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

In the Matter of the Second Amended Accusation Against:	)	
RUDOLPHO J. ALEGRIA, M.D.	)	**Case No. 09-2009-203411**
	)	**OAH No. 2013010754**
Physician's and Surgeon's Certificate No. A37049	)	
Respondent.	)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on December 31, 2014.

IT IS SO ORDERED July 14, 2014.

MEDICAL BOARD OF CALIFORNIA

By: 
Kimberly Kirchmeyer
Executive Director

KAMALA D. HARRIS
Attorney General of California
THOMAS S. LAZAR
Supervising Deputy Attorney General
MARTIN W. HAGAN
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Attorneys for Complainant

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

In the Matter of the Second Amended Accusation Against: **RUDOLPHO J. ALEGRIA, M.D.** **82-420 Miles Avenue** **Indio, CA 92201** **Physician's and Surgeon's Certificate No. A37049** Respondent.	Case No. 09-2009-203411 OAH No. 2013010754 **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. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Martin W. Hagan, Deputy Attorney General.

2. RUDOLPHO J. ALEGRIA, M.D. (Respondent) is represented in this proceeding by attorney Peter R. Osinoff, Esq., of Bonne Bridges Mueller O'Keefe and Nicholls whose address is 3699, Wilshire Boulevard, Tenth Floor, Los Angeles, CA 90010-2719.

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3. On July 15, 1981, the Medical Board of California issued Physician's and Surgeon's Certificate No. A37049 to RUDOLPHO J. ALEGRIA, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges and allegations brought in Second Amended Accusation No. 09-2009-203411 and will expire on March 31, 2015, unless renewed.

JURISDICTION

4. On June 4, 2012, Accusation No. 09-2009-203411 was filed against Respondent before the Medical Board of California (Board), Department of Consumer Affairs. On June 4, 2012, Respondent was properly served with a true and correct copy of Accusation No. 09-2009-203411, together with true and correct copies of all other statutorily required documents, at his address of record on file with the Board which was and is: 84-420 Miles Avenue, Indio, CA, 92201. On or about June 8, 2012, a Notice of Defense was filed on Respondent's behalf by his then attorney of record, Tracy Green, Esq.

5. On May 28, 2013, First Amended Accusation No. 09-2009-203411 was filed against Respondent before the Board. On May 28, 2013, a true and correct copy of the First Amended Accusation, along with true and correct copies of a Supplemental Statement to Respondent and further Request for Discovery, were properly served on Respondent at his address of record on file with the Board which was and is: 84-420 Miles Avenue, Indio, CA, 92201.

6. On April 29, 2014, Second Amended Accusation No. 09-2009-203411 was filed before the Board and is currently pending against Respondent. On April 29, 2014, a true and correct copy of the Second Amended Accusation, along with true and correct copy of a Supplemental Statement to Respondent, were properly served on Respondent at his address of record on file with the Board which was and is: 84-420 Miles Avenue, Indio, CA, 92201. A true and correct copy of Second Amended Accusation No. 09-2009-203411 is attached hereto as Exhibit A and incorporated by reference as if fully set forth herein.

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ADVISEMENT AND WAIVERS

7. Respondent has carefully read, fully discussed with counsel, and fully understands the charges and allegations in Second Amended Accusation No. 09-2009-203411. Respondent also has carefully read, fully discussed with counsel, and fully understands the effects of this Stipulated Surrender of License and Disciplinary Order.

8. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Second Amended Accusation No. 09-2009-203411; 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.

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

CULPABILITY

10. Respondent does not contest that, at an administrative hearing, complainant could establish a *prima facie* case with respect to the charges and allegations contained in Second Amended Accusation No. 09-2009-203411, a true and correct copy of which is attached hereto as Exhibit "A," and that he has thereby subjected his Physician's and Surgeon's Certificate No. A37049 to disciplinary action. Respondent hereby surrenders his Physician's and Surgeon's Certificate No. A37049 for the Board's formal acceptance. Respondent's surrender of his Physician's and Surgeon's Certificate No. A37049 shall become effective on December 31, 2014.

11. Respondent further agrees that if he ever petitions for reinstatement of his Physician's and Surgeon's Certificate No. A37049, or if an accusation and/or petition to revoke probation is filed against him before the Medical Board of California, all of the charges and allegations contained in Second Amended Accusation No. 09-2009-203411 shall be deemed true, correct, and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California or elsewhere.

12. Respondent understands that by signing this stipulation he enables the Executive Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his Physician's and Surgeon's Certificate No. A37049 without further notice or opportunity to be heard.

CONTINGENCY

13. 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."

14. This Stipulated Surrender of License and Disciplinary Order shall be subject to approval of the Executive Director on behalf of the Medical Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for her consideration in the above-entitled matter and, further, that the Executive Director 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 the Executive Director, on behalf of the Medical Board, considers and acts upon it.

15. 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 Director on behalf of the Board, 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 Director and/or the Board 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 Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Executive Director on behalf of the Board does not, in her discretion, 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 this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, Respondent will assert no claim that the Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

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

17. The parties agree that copies of this Stipulated Surrender of License and Disciplinary Order, including 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.

18. In consideration of the foregoing admissions and stipulations, the parties agree the Executive Director of the Medical Board may, without further notice to or opportunity to be heard by Respondent, issue and enter the following Disciplinary Order on behalf of the Board:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A37049, issued to Respondent RUDOLPHO J. ALEGRIA, M.D., is surrendered and accepted by the Medical Board of California.

1. The effective date of this Decision and Disciplinary Order shall be December 31, 2014.

2. The surrender of Respondent's Physician's and Surgeon's Certificate No. A37049 and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Medical Board of California.

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

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

5. If Respondent ever applies for licensure or petitions 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 licensure in effect at the time the application or petition is filed, and all of the charges and allegations contained in Second Amended Accusation No. 09-2009-203411 shall be deemed to be true, correct and fully admitted by Respondent when the Board determines whether to grant or deny the application or petition.

6. 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 or elsewhere, all of the charges and allegations contained in Second Amended Accusation No. 09-2009-203411 shall be deemed to be true, correct, and fully admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

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ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Disciplinary Order and have fully discussed it with my attorney, Peter R. Osinoff, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. A37049. 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 Medical Board of California.

DATED: 5/16/14

RUDOLPHO J. ALEGRIA, M.D.
Respondent

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

DATED: 5/16/14

PETER R. OSINOFF, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: 5-16-2014

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
THOMAS S. LAZAR
Supervising Deputy Attorney General

MARTIN W. HAGAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Second Amended Accusation No. 09-2009-203411

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Attorneys for Complainant

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

In the Matter of the Second Amended Accusation Against: **RUDOLPHO J. ALEGRIA, M.D.** **82-420 Miles Avenue** **Indio, CA 92201** **Physician's and Surgeon's Certificate No. A37049** Respondent.	Case No. 09-2009-203411 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberley Kirchmeyer (Complainant) brings this Second Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about July 15, 1981, the Medical Board of California issued Physician's and Surgeon's Certificate Number A37049 to RUDOLPHO J. ALEGRIA, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2015, unless renewed.

JURISDICTION

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

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, be publically reprimanded, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states:

"The board shall take action against any licensee who is charged with unprofessional conduct.[1] 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 [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

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

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

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but

[1] Unprofessional conduct has been defined as conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 654.)

not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

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

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

"...."

6. Section 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."

7. Section 2261 of the Code states:

"Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

8. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

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

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as

necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

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

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

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

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

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

9. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon...

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

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

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

10. 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."

11. Section 2241 of the Code states:

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

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

". . . ."

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INTRODUCTION

12. On or about December 17, 2008, the United States Department of Drug Enforcement Administration, Office of Diversion Control, Riverside District Office (DEA), received information that an individual identified as Rudolpho J. Alegria, M.D., "would prescribe anything to anyone without a medical examination." The DEA received a subsequent tip from a Source of Information indicating that "Dr. Alegria would prescribe methadone[2] in tablet form to opiate addicted patients." A review was conducted of respondent's prescribing history, by using a Controlled Substance Utilization Review and Evaluation System (CURES) report for the period November 1, 2007, through May 14, 2008. This review indicated that respondent wrote approximately 4,398 prescriptions for patients during this six-month period. The DEA initiated an investigation against respondent on or about April 30, 2009, which was assigned to DEA Diversion Investigator A.A., as the lead investigator. Further investigation, as discussed more fully herein, revealed additional serious concerns over respondent's prescribing of controlled substances and dangerous drugs.

13. On or about June 9, 2009, S.B., a licensed vocational nurse (LVN) at a methadone clinic reported that respondent was prescribing methadone tablets to opiate addicted patients for "pain management." S.B. stated that several patients of the methadone clinic, while still participating in the program and receiving daily doses of methadone, obtained prescriptions from respondent which put the patients at high risk of overdosing.[3] S.B. reported the clinic made

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[2] Methadone (Dolophine Hydrochloride) is a Schedule II Controlled Substance under Health and Safety Code section 11055(c) (14) and a dangerous drug under Code section 4022 (a). On November 27, 2006, the United States Federal Drug Administration (FDA) issued "Public Health Advisory: Methadone Use for Pain Control May Result in Death and Life-Threatening Changes in Breathing and Heart Beat." The public health advisory warned, in pertinent part, that "FDA has received reports of death and life-threatening side effects in patients taking methadone for pain control and in patients who have switched to methadone after being treated for pain with other strong narcotic pain relievers. Methadone can cause slow or shallow breathing and dangerous changes in heart beat that may not be felt by the patient."

[3] "Between 1999 and 2009, the rate of fatal overdoses involving methadone increased more than fivefold as its prescribed use for treatment of pain increased" and "[r]ecent analyses have shown that methadone was involved in one in three opioid-related deaths in 2008." (Vital Signs: Risk of Overdose from Methadone Used for Pain Relief – United States, 1999-2010, Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report (MMWR) Volume 61, No. 26, dated July 6, 2012.)

several attempts to contact respondent regarding this practice without any success due to a lack of cooperation by respondent and his staff.

14. On or about June 29, 2009, DEA Diversion Investigator A.A. obtained a patient profile history for A.M., who at the time was 29 years old. According to the profile, A.M. filled prescriptions from respondent for 390 tablets of methadone 10 mg on a consistent monthly basis with a prescription for Oxycodone 15 mg being filled on June 22, 2009.[4] Shortly thereafter, A.M. was interviewed and stated, among other things, that she obtained the Methadone and Oxycodone from respondent. A.M. further stated respondent never instructed her on how to take the medications, never warned her of the long term effects of taking pain medication, and never discussed any type of treatment plan to wean her off the medications. According to A.M., the first and only time she was examined by respondent was May 27, 2009.

15. On or about July 30, 2009, agents from the DEA Riverside Diversion Unit obtained additional information from a source associated with a narcotic treatment program (NTP) in Palm Springs, California, who advised them respondent was known to prescribe methadone for "pain" to addicts without valid justification or medical indication. DEA Diversion Investigator A.A. conducted a subsequent interview with the source who indicated that when NTP patients find a physician who will prescribe methadone outside of the NTP they typically will not return to the NTP. The source identified at least ten (10) patients that the NTP had lost to respondent. The source also stated several patients, prior to initiating treatment at the NTP had tested positive for methadone which indicated methadone in tablet form was available for purchase on the street.

16. On or about August 18, 2009, DEA Diversion Investigator A.A. interviewed a clinic director of another NTP located in Palm Springs, California. This source indicated, among other things, that she was aware of respondent through several of her patients who reported respondent prescribed methadone for "pain." The source provided information on patients who had been terminated from her NTP who were possibly patients of respondent. Further investigation

[4] The patient profile for A.M. indicated that Methadone 10 mg prescriptions from respondent being filled on October 21, 2008, November 11, 2008, January 9, 2009, February 9, 2009, March 12, 2009 and April 8, 2009.

revealed that some of the patients were, in fact, receiving methadone and other controlled substances and dangerous drugs from respondent.

17. On or about September 2009 through December 2009, DEA Diversion Investigator A.A. obtained information and documents from the Riverside County Coroner concerning patient deaths for patients who had received controlled substances from respondent:

(a) Patient J.M. died in 2008 from a suspected overdose. Respondent prescribed J.M. hydrocodone and alprazolam (Xanax).[5] The Deputy Coroner later confirmed J.M. died of natural causes unrelated to the controlled substances. However, the Deputy Coroner, indicated respondent had, on occasion, prescribed hydrocodone and alprazolam to J.M. at inappropriate intervals.

(b) Patient J.O. died on May 18, 2009, from acute alprazolam and morphine intoxication.[6] J.O. was last seen by respondent on March 13, 2009. A review of the CURES report for J.O. indicated he began filling prescriptions from respondent for alprazolam, morphine and other controlled substances on September 3, 2008, for approximately nine months; with additional prescriptions for alprazolam and morphine sulfate being filled in March and May 2009. Prior to his death on May 18, 2009, J.O. received a prescription for 90 tablets of alprazolam 90 mg and 90 tablets of morphine sulfate 15 mg from respondent. These prescriptions were filled on May 13, 2009 (five days before J.O. died).

(c) Patient C.C. died of acute methadone intoxication on August 25, 2009. Respondent prescribed C.C. methadone and alprazolam (Xanax). According to DEA Diversion Investigator A.A.'s report of investigation, the inventory of the

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[5] Alprazolam (Xanax), a benzodiazepine, is a Schedule IV Controlled Substance under Health and Safety Code section 11057(d)(1) and a dangerous drug under Code section 4022 (a).

[6] As noted by the CDC, in one of their weekly Morbidity and Mortality Reports, there is a distinct risk in prescribing methadone and alprazolam (Xanax), an antianxiety agent. The "primary disadvantages [of methadone] are its long and unpredictable half-life and associated risk for accumulating toxic levels leading to severe respiratory depression; its multiple interactions with other drugs, including frequently abused drugs such as antianxiety agents; and its ability to cause major disturbances of cardiac rhythm." (*Id.*, Vital Signs: Risk of Overdose from Methadone Used for Pain Relief – United States, 1999-2010, at p. 494.)

controlled substances taken by the Deputy Coroner revealed the levels of use were inappropriate. On August 18, 2009 (five days before C.C. died), respondent prescribed C.C. 150 tablets of methadone 10 mg; and 90 tablets of alprazolam (Xanax). There were 23 tablets of methadone and 54 tablets of alprazolam remaining at the time of C.C.'s death.

(d) Patient H.A. was involved in an early morning traffic accident on December 24, 2009, and was pronounced dead at the scene of the accident. Respondent prescribed patient H.A. 180 tablets of methadone 10 mg which H.A. filled on December 17, 2009.[7] A subsequent autopsy listed the cause of death for patient H.A. as acute methadone and alcohol intoxication and accident.

18. On or about April 2, 2010, DEA Diversion Investigator A.A. obtained information from the Palm Springs Police Department concerning B.W. and the death of his friend which involved alcohol and drugs. B.W. reported to a Palm Springs Detective that he started taking Vicodin, Xanax, Ecstasy and Oxycontin in approximately 2007 when he was fifteen (15) years old. In approximately 2009, B.W.'s friend took him to a physician in Indio "who gives out prescriptions with no questions asked."[8] B.W. identified the doctor as respondent who would prescribe Methadone and Xanax without running any tests and without obtaining a complete medical history.

19. On or about September 29, 2009 through June 17, 2010, the DEA ran five (5) undercover operations against respondent which are discussed more fully herein.

20. On or about October 13, 2011, representatives from the Inland Empire Health Plan (IEHP), a State health care provider, conducted an in-office medical audit on a random sample of thirteen (13) of respondent's patient files. The "Narcotic Drug Review" memorandum regarding

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[7] The Deputy Coroner's inventory of controlled substances also included other methadone prescriptions from a Dr. T. that had been filled in September, October and November 2009.

[8] A cross-reference with a CURES report for the period of November 1, 2008, to February 1, 2010, indicates B.W. filled the following prescriptions from respondent: alprazolam, 20 mg (#90) and methadone hydrochloride, 10 mg (#180) on December 14, 2009; and alprazolam, 20 mg (#90) and methadone hydrochloride, 10 mg (#210) on February 14, 2010.

the audit identified respondent as being "on the top 10 narcotic prescriber report [for the] last several years." The summary section of the "Narcotic Drug Review" memorandum stated:

> "After reviewing 13 patient records, it is clear that Dr. Alegria provided excessive narcotic prescriptions for his patients. In most cases, no pain related issues were identified. When [a] pain condition was documented, no evaluation was recorded such as pain scale, examination, evaluation and treatment plan. It was unclear why the treatment was initiated and continued for the condition. High potency narcotics were used without valid diagnoses. Poor documentation was also noted for non-pain chronic issues."

21. On or about October 13, 2010, the DEA served respondent with an Order to Show Cause and Immediate Suspension of Registration which suspended respondent's DEA Registration No. AA1285318.

22. On or about January 11, 2011, respondent voluntarily surrendered his DEA Registration No. AA1285318 in lieu of an Administrative Hearing for an Order to Show Cause to revoke his DEA registration.[9]

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

23. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subsection (b) of the Code, in that respondent committed gross negligence as more particularly alleged below:

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[9] Shortly after respondent surrendered his DEA certificate, DEA Diversion Investigator A.A. received a report prepared by Dr. J.G., identified as a Diplomat of the American Boards of Internal Medicine, Addiction Medicine and Pain Medicine, which set forth the results of his review of ten (10) of respondent's patient's files. This report noted, in pertinent part, "Dr. Alegria's medical records for the ten patients I reviewed share the following characteristics: [¶] His handwriting in extremely difficult to read and often completely illegible. [¶] He virtually never records sufficient information in the medical history or physical examination to provide a basis for the diagnosis or treatment of any condition. His notes are extremely skeletal and inadequate. Only in one patient, [A.M.], was there an adequate basis to evaluate and treat her chronic pain, and that came solely from an outside pain management specialty clinic. [¶] His stated diagnoses are most often just statements of symptoms, e.g., low back pain. A symptom is not a medical diagnosis. The role of a physician is to find and treat the cause of symptoms. [¶] He prescribed controlled drugs for patients who are addicts, even when he recorded "substance abuse" as a diagnosis. Seven of the ten patients I reviewed were definite or probable addicts: [list of names]. [¶] In two other patients, [patient names], Dr. Alegria provided the opiates and sedatives most prized by addicts without any evidence their use was warranted. [¶] For those reasons, and with the exception of [A.M.], Dr. Alegria prescribed controlled drugs to these patients without legitimate medical indication, and outside the usual course of medical practice."

DEA AGENT B.S.

24. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subsection (b) of the Code, in that respondent committed gross negligence in his care and treatment of B.S. as more particularly alleged hereinafter:

25. On or about September 29, 2009, DEA agent B.S. acting as an undercover operative under the undercover name "Brian Lowman," presented at respondent's medical offices located at 82-420 Miles Avenue in Indio. B.S. paid $80.00 for the visit. B.S. was initially attended to by a physician assistant (PA) who took his blood pressure, weight and height and sent him to the treatment room. In the treatment room, B.S. told respondent he wanted a prescription for Methadone, Oxycontin[10] and Xanax for his back pain. B.S. stated he hurt his back from an automobile accident a year earlier and that the injury was aggravated when he slipped and fell on some stairs. Respondent asked B.S. how much Methadone and Oxycontin he was taking. B.S. stated he was taking 100 milligrams of Methadone and 80 milligrams of Oxycontin a day, and that the drugs had been prescribed for him by a "Dr. Lister." Respondent told B.S. he could not prescribe Oxycontin without reviewing Dr. Lister's records, and in any case, would not prescribe Oxycontin and Xanax together for a patient of B.S.'s age because the state authorities were specifically "looking for Oxycontin and Xanax prescriptions given to younger people." B.S. told respondent he could examine his back to justify the prescription if he wished, but respondent said he did not need to. Respondent agreed to prescribe Methadone and Xanax but told B.S. he should bring Dr. Lister's records with him on the next visit. Respondent wrote a prescription for 300 Methadone 10 mg and 90 tablets of Xanax 1 mg for B.S. and recommended that B.S. could fill the prescription at a nearby pharmacy known as McIntosh Pharmacy. Respondent failed to provide adequate informed consent regarding, among other things, the risks and benefits of the use of controlled substances and other possible treatment modalities. B.S. had the prescriptions filled at McIntosh Pharmacy.

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[10] Oxycontin (Oxycodone) is a Schedule II Controlled Substance under Health and Safety Code section 11055(b)(1)(L) and a dangerous drug under Code section 4022 (a).

26. In his chart note of the September 29, 2009 visit,[11] respondent noted he performed a physical exam which showed B.S. had "Tender Post Neck" and "Back/Spine-L4-5 para-spinal areas." Respondent listed diagnoses for B.S. which included "Chronic Cervical strain due to whiplash" and "Anxiety/Stress." Respondent's medical documentation was false because respondent did not perform any physical examination, B.S. never complained of "whiplash" or that he was suffering from any stress and/or anxiety, the diagnoses were not based on any physical examination or any diagnostic tests and there was no reasonable justification for charting B.S. suffered from these conditions.

27. On or about November 10, 2009, B.S. made a return visit to respondent's offices in his undercover capacity. He paid $50.00 for the visit. B.S. was initially attended to by a PA who took his blood pressure, weight and height. At one point, the PA asked B.S. "are you always high?" B.S. informed the PA he was not in pain but wanted his prescription refilled. Respondent attended to B.S. Respondent told B.S. he had not received the medical records from Dr. Lister. B.S. stated he thought the medical records were only necessary if he wanted a prescription for Oxycontin. Among other things, respondent stated he could not prescribe Methadone to B.S. without "some records," that the 300 tablets of Methadone was an "extremely high dose" for a patient of B.S.'s age and that he was required to follow the state prescribing guidelines. However, respondent agreed to prescribe Methadone and Xanax for B.S. "one more time." He advised B.S. to have "lab work" done before the next visit. Respondent wrote a prescription for 300 tablets of Methadone 10 mg and 90 tablets of Xanax 2 mg. Respondent failed to provide adequate informed consent regarding, among other things, the risks and benefits of the use of controlled substances and other possible treatment modalities. B.S. filled the prescriptions at McIntosh Pharmacy.

28. In his chart note for the November 10, 2009 visit, respondent falsely documented that B.S. complained of "continued back pain" and that he performed a physical examination which was unremarkable. Respondent diagnosed B.S. as suffering from low back pain. Respondent's

[11] Respondent incorrectly noted September 26, 2009 as the date of service in his typewritten chart note.

medical documentation was false because B.S. did not complain of continued back pain, respondent did not perform any physical examination, and the diagnosis of low back pain was not based on any physical examination or any diagnostic tests and there was no reasonable justification for charting B.S. suffered from this condition.

29. On or about March 25, 2010, B.S. made a return visit to respondent's offices in his undercover capacity. He paid $50.00 for the visit. The receptionist told B.S. there was a "big note" in his medical file stating respondent wanted "labs done." B.S. showed the receptionist an x-ray he brought with him but the receptionist said respondent's instructions were that B.S. should not be scheduled for an appointment without "records or labs." Subsequently, B.S. was seen by a PA who also told B.S. respondent would not see him without his medical records or "lab work." However, the PA told B.S. to wait while he checked with respondent. When he returned, the PA told B.S. respondent would prescribe medications for him but a urine sample would have to be obtained. The PA took B.S.'s blood pressure, weight, height and urine sample[12] and sent him to the waiting room to be seen by respondent. When respondent entered the waiting room, he asked B.S. how he was doing and B.S. responded he was doing "alright" and he had "been better." B.S. also stated he had not been able to find Dr. Lister, that he had been to a "methadone clinic" but did not complete the "paper work" for enrollment because he did not feel comfortable at the clinic. B.S. told respondent that he was able to get an X-ray "from one of my friends who was with Dr. Lister and that's all I could get." After further discussion, respondent prescribed 300 tablets of Methadone 10 mg, 90 tablets of Xanax 2 mg and a blood pressure medication for B.S. Respondent failed to provide adequate informed consent regarding, among other things, the risks and benefits of the use of controlled substances and other possible treatment modalities and during the course of treatment failed to seek consultation from and/or provide a referral to the appropriate medical specialist(s).

30. In his chart note for the March 25, 2010 visit, respondent falsely indicated B.S. complained of "increased low back pain, still with anxiety" and that he performed a physical

[12] There were no urine screen results contained in the medical records for B.S.

examination which was unremarkable during the visit. Among other things, respondent diagnosed B.S. as suffering from "chronic back pain." Respondent's chart notes were false because B.S. did not complain of increased back pain or anxiety/stress, respondent did not perform any physical examination, and the diagnoses of "chronic back pain" and anxiety were not based on any physical examination or any diagnostic tests and there was no reasonable justification for charting B.S. suffered from these conditions.

31. Respondent committed gross negligence in his care and treatment of B.S., which included, but was not limited to, the following:

(a) Respondent repeatedly prescribed large amounts of Methadone and Xanax medications to B.S. without adequate justification and without an adequate history and physical examination including, but not limited to, obtaining a more detailed history, reviewing and verifying prior medical treatment, conducting a more thorough review of symptoms and/or more accurately assessing the patient's actual condition;

(b) Respondent repeatedly prescribed large amounts of Methadone and Xanax medications to B.S. without adequate justification and without clearly documenting an adequate treatment plan with stated objectives for the patient's care and treatment in regard to the narcotics and controlled substances that were prescribed;

(c) Respondent repeatedly prescribed large amounts of Methadone and Xanax medications to B.S. without adequate justification and without adequate informed consent of the various risks associated with the narcotics and controlled substances that were being prescribed and the possibility of alternative non-narcotic therapies;

(d) Respondent repeatedly prescribed large amounts of Methadone and Xanax medications to B.S. without seeking appropriate consultation from, or referring the patient to, the appropriate medical specialists;

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(e) Respondent repeatedly prescribed large amounts of Methadone and Xanax medications to B.S. without utilizing urine drug screens and/or other risk screening tools.

(f) Respondent failed to maintain, in whole or part, legible, complete, adequate, and/or accurate medical records concerning, among other things, B.S.'s medical history and physical examination, other evaluations and/or treatments, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient and/or periodic reviews of the treatment plan;

(g) Respondent made false medical record entries for patient B.S.'s visit of September 29, 2009, when he, among other things, documented he performed a physical examination of the patient pain, documented pain associated with "Tender Post Neck" and "Back/Spine-L4-5 para-spinal areas" and documented impressions of "Chronic Cervical strain due to whiplash" and "Anxiety/Stress." Respondent's medical record entries were false because, among other things, respondent did not perform a physical examination and there was no reasonable justification for documenting the aforementioned conditions and diagnoses;

(h) Respondent made false medical record entries for patient B.S.'s visit of November 10, 2009, when he, among other things, documented the patient complained of back pain during the visit and listed his diagnosis of back pain. Respondent's medical record entries were false because, among other things, B.S. did not complain of continued back pain, respondent did not perform a physical examination, and there was no reasonable justification for documenting the aforementioned condition and diagnosis; and

(i) Respondent made false medical record entries for patient B.S.'s visit of March 25, 2010, when he, among other things, documented B.S. complained of "increased low back pain, still with anxiety" during the visit and when he diagnosed B.S. as suffering from chronic back pain. Respondent's medical record

entries were false because, among other things, B.S. did not complain of increased back pain or anxiety, respondent did not perform a physical examination, and there was no reasonable justification for documenting the aforementioned conditions and diagnosis.

DEA AGENT M.J.

32. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subsection (b) of the Code, in that respondent committed gross negligence in his care and treatment of M.J. as more particularly alleged hereinafter:

33. On or about May 11, 2010, DEA agent M.J. acting as an undercover operative under the undercover name Michael Lopez, presented at respondent's offices located at 82-420 Miles avenue in Indio.[13] M.J. requested to see the "doctor" because he needed a prescription for Methadone. He was initially attended to by a female medical assistant who took his temperature, blood pressure, weight and height. M.J. gave a "medical history" that included heroin use "on and off" for seven to eight years, smoking a pack of cigarettes a day, and Methadone and Valium[14] use. M.J. denied experiencing any pain and stated he wanted Methadone because he was "just jonesin." [15] M.J. paid $80.00 for the visit. Respondent attended to M.J. and asked M.J. why he needed Methadone "right now." M.J. told respondent that he was "just jonesin" and had been using Methadone he obtained from friends, that he had not seen a doctor in awhile because he had no money and that he was not in pain, but was "jonesin." Respondent placed two fingers on M.J.'s left upper chest and listened to his breathing. Respondent stated, among other things, that he could only prescribe Methadone for pain and asked M.J. if he had any kind of pain. M.J. asked if "jonesin" counted as pain. Respondent said "No, cause that is just withdrawals." Respondent again asked M.J. if he had any pain such as lower back pain or joint pain. M.J. did

[13] M.J. was accompanied by another DEA Agent.

[14] Valium (Diazepam) is a Schedule IV Controlled Substance under Health and Safety Code section 11057(d)(9) and a dangerous drug under Code section 4022 (a).

[15] "Jonesin" or "jonesing" was originally used to describe withdrawal symptoms caused by addiction. It is defined as an intense withdrawal or craving for a drug.

not respond to the inquiries about lower back pain and joint pain and asked "does a headache count?" Respondent replied "Well, I guess - that is not a good reason to give Methadone for though [followed by laughter]."[16] Respondent then prescribed 270 tablets of Methadone 10 mg for M.J. Respondent failed to provide adequate informed consent regarding, among other things, the risks and benefits of the use of controlled substances and other possible treatment modalities.

34. In his chart note for the May 11, 2010 visit, respondent noted M.J.'s "Back/Spine-Tender" on examination and "Paraspinal once." Respondent charted that M.J. "c/o [complained of] chronic LBP [low back pain] x 5 years" and listed one of his impressions as "chronic low back pain" despite the fact that M.J. reported several times that he was just "jonesin," failed to report any "problems" with his "muscles and bones" or lower back on his Adult History Health Questionairre and never subjectively complained of any low back pain or "chronic low back pain" during the course of his visit with respondent. Respondent's medical documentation was false because respondent did not perform any physical examination, M.J. never complained of suffering from low back pain, the diagnoses were not based on any physical examination or any diagnostic tests and there was no reasonable justification for charting M.J. suffered from this condition.

35. On or about June 17, 2010, M.J. made a return visit to respondent's offices in his undercover capacity. M.J. requested a refill of his Methadone. He was initially attended to by a male attendant who took his temperature, blood pressure, weight and height. In response to the question whether he had any pain, M.J. stated he was "beginning to get sick." M.J. declined an invitation to provide a urine sample. Respondent attended to M.J. in the treatment room. M.J. told respondent he had run out of Methadone and wanted another prescription. Respondent advised M.J. to reduce his use of Methadone or he would have to obtain his Methadone medications from a "methadone maintenance clinic." He told M.J. the purpose of the Methadone prescriptions was to allow M.J. to reduce his dependence on heroin. Respondent asked M.J. if he

[16] "For chronic noncancer pain, methadone should not be considered a drug of first choice. This is especially true for conditions for which the benefits of opioids have not been demonstrated, *such as headache or low back pain*. (*Id.*, Vital Signs: Risk of Overdose from Methadone Used for Pain Relief – United States, 1999-2010, at p. 495, emphasis added.)

needed anti-anxiety and sleeping medications and M.J. said he did. Respondent wrote a prescription for 270 tablets of Methadone 10 mg, 90 tablets of Xanax 2 mg and Restoril 30 mg for M.J. Respondent failed to provide adequate informed consent regarding, among other things, the risks and benefits of the use of controlled substances and other possible treatment modalities and during the course of treatment failed to seek consultation from and/or provide a referral to the appropriate medical specialist(s).

36. In his chart note for the June 17, 2010 visit, respondent indicated that M.J. complained of low back pain, decreased sleep and excessive anxiety. Respondent also documented that he performed a physical exam that was unremarkable and his diagnoses included chronic low back pain and anxiety/stress. Respondent's medical documentation was false because respondent did not perform any physical examination, M.J. never complained of suffering from low back pain, decreased sleep and/or anxiety, the diagnoses were not based on any physical examination or any diagnostic tests; and, there was no reasonable justification for charting M.J. suffered from these conditions.

37. Respondent committed gross negligence in his care and treatment of M.J., which included, but was not limited to, the following:

(a) Respondent repeatedly prescribed large amounts of Methadone and Xanax on one occasion to M.J. without adequate justification and without an adequate history and physical examination including, but not limited to, obtaining a more detailed history, reviewing and verifying prior medical treatment, conducting a more thorough review of symptoms and/or more accurately assessing the patient's actual condition;

(b) Respondent repeatedly prescribed large amounts of Methadone and Xanax on one occasion to M.J. without adequate justification and without clearly documenting an adequate treatment plan with stated objectives for the patient's care and treatment in regard to the narcotics and controlled substances that were prescribed;

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(c) Respondent repeatedly prescribed large amounts of Methadone and Xanax on one occasion to M.J. without adequate justification and without adequate informed consent of the various risks associated with the narcotics and controlled substances that were being prescribed and the possibility of alternative non-narcotic therapies;

(d) Respondent repeatedly prescribed large amounts of Methadone and Xanax on one occasion to M.J. without seeking appropriate consultation from, or referring the patient to, the appropriate medical specialists;

(e) Respondent repeatedly prescribed large amounts of Methadone and Xanax on one occasion to M.J. without utilizing urine drug screens and/or other risk screening tools;

(f) Respondent failed to maintain, in whole or part, legible, complete, adequate, and/or accurate medical records concerning, among other things, M.J.'s medical history and physical examination, other evaluations and/or treatments, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient and/or periodic reviews of the treatment plan;

(g) Respondent made false medical record entries for M.J.'s visit of May 11, 2010, when he, among other things, documented M.J.'s "Back/Spine was tender" on examination, "Paraspinal once," that M.J. "c/o [complained of] chronic LBP [low back pain] x 5 years" and documented his impressions as "chronic low back pain" Respondent's medical record entries were false because, among other things, M.J. did not complain of back pain or chronic back pain, respondent did not perform a physical examination, and there was no reasonable justification for documenting the aforementioned conditions and diagnosis; and

(h) Respondent made false medical record entries for M.J.'s visit of June 27, 2010, when he, among other things, documented that M.J. complained of low back pain, decreased sleep and excessive anxiety and diagnosed M.J. as suffering

from "chronic low back pain" and "Anxiety/Stress." Respondent's medical record entries were false because, among other things, M.J. did not complain of back pain, decreased sleep and/or excessive anxiety respondent did not perform a physical examination, and there was no reasonable justification for documenting the aforementioned conditions and diagnoses.

PATIENT R.C.

38. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subsection (b) of the Code, in that respondent committed gross negligence in his care and treatment of R.C. as more particularly alleged hereinafter:

39. On or about January 2, 2008, R.C., a male patient then 20 years old, made a visit to respondent's offices with complaints of back, hand and neck pain. On this visit, respondent noted patient R.C.'s medical history included "ADD on Adderall," two surgeries on the right hand in 2005 and 2006, and knee pain from snowboarding. Respondent also noted the patient's medications included Oxycontin he received from the "ER." However, respondent failed to note the nature and severity of the patient's back, hand and neck pain, and failed to note the patient's history of Oxycontin use. On physical examination, respondent noted tenderness in the knees and decreased range of motion (DROM) in the right 5th metacarpal. However, respondent failed to perform a physical examination and/or note a physical examination of the patient's back and neck. Respondent's assessment was "ADD," post traumatic osteoarthritis (PTOA) of the knees and hands, tachycardia and lipidemia. Respondent prescribed 100 tablets of Percocet 325/5 mg[17] and 60 tablets of Xanax 1 mg for patient R.C. Respondent failed to note any medical justification for the Percocet and Xanax medications he prescribed for patient R.C. on this visit.

40. On or about February 4, 2008, respondent prescribed 90 tablets of Oxycontin 20 mg and 90 tablets of Xanax 1 mg for patient R.C. Also on or about March 3, 2008, respondent

[17] Percocet, oxycodone and acetaminophen, is a Schedule II Controlled Substance under Health and Safety Code section 11055(b)(1)(M) and a dangerous drug under Code section 4022. It is indicated for relief of moderate to moderately severe pain when a continuous, around the clock analgesic is needed for an extended period of time. It has the potential for abuse similar to morphine.

prescribed another 90 of Oxycontin and 60 tablets of Xanax 1 mg for patient R.C. There are no recorded visits on any of these dates, and respondent failed to note any medical justification for these prescriptions. On or about March 21, 2008, patient R.C. made a visit with a request for refills, among other things. Respondent noted the patient continued to have "hand pain with movement." Respondent's assessment included Tachycardia, ADD, PTOA and hyperlipidemia. On this visit, respondent prescribed Oxycontin and Xanax for patient R.C., however, he failed to note these prescriptions in his chart note for the patient.[18] Respondent also failed to note any medical justification for these prescriptions.

41. On or about May 3, 2008, respondent prescribed 90 tablets of Xanax 1 mg for patient R.C. There is no recorded visit on this date and there is no notation of the medical justification for this prescription. On or about May 19, 2008, patient R.C. made an office visit requesting refill and change of his medications. He reported he was "withdrawing" from Oxycontin and had been "started on Methadone." Respondent failed to inquire and/or note he inquired into the history of the patient's "withdrawal" or of a history of the patient's Methadone use. Respondent also failed to obtain any history and/or note any history of the patient's addiction to and/or abuse of controlled substances including Oxycontin and Xanax. On this visit, respondent prescribed 90 tablets of Methadone 10 mg for the patient. Respondent failed to note any medical justification for these prescriptions.

42. On or about May 22, 2008, patient R.C.'s mother telephoned respondent's office and spoke to a "nurse" called Carol. The patient's mother told Carol that patient R.C. did not have a legitimate pain and was addicted to prescription medications. Carol assured the patient's mother that respondent would no longer provide treatment or prescribe medication for patient R.C.

43. On or about June 13, 2008, patient R.C. made an office visit requesting refills. On this visit, patient R.C. reported he had severe panic attacks and had been seen at a hospital and was treated with Xanax. Respondent failed to note any history of the panic attacks and again failed to note the patient's history of drug addiction and/or drug abuse. He prescribed 90 tablets

[18] According to the pharmacy records, patient R.C. filled the Xanax medication on March 21, 2008 and filled the Oxycontin on March 22, 2008.

of Methadone 10 mg and 90 tablets of Xanax 1 mg for the patient. There is no notation of the medical justification for these prescriptions. Respondent also failed to refer patient R.C. to a specialist for treatment of his anxiety attacks.

44. Patient R.C. made an office visit on or about July 7, 2008 with a request for refill of his medications. On this visit, respondent noted patient R.C. reported he had been seen at the "ER" a month earlier for "anxiety attacks." Respondent again failed to note any history of the patient's "anxiety attacks" or of the results of the patient's visit to the "ER." Respondent prescribed 90 tablets of Oxycontin 40 mg and 90 tablets of Xanax 2 mg for the patient. There is no notation of the medical justification for these prescriptions. On this visit, respondent noted he instructed patient R.C. to seek follow-up care with Kaiser Permanente because he would no longer prescribe medications for patient R.C.

45. Nonetheless, patient R.C. made an office visit on or about September 29, 2008, with a complaint of lower back pain. On this visit, respondent noted that the patient reported he was enrolled in the Kaiser Permanente "pain management program" for his lower back pain. Despite this information, respondent prescribed 90 tablets of Oxycontin 40 mg and 30 tablets of Clonazepam 2 mg[19] for the patient. There is no notation of the medical justification for these prescriptions.

46. Thereafter, patient R.C. was treated for drug addiction at Kaiser Permanente. On or about September 4, 2009, patient R.C. died from drug toxicity.

47. Respondent committed gross negligence in his care and treatment of R.C., which included, but was not limited to, the following:

(a) Between about January 2, 2008 and September 29, 2008, respondent repeatedly prescribed large amounts of Oxycontin, Xanax and Methadone without adequate justification and without an adequate history and physical examination including, but not limited to, obtaining a more detailed history, reviewing and

[19] Clonazepam (Klonopin) is a Schedule IV Controlled Substance under Health and Safety Code section 11057(d)(7) and a dangerous drug under Code section 4022 (a).

verifying prior medical treatment, conducting a more thorough review of symptoms and/or more accurately assessing the patient's actual condition;

(b) Between about January 2, 2008 and September 29, 2008, respondent repeatedly prescribed large amounts of Oxycontin, Xanax and Methadone to R.C. without adequate justification and without clearly documenting an adequate treatment plan with stated objectives for the patient's care and treatment in regard to the narcotics and controlled substances that were prescribed;

(c) Between about January 2, 2008 and September 29, 2008, respondent repeatedly prescribed large amounts of Oxycontin, Xanax and Methadone to R.C. without adequate justification and without adequate informed consent of the various risks associated with the narcotics and controlled substances that were being prescribed and the possibility of alternative non-narcotic therapies;

(d) Respondent repeatedly prescribed large amounts of Oxycontin, Xanax and Methadone to R.C. without seeking appropriate consultation from, or referring the patient to, the appropriate medical specialists;

(e) Respondent repeatedly prescribed large amounts of Oxycontin, Xanax and Methadone to R.C. without utilizing urine drug screens and/or other risk screening tools.

(f) Respondent failed to maintain, in whole or part, legible, complete, adequate, and/or accurate medical records concerning, among other things, R.C.'s medical history and physical examination, other evaluations and/or treatments, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient and/or periodic reviews of the treatment plan;

(g) On or about February 4, 2008, March 3, 2008 and May 3, 2008, respondent prescribed Oxycontin and Xanax for patient R.C. without any recorded office visit and without any notation of a medical justification for the prescriptions; and

(h) Between about June 13, 2008 and September 29, 2008, respondent prescribed Oxycontin, Methadone and Xanax to patient R.C. for treatment of R.C.'s back pain and anxiety even though respondent knew or should have known that patient R.C. did not have a legitimate pain, was addicted to prescription medications and was drug seeking.

PATIENT C.W.

48. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subsection (b) of the Code, in that respondent committed gross negligence in his care and treatment of C.W. as more particularly alleged hereinafter:

49. On or about July 30, 2008, C.W., a male patient then 57 years old, made a visit to respondent's offices for "follow up and medication." The patient was 6 feet 6 inches tall, weighed 309 pounds, and his B/P was 144/73. On this visit, respondent noted patient C.W. complained of problems related to the lower extremities.[20] As history, respondent noted the patient had an "old fracture of the foot," a history of "past use of cocaine and PCP," and a family history that included his father's death from coronary artery disease. On physical examination, respondent noted the patient's feet were tender with "decreased range of motion due to pain." Respondent ordered labs including EKG, echocardiogram and peripheral vascular studies and nerve conduction velocity study of the lower extremities.[21] His diagnosis included "possible chronic obstructive pulmonary disease (COPD)." Respondent's prescriptions included Spivira, Percocet 5/325, and Phenergan Expectorant with Codeine. Thereafter, patient C.W. made periodic visits until about September 12, 2011.

50. During the period of treatment, patient C.W. repeatedly complained of pain in his lower back, shoulders, hands, legs and knees. Respondent repeatedly failed to obtain and/or document a history of the patient's complaint; failed to perform and/or document a thorough

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[20] At the physician's interview on January 25, 2012, respondent admitted he was unable read his notation related to the patient's complaints on July 30, 2008.

[21] At the physician's interview, respondent stated he was unsure why he ordered the EKG and echocardiogram but could because he heard a "heart murmur" which he failed to document.

physical examination related to the patient's pain complaints; failed to order appropriate diagnostic tests in order to arrive at a diagnosis for the patient's pain; and failed to note a diagnosis for the patient's pain complaints. However, respondent repeatedly prescribed narcotic analgesics for management of the patient's pain. On patient C.W.'s visits on or about September 8, 2008, November 10, 2008 and December 10, 2008, respondent prescribed 120 tablets of Percocet on each visit, for management of the patient's pain complaints. Respondent failed to perform and/or document a physical examination of patient C.W. on any of these visits.

51. Patient C.W. repeatedly complained of pain in his lower back, legs, hands and knees during visits in 2009. On the visit of January 12, 2009, respondent noted patient C.W. complained of "increased knee pain." On the visits of on or about February 6 and March 16, 2009, respondent noted the patient complained of "bilateral leg and knee pain and stiffness," among other things. Respondent noted that patient C.W. complained of "continual pain in the knees" on the visit of June 9, 2009; complained of "pain in both legs" on the visit on or about July 29, 2009, and complained of knee pain on the visit on or about November 2, 2009. Despite patient C.W.'s repeated complaints of pain, respondent failed to obtain and/or document a history of the pain complaints and failed to perform and/or document a thorough physical examination related to the patient's pain complaints. Moreover, respondent failed to order appropriate diagnostic tests in order to determine the cause of the patient's pain and failed to note a diagnosis for the patient's pain complaints.

52. Beginning in about January 2009, respondent commenced prescribing MS Contin [22] for management of patient C.W.'s complaints of pain in his lower back, legs, hands and knees. This was in addition to the Percocet medication respondent prescribed each month for the patient. There is no explanation for the addition of MS Contin in respondent's chart notes for the patient. According to the Controlled Substances Utilization and Review Evaluations (CURES) report for the year 2009, respondent prescribed 120 tablets of Percocet and 90 tablets of MS Contin 30 mg

[22] MS Contin (Morphine Sulphate Controlled release) is a Schedule II Controlled Substance under Health and Safety Code section 11055(b)(1)(L) and a dangerous drug under Code section 4022. It is indicated for relief of moderate to moderately severe pain.

each month for patient C.W. These include prescriptions for Percocet and MS Contin respondent wrote for the patient on April 13, 2009, May 26, 2009, August 31, 2009 and September 29, 2009, even though the patient did not make office visits on these dates. Despite patient C.W.'s repeated complaints of pain in his lower back, legs, hands and knees, respondent failed to refer the patient to a pain management specialist for appropriate management of his pain.[23]

53. Patient C.W. repeatedly complained of pain in his lower back legs, hands and knees during visits in 2010. According to respondent's chart, patient C.W. complained of "increased low back pain" on the visit on or about April 12, 2010; complained of "knee and lower back pain" on the visit on or about July 9, 2010; complained of "knee and low back pain without change" on the visit on about August 2, 2010; complained of "excess joint pain, especially knees, and ankles" on the visit of October 20, 2010; and complained of "knee and ankle pain" and "continued low and joint pains, especially at night" on the visit on or about December 9, 2010. Respondent failed to obtain and/or document a history of the pain complaints and failed to perform and/or document a thorough physical examination related to the patient's pain complaints on any of these visits. Respondent also failed to arrive at and/or note a diagnosis for the patient's pains on any of these visits.

54. In about January 2010, respondent commenced prescribing Vicodin ES[24] instead of MS Contin for management of C.W.'s complaints of pain in his lower back, legs, hands and knees. This was in addition to the Percocet respondent prescribed each month for the patient. There is no documentation of the medical justification for the addition of Vicodin ES to the patient's medications. According to the CURES report for the year 2010, respondent prescribed

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[23] At the physician's interview, respondent explained his custom and practice of referring patients to specialists this way: "...Usually, when a person tells me [he has pain] I usually ask them...do you want to have something done about the knee...[to be] sent to a surgeon, to ortho..., then that's when I order an MRI, because now we need to get something to send to ortho. But as long as they tell me they just want the pain medication then I don't order any tests until -- and there is something to send to ortho."

[24] Vicodin ES, Hydrocodone Bitartrate 7.5 mg and Acetaminophen 750 mg, is a Schedule III controlled substance as defined by Section 11056(c) of the Health and Safety Code and a dangerous drug under Code section 4022. It is indicated for relief of moderate to moderately severe pain.

approximately 1,380 tablets of Percocet for patient C.W. between January 4, 2010 and October 1, 2010. During this same period, respondent prescribed approximately 1,080 tablets of Vicodin for patient C.W. These prescriptions included prescriptions for 120 tablets of Percocet and 90 tablets of Vicodin ES respondent wrote for patient C.W. on January 4, 2010, although the patient did not make an office visit on this date.

55. Despite the large amounts of Percocet and Vicodin respondent prescribed for patient C.W. during 2010, respondent failed to note the dosages of these medications in the patient's chart; failed to inquire and document the number of these medications patient C.W. was taking daily; failed to note the patient's response to the medications; and failed to note how the patient was functioning on these medications. Moreover, respondent failed to calculate the amount of acetaminophen patient C.W. was consuming daily from the combined use of Percocet and Vicodin ES., and failed to discuss or to note he discussed the risk of acetaminophen toxicity with patient C.W. Furthermore, respondent failed to assess patient C.W. for the risk of addiction and failed to make any inquiry and/or note he inquired into whether patient C.W. was abusing the medications he was prescribing. Respondent also failed to refer patient C.W. to a pain management specialist.

56. On or about October 20, 2010, respondent ordered a series of MRI's including MRI of left knee, left and right ankles and right wrist. The results indicated, among other things, that patient C.W. had had previous left knee surgery, and there was evidence of deterioration of the medial meniscus and instability of the anterior cruciate. Despite these findings, respondent failed to refer patient C.W. to an orthopedist.[25]

57. Patient C.W. made an office visit on or about March 1, 2011 with a complaint of "pain in the right hand," among other things. Respondent noted he referred the patient to a pain management specialist on this date.[26] On or about March 31, 2011, patient C.W. made a visit

[25] At the physician's interview on January 25, 2012, respondent stated that patient C.W. "probably" refused a referral to an orthopedist during the visit on December 9, 2010. He admitted he failed to note the discussion about the referral or the patient's refusal in the chart note of the visit of December 9, 2010.

[26] Respondent's DEA certificate was suspended on or about October 13, 2010.

during which he complained of "pain in the right wrist for six months getting worse" and continuing pain in his left shoulder. Respondent noted he referred patient C.W. to an orthopedist on this date.

58. During the period of treatment, patient C.W. repeatedly complained of shortness of breath. Respondent noted patient C.W. complained of shortness of breath on the visits of September 8, 2008, November 10, 2008, February 2, 2009, March 16, 2009, June 29, 2009, July 29, 2009 and November 2, 2009. Despite patient C.W.'s repeated complaints respondent failed to obtain and/or document a history of the complaints, and failed to perform and/or document a thorough physical examination related to the patient's complaints of shortness of breath. Moreover, respondent failed to order appropriate diagnostic tests in order to determine the cause of the patient's shortness of breath and failed to arrive at and/or note a diagnosis for the patient's shortness of breath. Furthermore, respondent failed to refer patient C.W. to a cardiologist for evaluation of the patient's complaints of shortness of breath.

59. On or about July 9, 2010, patient C.W. made an office visit with complaints that included "shortness of breath for two years" and his inability to walk for more than 30 feet without getting out of breath. On this visit, respondent ordered a chest x-ray, an echocardiogram, and an EKG. The echocardiogram revealed the patient had mild mitral tricuspid, pulmonary regurgitation and aortic sclerosis, among other things. Patient C.W. continued to complain of shortness of breath on the visits on or about August 2, 2010, and October 20, 2010. Despite the findings of the echocardiogram the patient's continuing complaints of shortness of breath, respondent failed to refer patient C.W. to a cardiologist.

60. During the period of treatment, patient C.W. repeatedly complained of anxiety, "increased worry," stress and insomnia. Patient C.W. complained of either stress, "worry," anxiety or insomnia on the visits on or about June 29, 2009, July 29, 2009, November 2, 2009, and February 11, 2011. Despite patient C.W.'s repeated complaints, respondent failed to obtain and/or document a history of the complaints and failed to perform and/or document a thorough physical examination related to the patient's complaints of stress, "worry," anxiety or insomnia. Moreover, respondent failed to order appropriate diagnostic tests in order to determine the cause

of the patient's stress, "worry," anxiety or insomnia, and failed to note a diagnosis for the patient's complaints. Furthermore, respondent failed to refer patient C.W. to a psychiatrist or a psychologist for evaluation of the patient's complaints of stress, "worry," anxiety or insomnia.

61. Patient C.W. complained of abdominal or epigastric pain on the visits of February 3, 2010 and April 14, 2010. Respondent failed to obtain and/or document a history of the abdominal pain and failed to perform and/or document a thorough physical examination related to the patient's abdominal pain. Moreover, respondent failed to order appropriate diagnostic tests in order to arrive at a diagnosis for the patient's abdominal pain, and failed to properly treat the patient's abdominal pain.

62. Respondent committed gross negligence in his care and treatment of C.W., which included, but was not limited to, the following:

(a) From approximately July 30, 2008, to October 2010, respondent, on occasion, prescribed various controlled substances, including, but not limited to, Percocet, MS Contin and Vicodin to C.W., without adequate justification and without examining the patient in a timely fashion and without adequate periodic review to assess the appropriateness of the course of treatment and the continued use of the various controlled substances, including, but not limited to, Percocet, MS Contin and Vicodin;

(b) From approximately July 30, 2008, to October 2010, respondent prescribed various controlled substances, including, but not limited to, Percocet, MS Contin and Vicodin to C.W., without adequate justification and without seeking appropriate consultation from, or referring the patient to, the appropriate medical specialists; and

(c) On or about April 13, 2009, May 26, 2009, August 31, 2009 and January 4, 2010, respondent prescribed Percocet, MS Contin and Vicodin for patient C.W. without any recorded office visit and without any notation of a medical justification for the prescriptions.

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PATIENT N.A.

63. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subsection (b) of the Code, in that respondent committed gross negligence in his care and treatment of N.A., as more particularly alleged hereinafter:

64. On or about September 20, 2006, N.A., a female patient then 43 years old, made a visit to respondent's offices with complaints of frequent urination which "was getting worse." On this visit, respondent noted that the patient's medical history included a "bladder problem for two years" and that the patient had been prescribed Ibuprofen 800 mg for pain by her previous care provider. Respondent performed a physical examination, however, with the exception of the word "fingers" under "Extremities," respondent failed to note any other findings upon physical examination. Respondent ordered laboratory tests. His impression included bilateral carpal tunnel syndrome and osteoarthritis of the hand, obesity elevated blood pressure, sleep apnea and possible urinary tract infection. His recommendation included referral to an urologist, wrist splint for the carpal tunnel syndrome. He prescribed Ketoprofen 75 mg[27] for the patient. On or about October 23, 2006, patient N.A. made a follow up visit for her laboratory results. On this date, respondent noted the patient complained of "right upper extremity pain, especially the right elbow." However, respondent failed to perform and/or note a physical examination related to the patient's "right upper extremity pain" complaint. Respondent's prescriptions for the patient on this visit included Naprosyn 500 mg[28] and 30 tablets of Vicodin. Respondent failed to note any medical justification for the combination of Naprosyn and Vicodin medications he prescribed for the patient.

65. Thereafter, patient N.A. made periodic visits to respondent's offices with various complaints until about March 8, 2011. These included four (4) visits in 2007 (on or about January 17, June 27, July 30 and November 9, 2007), one (1) visit in 2008 (on or about April 25,

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[27] Ketoprofen is a nonsteroidal anti-inflammatory drug It is indicated for management of the signs and symptoms of rheumatoid arthritis and osteoarthritis.

[28] Naprosyn is a nonsteroidal anti-inflammatory drug. It is indicted for the treatment of rheumatoid arthritis and osteoarthritis.

2008), six (6) visits in 2009 (on or about February 27, May 27, July 15, August 21, October 1, and December 22, 2009) and five (5) visits in 2010 (on or about January 18, April 19, July 2, October 4 and October 26, 2010). During the period of treatment, patient N.A. repeatedly complained of pain in the right upper extremities, including pain in the shoulders and elbows, pain in the left arm, pain in the hands and pain in both legs. Patient N.A. complained of pain in the shoulders, elbows, hands and legs on the visits on or about October 23, 2006, June 27, 2007, April 28, 2008 and February 27, 2009. Despite these complaints, respondent failed to obtain and/or note a history of the patient's pain complaints and failed to perform and/or note an examination related to the patient's pain complaints at anytime during the period of treatment. However, on nearly every visit, respondent's assessment of the patient included osteoporosis. There is no medical justification noted for the assessment of osteoporosis. Respondent prescribed pain medications including controlled substances, for patient N.A. throughout the period of treatment.

66. On or about March 15, 2007, respondent prescribed 30 tablets of Vicodin to treat patient N.A.'s pain even though the patient did not make an office visit on this date. On about July 30, 2007, respondent prescribed 100 tablets of Percocet for management of patient N.A.'s osteoarthritis. However, beginning on the visit on or about November 9, 2007, respondent increased the dosage and variety of pain medications he prescribed for treatment of patient N.A.'s osteoporosis. On this visit, respondent prescribed 200 tablets of Percocet and 30 tablets of Avinza 60 mg[29] for the patient. Respondent also prescribed another 200 tablets of Percocet and 30 tablets of Avinza 60 mg for the patient on or about January 7, 2008. Respondent failed to note any medical justification for increase in dosage and variety of the controlled substances he prescribed for the patient. On or about February 21, 2008, respondent prescribed 200 tablets of Vicodin for patient N.A. even though the patient did not make an office visit on this date. On patient N.A.'s visit on or about April 25, 2008, respondent prescribed 200 tablets of Percocet and

[29] Avinza, a brand name for Morphine Sulphate, is a Schedule II Controlled Substance under Health and Safety Code section 11055(b)(1)(L) and a dangerous drug under Code section 4022. It is indicated for relief of moderate to moderately severe pain.

90 tablets of Oxycodone 20 mg for the patient. Respondent failed to note any medical justification for prescribing a combination of Percocet and Oxycodone for the patient on this visit.

67. On or about February 27, 2009, (seven months after the patient's previous visit), patient N.A. made a return visit with complaints that included "pain in the left arm." On this visit, respondent noted the patient reported a history that included "right wrist and hand pain getting worse." Respondent failed to perform and/or note he performed a physical examination related to the patient's left arm pain complaint. Respondent also failed to inquire and/or note he inquired into the reason(s) for the seven-month interval between the patient's visits, and failed to inquire and/or note he inquired into whether the patient was obtaining pain medications from other sources. Respondent's assessment included carpal tunnel syndrome and osteoarthritis of the right hand. Respondent's prescriptions for the patient included 200 tablets of Roxicet 5/325 mg[30] Respondent failed to note any medical justification for prescribing the Roxicet medication. Respondent also failed to refer patient N.A. to an orthopedist.

68. According to CURES report for the year 2009, respondent prescribed approximately 200 tablets of Percocet, 630 tablets of Oxycontin and 480 tablets of Norco 7.5 for management of the patient's pain between about May 27, 2009 and December 31, 2009. Also, according to the CURES report for the year 2010, between about January 12, 2010 and October 8, 2010, respondent prescribed approximately 1,000 tablets of Norco, 360 tablets of Oxycontin and 180 tablets of Morphine Sulphate for the management of patient N.A.'s pain. This was in addition to the many prescriptions for Ambien[31] or Temazepam[32] respondent wrote for the patient during this

[30] Roxicet, oxycodone and acetaminophen, is a Schedule II Controlled Substance under Health and Safety Code section 11055(b)(1)(M) and a dangerous drug under Code section 4022. It is indicated for relief of moderate to moderately severe pain.

[31] Ambien, a brand name for zolpidem tartrate, is a Schedule IV controlled substance under Health and Safety Code section 11075(d)(32) and a dangerous drug under Business and Professions Code section 4022. It is a non-benzodiazepam hypnotic indicated for short-term treatment of insomnia. Use of Ambien comes with the following WARNING "Since sleep disturbances may be the presenting manifestation of a physical and/or psychiatric disorder, symptomatic treatment of insomnia should initiated only after a careful evaluation of the patient. The failure of insomnia to remit after 7 to 10 days of treatment may indicate the presence of primary psychiatric and/or medical illness which should be evaluated."

period. Despite the large amounts of Norco, Oxycontin and Percocet respondent prescribed for patient N.A. during 2009 and 2010, respondent failed to note the dosages of these medications in the patient's chart; failed to inquire and document the number of these medications patient N.A. was taking daily; failed to note the patient's response to the medications; and failed to note how the patient was functioning on these medications. Moreover, respondent failed to assess patient N.A. for the risk of addiction and failed to make any inquiry and/or note he inquired into whether patient N.A. was abusing the medications. Respondent also failed to refer patient N.A. to a pain management specialist at any time during the period of treatment.

69. During the period of treatment, patient N.A. repeatedly complained of shortness of breath, dizziness and chest pain. Respondent noted patient N.A. complained of dizziness, shortness of breath and chest pain on the visits of July 15, 2009, December 22, 2009 and April 19, 2010. Despite the repeated complaints, respondent failed to obtain and/or document a history of the complaints and failed to perform and/or document a thorough physical examination related to the patient's complaints of shortness of breath, dizziness and chest pain. Moreover, respondent failed to order appropriate diagnostic tests in order to determine the cause of the patient's complaints and failed to note a diagnosis for the patient's shortness of breath, dizziness and chest pain. Furthermore, respondent failed to refer patient N. A. to a cardiologist for evaluation of the patient's complaints of shortness of breath, chest pain and dizziness.

70. During the period of treatment, patient N.A. repeatedly complained of anxiety, "excess worry" stress and insomnia. On the visits on or about May 27, 2009, August 21, 2009, July 2, 2010 and October 4, 2010, respondent noted Patient N.A complained of stress, "excess worry," anxiety or insomnia. Despite patient N.A.'s repeated complaints, respondent failed to obtain and/or document a history of the complaints and failed to perform and/or document a thorough physical examination related to the patient's complaints of stress, "excess worry," anxiety or insomnia. Moreover, respondent failed to order appropriate diagnostic tests in order to determine the cause of the patient's stress, "excess worry," anxiety or insomnia, and failed to

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[32] Temazepam is a Schedule IV controlled substance under Health and Safety Code section 11075(d)(29) and dangerous drugs under Business and Professions Code section 4022.

arrive at and/or note a diagnosis for the patient's complaints. Beginning on or about July 17, 2009, and continuing to about September 28, 2010, respondent prescribed approximately 30 tablets of Ambien each month for management of patient N.A.'s stress, "excess worry," anxiety or insomnia. There is no medical justification noted for the monthly prescription of Ambien for patient N.A. At no time during the period of treatment did respondent refer patient N.A. to a psychiatrist or a psychologist for evaluation of the patient's complaints of stress, "worry," anxiety or insomnia.

71. Respondent committed gross negligence in his care and treatment of N.A., which included, but was not limited to, the following:

(a) During his course of treatment, respondent, on occasion, prescribed various controlled substances, including, but not limited to, Percocet, Norco, Oxycontin and/or Ambien to N.A., without adequate justification and without examining the patient in a timely fashion and without adequate periodic review to assess the appropriateness of the course of treatment and the continued use of the various controlled substances, including, but not limited to, Percocet, Norco, Oxycontin and/or Ambien.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

DEA AGENT B.S.

72. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of B.S., as more particularly alleged hereinafter:

(a) Paragraphs 24 through 31, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent repeatedly prescribed large amounts of Methadone and Xanax medications to B.S. without adequate justification and without an adequate history and physical examination including, but not limited to, obtaining a more detailed history, reviewing and verifying prior medical treatment, conducting a

more thorough review of symptoms and/or more accurately assessing the patient's actual condition;

(c) Respondent repeatedly prescribed large amounts of Methadone and Xanax medications to B.S. without adequate justification and without clearly documenting an adequate treatment plan with stated objectives for the patient's care and treatment in regard to the narcotics and controlled substances that were prescribed;

(d) Respondent repeatedly prescribed large amounts of Methadone and Xanax medications to B.S. without adequate justification and without adequate informed consent of the various risks associated with the narcotics and controlled substances that were being prescribed and the possibility of alternative non-narcotic therapies;

(e) Respondent repeatedly prescribed large amounts of Methadone and Xanax medications to B.S. without seeking appropriate consultation from, or referring the patient to, the appropriate medical specialists;

(f) Respondent repeatedly prescribed large amounts of Methadone and Xanax medications to B.S. without utilizing urine drug screens and/or other risk screening tools;

(g) Respondent failed to maintain, in whole or part, legible, complete, adequate, and/or accurate medical records concerning, among other things, B.S.'s medical history and physical examination, other evaluations and/or treatments, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient and/or periodic reviews of the treatment plan;

(h) Respondent made false medical record entries for patient B.S.'s visit of September 29, 2009, when he, among other things, documented he performed a physical examination of the patient's pain, documented pain associated with "Tender Post Neck" and "Back/Spine-L4-5 para-spinal areas" and documented

impressions of "Chronic Cervical strain due to whiplash" and "Anxiety/Stress." Respondent's medical record entries were false because, among other things, respondent did not perform a physical examination and there was no reasonable justification for documenting the aforementioned conditions and diagnoses;

(i) Respondent made false medical record entries for patient B.S.'s visit of November 10, 2009, when he, among other things, documented the patient complained of back pain during the visit and listed his diagnosis of back pain. Respondent's medical record entries were false because, among other things, B.S. did not complain of continued back pain, respondent did not perform a physical examination, and there was no reasonable justification for documenting the aforementioned condition and diagnosis; and

(j) Respondent made false medical record entries for patient B.S.'s visit of March 25, 2010, when he, among other things, documented B.S. complained of "increased low back pain, still with anxiety" during the visit and when he diagnosed B.S. as suffering from chronic back pain. Respondent's medical record entries were false because, among other things, B.S. did not complain of increased back pain or anxiety, respondent did not perform a physical examination, and there was no reasonable justification for documenting the aforementioned conditions and diagnosis.

DEA AGENT M.J.

73. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of M.J., as more particularly alleged hereinafter:

(a) Paragraphs 32 through 37, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent repeatedly prescribed large amounts of Methadone and Xanax on one occasion to M.J. without adequate justification and without an adequate history and physical examination including, but not limited to, obtaining a more detailed history, reviewing and verifying prior medical treatment,

conducting a more thorough review of symptoms and/or more accurately assessing the patient's actual condition;

(c) Respondent repeatedly prescribed large amounts of Methadone and Xanax on one occasion to M.J. without adequate justification and without clearly documenting an adequate treatment plan with stated objectives for the patient's care and treatment in regard to the narcotics and controlled substances that were prescribed;

(d) Respondent repeatedly prescribed large amounts of Methadone and Xanax on one occasion to M.J. without adequate justification and without adequate informed consent of the various risks associated with the narcotics and controlled substances that were being prescribed and the possibility of alternative non-narcotic therapies;

(e) Respondent repeatedly prescribed large amounts of Methadone and Xanax on one occasion to M.J. without seeking appropriate consultation from, or referring the patient to, the appropriate medical specialists;

(f) Respondent repeatedly prescribed large amounts of Methadone and Xanax on one occasion to M.J. without utilizing urine drug screens and/or other risk screening tools;

(g) Respondent failed to maintain, in whole or part, legible, complete, adequate, and/or accurate medical records concerning, among other things, M.J.'s medical history and physical examination, other evaluations and/or treatments, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient and/or periodic reviews of the treatment plan;

(h) Respondent made false medical record entries for M.J.'s visit of May 11, 2010, when he, among other things, documented M.J.'s "Back/Spine was tender" on examination, "Paraspinal once," that M.J. "c/o [complained of] chronic LBP [low back pain] x 5 years" and documented his impressions as "chronic low

back pain" Respondent's medical record entries were false because, among other things, M.J. did not complain of back pain or chronic back pain respondent did not perform a physical examination, and there was no reasonable justification for documenting the aforementioned conditions and diagnosis; and

(i) Respondent made false medical record entries for M.J.'s visit of June 27, 2010, when he, among other things, documented that M.J. complained of low back pain, decreased sleep and excessive anxiety and diagnosed M.J. as suffering from "chronic low back pain" and "Anxiety/Stress." Respondent's medical record entries were false because, among other things, M.J. did not complain of back pain, decreased sleep and/or excessive anxiety respondent did not perform a physical examination, and there was no reasonable justification for documenting the aforementioned conditions and diagnoses.

PATIENT R.C.

74. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of R.C., as more particularly alleged hereinafter:

(a) Paragraphs 38 through 47, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Between about January 2, 2008 and September 29, 2008, respondent repeatedly prescribed large amounts of Oxycontin, Xanax and Methadone without adequate justification and without an adequate history and physical examination including, but not limited to, obtaining a more detailed history, reviewing and verifying prior medical treatment, conducting a more thorough review of symptoms and/or more accurately assessing the patient's actual condition;

(c) Between about January 2, 2008 and September 29, 2008, respondent repeatedly prescribed large amounts of Oxycontin, Xanax and Methadone to R.C. without adequate justification and without clearly documenting an adequate

treatment plan with stated objectives for the patient's care and treatment in regard to the narcotics and controlled substances that were prescribed;

(d) Between about January 2, 2008 and September 29, 2008, respondent repeatedly prescribed large amounts of Oxycontin, Xanax and Methadone to R.C. without adequate justification and without adequate informed consent of the various risks associated with the narcotics and controlled substances that were being prescribed and the possibility of alternative non-narcotic therapies;

(e) Respondent repeatedly prescribed large amounts of Oxycontin, Xanax and Methadone to R.C. without utilizing urine drug screens and/or other risk screening tools;

(f) Respondent failed to maintain, in whole or part, legible, complete, adequate, and/or accurate medical records concerning, among other things, R.C.'s medical history and physical examination, other evaluations and/or treatments, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient and/or periodic reviews of the treatment plan;

(g) On or about February 4, 2008, March 3, 2008 and May 3, 2008, respondent prescribed Oxycontin and Xanax for patient R.C. without any recorded office visit and without any notation of a medical justification for the prescriptions;

(h) Between about June 13, 2008 and September 29, 2008, respondent prescribed Oxycontin, Methadone and Xanax to patient R.C. for treatment of R.C.'s back pain and anxiety even though respondent knew or should have known that patient R.C. did not have a legitimate pain, was addicted to prescription medications and was drug seeking.

PATIENT C.W.

75. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of C.W, as more particularly alleged hereinafter:

(a) Paragraphs 48 through 62, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) From approximately July 30, 2008, to October 2010, respondent, on occasion, prescribed various controlled substances, including, but not limited to, Percocet, MS Contin and Vicodin to C.W., without adequate justification and without examining the patient in a timely fashion and without adequate periodic review to assess the appropriateness of the course of treatment and the continued use of the various controlled substances;

(c) From approximately July 30, 2008, to October 2010, respondent prescribed various controlled substances, including, but not limited to, Percocet, MS Contin and Vicodin to C.W., without adequate justification and without an adequate history and physical examination including, but not limited to, obtaining a more detailed history, reviewing and verifying prior medical treatment, conducting a more thorough review of symptoms and more accurately assessing the patient's actual condition;

(d) From approximately July 30, 2008, to October 2010, respondent prescribed various controlled substances, including, but not limited to, Percocet, MS Contin and Vicodin to C.W., without adequate justification and without clearly documenting an adequate treatment plan with stated objectives for the patient's care and treatment in regard to the narcotics and/or controlled substances that were prescribed;

(e) From approximately July 30, 2008, to October 2010, respondent prescribed various controlled substances, including, but not limited to, Percocet, MS Contin and Vicodin to C.W., without adequate justification and without adequate informed consent of the various risks associated with the narcotics and controlled substances that were being prescribed and the possibility of alternative non-narcotic therapies;

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(f) From approximately July 30, 2008, to October 2010, respondent prescribed various controlled substances, including, but not limited to, Percocet, MS Contin and Vicodin to C.W., without adequate justification and without seeking appropriate consultation from, or referring the patient to, the appropriate medical specialists;

(g) From approximately July 30, 2008, to October 2010, respondent prescribed various controlled substances to C.W., including, but not limited to, Percocet, MS Contin and Vicodin, without adequate justification and without utilizing urine drug screens and/or other risk screening tools;

(h) On or about April 13, 2009, May 26, 2009, August 31, 2009 and January 4, 2010, respondent prescribed Percocet, MS Contin and Vicodin for patient C.W. without any recorded office visit and without any notation of a medical justification for the prescriptions;

(i) Between September 8, 2008 and March 30, 2011, respondent failed to refer patient C.W. to an orthopedist for evaluation despite the patient's repeated complaints of lower back, legs, hands and knee pain; and

(j) Respondent failed to maintain, in whole or part, legible, complete, adequate, and/or accurate medical records concerning, among other things, M.J.'s medical history and physical examination, other evaluations and/or treatments, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient and/or periodic reviews of the treatment plan.

PATIENT N.A.

76. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of N.A., as more particularly alleged hereinafter:

(a) Paragraphs 63 through 71, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) During his course of treatment, respondent, on occasion, prescribed various controlled substances, including, but not limited to, Percocet, Norco, Oxycontin and/or Ambien to N.A., without adequate justification, and without examining the patient in a timely fashion and without adequate periodic review to assess the appropriateness of the course of treatment and the continued use of the various controlled substances;

(c) During his course of treatment, respondent, prescribed various controlled substances to N.A., including, but not limited to, Percocet, Norco, Oxycontin and/or Ambien without adequate justification and without an adequate history and physical examination including, but not limited to, obtaining a more detailed history, reviewing and verifying prior medical treatment, conducting a more thorough review of symptoms and more accurately assessing the patient's actual condition;

(d) During his course of treatment, respondent, prescribed various controlled substances to N.A., including, but not limited to, Percocet, Norco, Oxycontin and/or Ambien without adequate justification and without clearly documenting an adequate treatment plan with stated objectives for the patient's care and treatment in regard to the narcotics and controlled substances that were prescribed;

(e) During his course of treatment, respondent, prescribed various controlled substances to N.A., including, but not limited to, Percocet, Norco, Oxycontin and/or Ambien without adequate justification and without adequate informed consent of the various risks associated with the narcotics and controlled substances that were being prescribed and the possibility of alternative non-narcotic therapies;

(f) During his course of treatment, respondent, prescribed various controlled substances to N.A., including, but not limited to, Percocet, Norco, Oxycontin and/or Ambien without adequate justification and without seeking

appropriate consultation from, or referring the patient to, the appropriate medical specialists;

(g) From approximately July 30, 2008, to October 2010, respondent prescribed various controlled substances to C.W., including, but not limited to, Percocet, MS Contin and Vicodin, without adequate justification and without utilizing urine drug screens and/or other risk screening tools; and

(h) Respondent failed to maintain in whole or part complete, adequate, and/or accurate medical records concerning, among other things, N.A.'s medical history and physical examination, other evaluations and/or treatments, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient and/or periodic reviews of the treatment plan.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

77. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivisions (d), of the Code, in that respondent has demonstrated incompetence and lack of knowledge regarding the guidelines and proper protocol for the prescribing of narcotics and controlled substances as to B.S., M.J., J.C., C.W. and N.A., as more particularly alleged in paragraphs 24 through 76, above, which are hereby incorporated by reference as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Acts of Dishonesty or Corruption)

78. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivisions (e), of the Code, in that respondent committed an act or acts of dishonesty or corruption when he made false medical record entries for B.S. and M.J. as more particularly alleged in paragraphs 24 through 37, above, which are hereby incorporated by reference as if fully set forth herein.

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FIFTH CAUSE FOR DISCIPLINE

(Violation of Statutes Regulating Drugs)

79. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2238, of the Code, in that respondent has violated a federal or state statute or regulation regulating dangerous drugs or controlled substances, as more particularly alleged in paragraphs 24 through 76, above, which are hereby incorporated by reference as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Furnishing Dangerous Drugs Without Examination)

80. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2242, of the Code, in that respondent prescribed dangerous drugs to B.S., M.J., R.C., C.W. and N.A. without an appropriate prior examination and medical indication, as more particularly alleged in paragraphs 24 through 76, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

SEVENTH CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

81. Respondent is further subject to disciplinary action under sections 2227 and 725 of the Code in that respondent engaged in repeated acts of clearly excessive prescribing or administrating of drugs or treatment as determined by the standard of the community of licensees in his care and treatment of B.S., M.J., R.C., C.W. and N.A. as more particularly alleged in paragraphs 24 through 76, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

EIGHTH CAUSE FOR DISCIPLINE

(Furnishing Drugs to Addict)

82. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2241 of the Code, in that respondent prescribed controlled substances and dangerous drugs to M.J., B.S. and R.C., whom he knew or reasonably should have known were using or would be using the controlled substances and dangerous drugs for a nonmedical purpose,

as more particularly alleged in paragraphs 24 through 47, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

NINTH CAUSE FOR DISCIPLINE

(Signing a Document that Falsely Represents the Existence or Non-Existence of a State of Facts)

83. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by sections 2261 of the Code, in that respondent signed documents for B.S. and M.J. that falsely represented the existence or non-existence of a state of facts, as more particularly alleged in paragraphs 24 through 37, above, which are incorporated by reference and realleged as if fully set forth herein.

TENTH CAUSE FOR DISCIPLINE

(Creation of False Medical Record)

84. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2262, of the Code, in that respondent created false medical records for B.S. and M.J., as more particularly alleged in paragraphs 24 through 37, above, which are incorporated by reference and realleged as if fully set forth herein.

ELEVENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Record)

85. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that respondent failed to maintain adequate and accurate records regarding his care and treatment of B.S., M.J., R.C., C.W. and N.A., as more fully particularly alleged in paragraphs 24 through 76, above, which are incorporated by reference and realleged as if fully set forth herein.

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TWELVE CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

86. Respondent has further subjected his license to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breached the rules or ethical code of the medical profession or which was unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, in his care of B.S., M.J., J.C., C.W. and N.A., as more particularly alleged in paragraphs 12 through 85, above, which are incorporated herein 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 Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A37049, issued to respondent RUDOLPHO J. ALEGRIA, M.D;

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

3. Ordering respondent RUDOLPHO J. ALEGRIA, M.D. to pay the Medical Board of California to pay the costs of probation if placed on probation; and

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

DATED: April 29, 2014

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant