documented that "*every bite of food she takes is very severely painful.*" A handwritten notation further indicated that "*Pt want to go up on meds. Pt informed no.*" Under the treatment/plan section for this visit, respondent only documented "*pt informed we will not go up on anything.*" The bill for this visit indicated "*D/S next visit!*" On or about September 7, 2012, patient K.M. was seen by another physician assistant at FCCF. The documented information in the progress note was essentially the same as the information previously documented by respondent for patient K.M.'s prior visits to FCCF. On or about October 9, 2012, a clinic note containing a "Medical Assistant Intake" section was completed by "MA [M]." This same clinic note included a printed notation entitled "Report Created With Dragon Medical Voice System," but there was no dictated note attached to the note and it is not signed by a physician or physician assistant. However, a bill for the visit was paid by patient K.M. on that same date. A urine drug screen for patient K.M., dated

October 9, 2012, indicated her urine tested positive for methamphetamine, and negative for opioids and benzodiazepines. On or about October 15, 2012, patient K.M. was seen by another physician assistant at FCCF. The documented information in the progress note was essentially the same as the information previously documented by respondent for patient K.M.'s prior visits to FCCF. The treatment/plan section indicated "*PTN denies meth use, states has HTN meth use would kill me. Explained that she would have to be* [illegible] *on next visit.*" An undated and mostly blank progress note, without a patient name or vital signs, indicated that patient K.M. was "Not seen" and under the treatment/plan section, "see discharge letter." This progress note was cosigned by Dr. R.M. on or about November 21, 2012. An unsigned discharge letter dated December 14, 2012, was addressed to patient K.M. and indicated that she was being discharged from FCCF for receiving medications from more than one (1) provider.

(l) Respondent committed gross negligence in his care and treatment of patient K.M., which included, but was not limited to, the following:

(1) Respondent failed to document a comprehensive history and examination prior to initiating and/or continuing high dose chronic opioid therapy for patient K.M.;

(2) Respondent failed to document any contact and/or consult with the provider of patient K.M.'s intrathecal therapy, Dr. I, regarding her care and treatment, and the potential risks of concurrent use of opioids for long-term chronic pain management;

(3) Respondent failed to adequately document treatment plans with stated objectives for patient K.M.'s chronic pain management over eighteen (18) visits;

(4) Respondent failed to document any assessment of progress, responses and/or adverse effects of patient K.M.'s long-term opioid therapy for chronic pain management;

(5) Respondent failed to adequately document or follow-up and/or monitor

patient K.M.'s multiple lost prescriptions, and a urine drug screen that tested negative for the controlled substances prescribed to patient K.M.;

(6) Respondent failed to address with patient K.M. the fact that her two (2) urine drug screens tested negative for her prescribed medications;

(7) Respondent failed to make appropriate referral for patient K.M. for substance abuse evaluation in light of evidence of possible diversion and possible substance abuse;

(8) Respondent failed to maintain adequate and accurate medical records for patient K.M. during his care and treatment of her over eighteen (18) visits, including, but not limited to, a failure to include a focused history and/or physical examination; ongoing evaluations; consultations; assessments; lack of treatment plan for pain and/or anxiety in many notes; rationale for changes in treatment plans; lack of an interval history of patient K.M.'s pain; lack of records from the prescriber for patient K.M.'s intrathecal pump; and the missing progress note for patient K.M.'s October 9, 2012, office visit.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

25. Respondent is further subject to disciplinary action under sections 3527 and 2234, as defined by section 2234, subdivision (c), of the Code, and California Code of Regulations, Title 16, section 1399.521, subdivision (a), in that he committed repeated negligent acts in his care and treatment of patients T.T., A.W., P.H., E.R., P.P., L.A., and W.J., as more particularly alleged hereinafter:

Patient T.T.

(a) Paragraphs 24(a) and 24(b), above, are hereby incorporated by reference and realleged as if fully set forth herein.

Patient A.W.

(b) Respondent treated patient A.W. for low back pain and knee pain. Respondent saw patient A.W. at FCCF approximately five (5) times between on or

about November 14, 2011, and on or about August 17, 2012. During the course of treatment, respondent prescribed Norco and Xanax to patient A.W. Patient A.W. told respondent that she had taken Vicodin[11] for pain in the past but it was not effective in relieving her pain. On or about December 13, 2011, a lumbar x-ray of patient A.W. was ordered but there is no record that this examination ever occurred. A urine drug screen documented from patient A.W.'s initial visit on November 14, 2011, indicated "negative" results for opioids. A urine drug screen documented from patient A.W.'s last visit on August 17, 2012, indicated "negative" results for opioids, but tested "positive" for "THC."[12] Respondent's handwritten clinic notes for patient A.W. are mostly illegible.

(c) Respondent committed repeated negligent acts in his care and treatment of patient A.W., which included, but was not limited to, the following:

(1) Respondent failed to document a comprehensive history of pain, social history, or review of systems;

(2) Respondent failed to conduct a mental status examination and/or history regarding the diagnosis of anxiety disorder;

(3) Respondent failed to document whether patient A.W. had been previously prescribed opioids and/or benzodiazepines;

(4) Respondent ordered an x-ray but one was never done;

(5) Respondent failed to document any discussion with patient A.W. regarding the "negative" test results for opioids;

(6) Respondent failed to document any discussion with patient A.W.

---

[11] Vicodin is a brand name for acetaminophen and hydrocodone bitartrate, a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. Vicodin is an opioid pain medication that is used to relieve moderate to severe pain.

[12] THC, or Tetrahydrocannabinol, commonly known as marijuana, is a Schedule I controlled substance pursuant to Health and Safety Code section 11054, subdivision (d). Significantly, Patient A.W. did not have a medical marijuana card that permitted her to use marijuana based on a recommendation made by a licensed medical doctor for a diagnosed physical condition.

regarding the "positive" test results for "THC";

(7) Respondent failed to document any discussion with patient A.W. regarding the possible diversion of controlled substances;

(8) Respondent failed to document patient A.W.'s response to and/or progress in therapy;

(9) Respondent failed to document a complete examination related to patient A.W.'s initial pain complaint and during her follow-up visits; and

(10) Respondent failed to maintain legible medical records.

Patient P.H.

(d) Paragraphs 24(c) and 24(d), above, are hereby incorporated by reference and realleged as if fully set forth herein.

(e) Respondent committed repeated negligent acts in his care and treatment of patient P.H., which included, but was not limited to, the following:

(1) Respondent failed to adequately document his assessment of patient P.H.'s progress and/or whether any adverse effects to treatment had occurred;

(2) Respondent failed to adequately document a complete history and/or examination related to patient P.H.'s pain complaint at the initiation of opioid therapy; and

(3) Respondent failed to adequately document a complete history and/or examination related to patient P.H.'s reported history of anxiety.

Patient E.R.

(f) Respondent treated patient E.R. for bruised ribs. Respondent saw patient E.R. at FCCF approximately seven (7) times between on or about August 5, 2011, and on or about August 20, 2012. Although respondent's first documented visit with patient E.R. occurred on or about August 5, 2011, the CURES reports indicated that respondent had been prescribing controlled

///

///

substances to patient E.R. since in or around August, 2010.[13] However, there is no mention in the clinic notes from the first documented visit on or about August 5, 2011, of any prior prescribing by respondent. During patient E.R.'s first documented visit on or about August 5, 2011, respondent recorded a cursory pain history but did not document any past medical history, review of systems, psychiatric history, or social history. Nor did respondent document a mental status exam or history for patient E.R. that would account for a prescription of a benzodiazepine for treatment of anxiety. Respondent did order x-rays of patient E.R.'s ribs, however, there is no record that this examination ever occurred. A urine drug screen documented from patient E.R.'s visit on or about August 20, 2012, indicated "negative" test results for opioids and benzodiazepines, but tested "positive" for "THC." Notwithstanding the urine drug screen's negative test results for opiates and benzodiazepines, respondent again issued patient E.R. prescriptions for hydrocodone and alprazolam. A printed CURES report for patient E.R., dated on or about October 30, 2012, contained a handwritten notation regarding opioid prescriptions issued by a provider other than respondent, indicating, "*Discharged from clinic. Pt was warned about this! Stick with Dr.* [Y]." Respondent did not document in a clinic note or elsewhere in patient E.R.'s medical records any further explanation as to why a CURES report was obtained.

(g) Respondent committed repeated negligent acts in his care and treatment of patient E.R., which included, but was not limited to, the following:

(1) Respondent failed to adequately document patient E.R.'s pain history;

(2) Respondent failed to document patient E.R.'s medical history, review of systems, psychiatric history, or social history;

(3) Respondent failed to document a mental status exam for patient E.R.;

(4) Respondent failed to document the diagnosis and/or plan regarding the

[13] On or about August 6, 2010, patient E.R. filled a prescription issued by respondent for hydrocodone and alprazolam.

prescribing of a benzodiazepine for the treatment of anxiety;

(5) Respondent failed to document any discussion with patient E.R. regarding his negative test results for opiates and benzodiazepines in the urine drug screen; and

(6) Respondent failed to adequately document a complete history and examination of patient E.R. at initiation of opioid therapy for pain.

Patient P.P.

(h) Paragraphs 24(e) and 24(f), above, are hereby incorporated by reference and realleged as if fully set forth herein.

(i) Respondent committed repeated negligent acts in his care and treatment of patient P.P., which included, but was not limited to, the following:

(1) Respondent failed to adequately document patient P.P.'s pain history;

(2) Respondent failed to adequately document a physical examination;

(3) Respondent failed to document any prior prescribing of controlled substances to patient P.P. by respondent for care and treatment that he provided prior to on or about July 20, 2011;

(4) Respondent failed to document any past medical history, review of systems, or social history;

(5) Respondent failed to document a mental status examination and/or psychiatric history that would account for a prescription for benzodiazepines; and

(6) Respondent failed to document the results from the second urine drug screen.

Patient L.A.

(j) Paragraphs 24(g) and 24(h), above, are hereby incorporated by reference and realleged as if fully set forth herein.

(k) Respondent committed repeated negligent acts in his care and treatment of patient L.A., which included, but was not limited to, the following:

(1) Respondent failed to document a complete history and examination

prior to prescribing opioids to patient L.A. for treatment of chronic pain;

(2) Respondent failed to document a complete history and examination of patient L.A. prior to prescribing benzodiazepines for treatment of anxiety;

(3) Respondent failed to document any prior prescribing of controlled substances to patient L.A. by respondent for care and treatment that he provided prior to on or about July 15, 2011;

(4) Respondent failed to document patient L.A.'s responses to ongoing opioid therapy for intractable pain; and

(5) Respondent failed to adequately document any follow up with patient L.A. regarding "stolen medications" and "police reports."

Patient W.J.

(l) Paragraphs 24(i) and 24(j), above, are hereby incorporated by reference and realleged as if fully set forth herein.

(m) Respondent committed repeated negligent acts in his care and treatment of patient W.J., which included, but was not limited to, the following:

(1) Respondent failed to document a complete pain history, including, conducting a complete pain examination of the painful area of patient W.J.;

(2) Respondent failed to document patient W.J.'s social history and/or review of systems;

(3) Respondent failed to document patient W.J.'s psychiatric history and/or perform a mental status examination prior to the prescribing of controlled substances for pain and/or anxiety; and

(4) Respondent failed to adequately document a history and examination of patient W.J. prior to prescribing him controlled substances for the treatment of pain and/or anxiety.

///

///

///

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

26. Respondent is further subject to disciplinary action under sections 3527 and 2234, as defined by section 2234, subdivision (d), of the Code, in that he has demonstrated incompetence in his care and treatment of patients T.T., A.W., P.H., E.R., P.P., L.A., W.J., and K.M., as more particularly alleged hereinafter:

27. Paragraphs 24 and 25, above, are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Prescribing Dangerous Drugs or Controlled Substances Without an Appropriate Prior Examination and/or Medical Indication)

28. Respondent is further subject to disciplinary action under sections 3527 and 2234, as defined by section 2242, of the Code, in that he prescribed, dispensed, or furnished dangerous drugs as defined by section 4022 of the Code, without an appropriate prior examination and/or medical indication, to patients T.T., A.W., P.H., E.R., P.P., L.A., W.J. and K.M., as more particularly alleged hereinafter:

29. Paragraphs 24 through 25, above, are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Violation of State Statute or Regulation Regulating Drugs)

30. Respondent is further subject to disciplinary action under sections 3527 and 2234, as defined by section 2238, of the Code, in that he has violated a federal or state statute or regulation regulating dangerous drugs or controlled substances, as more particularly alleged hereinafter:

31. Paragraphs 24 through 25, above, are hereby incorporated by reference and realleged as if fully set forth herein.

32. Respondent repeatedly prescribed dangerous drugs as defined by Business and Professions Code section 4022, to patients T.T., A.W., P.H., E.R., P.P., L.A., W.J. and K.M., without an appropriate prior examination and a medical indication, in violation of Business and

Professions Code section 2242.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

33. Respondent is further subject to disciplinary action under sections 3527 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records regarding his care and treatment of patients T.T., A.W., P.H., E.R., P.P., L.A., W.J. and K.M., as more particularly alleged hereinafter:

34. Paragraphs 24 through 25, above, are hereby incorporated by reference and realleged as if fully set forth herein.

SEVENTH CAUSE FOR DISCIPLINE

(Unlicensed Practice of Medicine)

35. Respondent is further subject to disciplinary action under sections 3527, 3502, 2052, 2234, 2286, 2400 and California Code of Regulations, title 16, section 1399.545, in that he engaged in the unlicensed practice of medicine, as more particularly alleged hereinafter:

36. On May 6, 2011, articles of incorporation were filed in the Office of the Secretary of State of the State of California, which incorporated the entity "First Choice Clinica Familiar, A Professional Corporation," (FCCF) and described the purpose of the corporation as, "... *to engage in the Profession of Medicine and any other lawful activities (other than the banking or trust company business) not prohibited to a corporation engaging in such profession by applicable laws and regulations*."

37. On November 17, 2011, a statement of information was filed on behalf of FCCF with the Office of the Secretary of State of the State of California, and it identified "Billy Earley" as the "Chief Executive Officer," "Secretary," and "Chief Financial Officer" of FCCF. It was signed by respondent, under the title of "President" of FCCF, on June 2, 2011.

38. On August 30, 2012, a statement of information was filed on behalf of FCCF with the Office of the Secretary of State of the State of California, and it indicated that

there had been no change in any of the information contained in the last statement of information filed with the California Secretary of State. Respondent completed this form under the title of "President" of FCCF.

39. In or around the summer of 2011, a business license application was filed on behalf of FCCF with the Business License Division of the City of Corona. The application was completed and signed by respondent under the title of "Owner" of FCCF, and, wherein, he described FCCF's business activity as "*Family Medical Clinic*." Respondent signed the business license application on or about June 9, 2011. According to FCCF's business license tax account information with the City of Corona, FCCF's start date for business was June 30, 2011.

40. On or about October 18, 2012, the Medical Board of California confirmed that FCCF had not been issued a Fictitious Name Permit. In fact, no fictitious name permit was ever filed or obtained by FCCF from any licensing board/committee. At all times relevant to the charges and allegations in this Accusation, respondent was the sole owner and shareholder of FCCF.

41. Sometime prior to on or about June 30, 2011, respondent met R.M., a licensed physician. Respondent was referred to R.M. by some of his patients who had told him about R.M., and that they had been referred to R.M.'s clinic for medical marijuana. At some point, respondent met with R.M., and then he subsequently hired R.M. for the position of FCCF's supervising physician. Although R.M. was hired as a "Supervising Physician" to directly supervise respondent at FCCF, he was paid by respondent to perform his role as a Supervising Physician at FCCF. R.M. held no ownership interest in FCCF, had no authority to hire and/or fire FCCF employees, did not set work schedules for FCCF employees, did not sign paychecks for FCCF employees, did not conduct any competency evaluations of FCCF employees, including medical assistants, related to their job performance and/or adequacy of their training, and never saw patients at FCCF.

42. Pursuant to the Delegation of Services Agreement (DSA) between R.M. and respondent, R.M. was to review, audit, and countersign every medical record written by

respondent within seven (7) days of the encounter. The DSA did not establish a schedule under which R.M. would be physically present at FCCF. Significantly, regarding controlled substances, the DSA indicated, "*Drug orders shall either be based on protocols established or adopted by Supervising Physician, or shall be approved by Supervising Physician for the specific patient prior to being issued or carried out. Notwithstanding the foregoing, all drug orders for Controlled Substances shall be approved by Supervising Physician for the specific patient prior to being issued or carried out.*" (Emphasis added.) Lastly, the DSA indicated that R.M. had authorized respondent to "... *perform all tasks set forth in subsections (a), (b), (c), (d), (e), (f), and (g) of Section 1399.541 of the Physician Assistant Regulations, subject to the limitations and conditions described in this Agreement or established by Supervising Physician in any applicable protocols or otherwise.*" The DSA did not authorize respondent to supervise any other licensed or non-licensed medical staff at FCCF, including, but not limited to, medical assistants working at FCCF.

43. Pursuant to undated and unsigned protocols for FCCF, the general principles of pain management were established for treating patients seeking chronic pain management at FCCF. The protocols identified the principles of pain management, and included steps for FCCF's pain management team to follow. R.M.'s full typewritten name appears on the last page of the protocols under the title, "Medical Director." The protocols did not authorize respondent to supervise any other licensed or non-licensed medical staff at FCCF including, but not limited to, medical assistants working at FCCF. Lastly, the protocols did not establish a schedule under which R.M. will be physically present at FCCF.

44. At all times relevant to the charges and allegations in this Accusation, FCCF employed numerous medical assistants, including, but not limited to, E.H., E.M., E.S., and M.F. Respondent was responsible for interviewing and hiring all employees at FCCF, including, E.H., E.M., E.S., and M.F., was responsible for writing and signing FCCF's employee paychecks, was responsible for setting FCCF employee's work schedules and

granting vacation time off, and was responsible for supervising FCCF's medical assistants. FCCF's medical assistants were allowed to routinely perform various medical services at FCCF including, but not limited to, intravenous placement on patients even though no Supervising Physician was physically present at FCCF when the services were being performed.

EIGHTH CAUSE FOR DISCIPLINE

(Aiding and Abetting the Unlicensed Practice of Medicine)

45. Respondent is further subject to disciplinary action under sections 3527, 2052, 2069, 2234, and 2264, in that he aided and abetted the unlicensed practice of medicine, as more particularly alleged hereinafter:

46. Paragraphs 35 through 43, above, are hereby incorporated by reference and realleged as if fully set forth herein.

NINTH CAUSE FOR DISCIPLINE

(Practicing Under False or Fictitious Name Without Fictitious Name Permit)

47. Respondent is further subject to disciplinary action under sections 3527, 2285, 2286, 2400, 2406, and 2415, in that he practiced medicine under a fictitious name without a fictitious name permit issued by the licensing agency, as more particularly alleged hereinafter:

48. Paragraphs 35 through 43, above, are hereby incorporated by reference and realleged as if fully set forth herein.

TENTH CAUSE FOR DISCIPLINE

(Improper Supervision of Medical Assistants)

49. Respondent is further subject to disciplinary action under sections 3527, 2227 and 2234, as defined by section 2069, of the Code, in that he supervised medical assistants without authorization from a licensed supervising physician and surgeon, as more particularly alleged hereinafter:

50. Paragraphs 35 through 43, above, are hereby incorporated by reference and realleged as if fully set forth herein.

///

ELEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

51. Respondent is further subject to disciplinary action under sections 3527, 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged hereinafter:

52. Paragraphs 24 through 49, above, are hereby incorporated by reference and realleged as if fully set forth herein.

TWELFTH CAUSE FOR DISCIPLINE

(Violation of the Medical Practice Act)

53. Respondent is further subject to disciplinary action under sections 3527, 2227 and 2234, as defined by section 2234, subdivision (a), of the Code, in that he has violated or attempted to violate, directly or indirectly, assisted in or abetted the violation of, or conspired to violate a provision or provisions of the Medical Practice Act, as more particularly alleged hereinafter:

54. Paragraphs 24 through 51, above, are hereby incorporated by reference and realleged as if fully set forth herein.

///

///

///

///

///

///

///

///

///

///

PRAYER

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

1. Revoking or suspending Physician Assistant License Number PA 15350, issued to respondent Billy Zachery Early, P.A.;

2. Ordering respondent Billy Zachery Early, P.A., to pay the Physician Assistant Board of California the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring; and,

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

DATED: December 19, 2014

GLENN L. MITCHELL, JR.
Executive Officer
Physician Assistant Committee
State of California
Complainant

SD2014708189
Doc.No.80986096