

**BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA**

**In the Matter of the Second Amended
Accusation Against:**

JAMES SANTIAGO GRISOLIA, M.D.

**Physician's and Surgeon's
Certificate No. G 42884**

Respondent.

File No. 10-2004-154474

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Division of Medical Quality 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 10, 2007.

IT IS SO ORDERED November 9, 2007.

MEDICAL BOARD OF CALIFORNIA

By:



Cesar A. Aristeiguieta, M.D., F.A.C.E.P.

Chair

Panel A

Division of Medical Quality

1 EDMUND G. BROWN JR., Attorney General
of the State of California
2 THOMAS S. LAZAR
Supervising Deputy Attorney General
3 SAMUEL K. HAMMOND, State Bar No. 141135
Deputy Attorney General
4 California Department of Justice
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9 Attorneys for Complainant

10 **BEFORE THE**
11 **DIVISION OF MEDICAL QUALITY**
12 **MEDICAL BOARD OF CALIFORNIA**
13 **DEPARTMENT OF CONSUMER AFFAIRS**
14 **STATE OF CALIFORNIA**

15 In the Matter of the Second Amended Accusation
16 Against:

17 **JAMES SANTIAGO GRISOLIA, M.D.**
18 4033 Third Avenue, #410
19 San Diego, CA 92103

20 Physician's and Surgeon's
21 Certificate No. G 42884

22 Respondent.

Case No. 10-2004-154474

OAH No. L-2006110388

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

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

25 PARTIES

26 1. Barbara Johnston (Complainant) is the Executive Director of the Medical
27 Board of California and is represented in this matter by Edmund G. Brown Jr., Attorney General
28 of the State of California, by Samuel K. Hammond, Deputy Attorney General.

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2. Respondent James Santiago Grisolia, M.D. (Respondent) is represented in this proceeding by attorney Barton H. Hegeler, Esq., whose address is 4660 La Jolla Village Drive, Suite 670, San Diego, CA 92122.

3. On or about August 4, 1980, the Medical Board of California issued Physician's and Surgeon's Certificate No. G42884 to James Santiago Grisolia, M.D. The Certificate was in full force and effect at all times relevant to the charges brought in Second Amended Accusation No. 10-2004-154474 and will expire on April 30, 2008, unless renewed.

JURISDICTION

4. Accusation No. 10-2004-154474 was filed before the Division of Medical Quality, Medical Board of California, Department of Consumer Affairs, State of California (Division). On January 6, 2006, a true and correct copy of the Accusation and all other statutorily required documents were properly served on respondent, and respondent timely filed his Notice of Defense contesting the Accusation.

5. First Amended Accusation 10-2004-154474 which superseded Accusation No. 10-2004-154474, was filed before the Division on January 31, 2007. On January 31, 2007, a true and correct copy of the First Amended Accusation was served on respondent.

6. Second Amended Accusation No 10-2004-154474 which superseded First Accusation No. 10-2004-154474, was filed before the Division on September 11, 2007, and is currently pending against respondent. On September 11, 2007, a true and correct copy of the Second Amended Accusation was served on respondent. A true and correct copy of Second Amended Accusation No. 10-2004-154474 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

7. Respondent has carefully read, discussed with counsel, and fully understands the charges and allegations in Second Amended Accusation No. 10-2004-154474. Respondent has also carefully read, discussed with counsel, and fully understands the effects of this Stipulated Settlement and Disciplinary Order.

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

CULPABILITY

10. Respondent admits the truth of each and every charge and allegation in Second Amended Accusation No. 10-2004-154474, and further agrees that he has thereby subjected his Physician's and Surgeon's Certificate No. G 42884 to disciplinary action. Respondent agrees to be bound by the Division's imposition of discipline as set forth in the Disciplinary Order below.

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

CONTINGENCY

12. The parties agree that this Stipulated Settlement and Disciplinary Order shall be submitted to the Division for its consideration in the above-entitled matter and, further, that the Division shall have a reasonable period of time in which to consider and act on this Stipulated Settlement and Disciplinary Order after receiving it.

13. The parties agree that this Stipulated Settlement and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Division, 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 Settlement and Disciplinary Order, the Division may receive oral and written communications

1 from its staff and/or the Attorney General's office. Communications pursuant to this paragraph
2 shall not disqualify the Division, any member thereof, and/or any other person from future
3 participation in this or any other matter affecting or involving respondent. In the event that the
4 Division, in its discretion, does not approve and adopt this Stipulated Settlement and Disciplinary
5 Order, with the exception of this paragraph, it shall not become effective, shall be of no
6 evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary
7 action by either party hereto. Respondent further agrees that should the Division reject this
8 Stipulated Settlement and Disciplinary Order for any reason, respondent will assert no claim that
9 the Division, or any member thereof, was prejudiced by its/his/her review, discussion and/or
10 consideration of this Stipulated Settlement and Disciplinary Order or of any matter or matters
11 related hereto.

12 ADDITIONAL PROVISIONS

13 14. The parties agree that, if accepted by the Division, this Stipulated
14 Settlement and Disciplinary Order shall constitute a complete and final resolution of the charges
15 and allegations contained in Second Amended Accusation No. 10-2004-154474, and also the
16 pending investigation in Case No. 10-2006-174102 involving patient S.P.

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

20 16. The parties understand and agree that facsimile copies of this Stipulated
21 Settlement and Disciplinary Order, including facsimile signatures thereto, shall have the same
22 force and effect as the originals.

23 17. In consideration of the foregoing admissions and stipulations, the parties
24 agree the Division may, without further notice to or opportunity to be heard by respondent, issue
25 and enter the following Decision and Disciplinary Order:

26 DISCIPLINARY ORDER

27 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate
28 No. G42884 issued to respondent James Santiago Grisolia, M.D., is revoked. However, the

1 revocation is stayed and respondent is placed on probation for seven (7) years on the following
2 terms and conditions.

3 1. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND
4 ACCESS TO RECORDS AND INVENTORIES Respondent shall maintain a record of all
5 controlled substances ordered, prescribed, dispensed, administered or possessed by respondent,
6 and any recommendation or approval which enables a patient or patient's primary caregiver to
7 possess or cultivate marijuana for the personal medical purposes of the patient within the
8 meaning of Health and Safety Code section 11362.5, during probation, showing all the
9 following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of
10 controlled substances involved; and 4) the indications and diagnoses for which the controlled
11 substance was furnished.

12 Respondent shall keep these records in a separate file or ledger, in chronological
13 order. All records and any inventories of controlled substances shall be available for immediate
14 inspection and copying on the premises by the Division or its designee at all times during
15 business hours and shall be retained for the entire term of probation.

16 Failure to maintain all records, to provide immediate access to the inventory, or to
17 make all records available for immediate inspection and copying on the premises, is a violation
18 of probation.

19 2. PRESCRIBING PRACTICES COURSE Within 60 calendar days of the
20 effective date of this Decision, respondent shall enroll in a course in prescribing practices, at
21 respondent's expense, approved in advance by the Division or its designee. Failure to
22 successfully complete the course during the first 6 months of probation is a violation of
23 probation.

24 A prescribing practices course taken after the acts that gave rise to the charges in
25 the Second Amended Accusation, but prior to the effective date of the Decision may, in the sole
26 discretion of the Division or its designee, be accepted towards the fulfillment of this condition if
27 the course would have been approved by the Division or its designee had the course been taken
28 after the effective date of this Decision.

1 Respondent shall submit a certification of successful completion to the Division
2 or its designee not later than 15 calendar days after successfully completing the course, or not
3 later than 15 calendar days after the effective date of the Decision, whichever is later.

4 3. MEDICAL RECORD KEEPING COURSE Within 60 calendar days of
5 the effective date of this decision, respondent shall enroll in a course in medical record keeping,
6 at respondent's expense, approved in advance by the Division or its designee. Failure to
7 successfully complete the course during the first 6 months of probation is a violation of
8 probation.

9 A medical record keeping course taken after the acts that gave rise to the charges
10 in the Second Amended Accusation, but prior to the effective date of the Decision may, in the
11 sole discretion of the Division or its designee, be accepted towards the fulfillment of this
12 condition if the course would have been approved by the Division or its designee had the course
13 been taken after the effective date of this Decision.

14 Respondent shall submit a certification of successful completion to the Division
15 or its designee not later than 15 calendar days after successfully completing the course, or not
16 later than 15 calendar days after the effective date of the Decision, whichever is later.

17 4. ETHICS COURSE Within 60 calendar days of the effective date of this
18 Decision, respondent shall enroll in a course in ethics, at respondent's expense, approved in
19 advance by the Division or its designee. Failure to successfully complete the course during the
20 first year of probation is a violation of probation.

21 An ethics course taken after the acts that gave rise to the charges in the Second
22 Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of
23 the Division or its designee, be accepted towards the fulfillment of this condition if the course
24 would have been approved by the Division or its designee had the course been taken after the
25 effective date of this Decision.

26 Respondent shall submit a certification of successful completion to the Division
27 or its designee not later than 15 calendar days after successfully completing the course, or not
28 later than 15 calendar days after the effective date of the Decision, whichever is later.

1 5. CLINICAL TRAINING PROGRAM Within 60 calendar days of the
2 effective date of this Decision, respondent shall enroll in a clinical training or educational
3 program equivalent to the Physician Assessment and Clinical Education Program (PACE)
4 offered at the University of California - San Diego School of Medicine ("Program").

5 The Program shall consist of a Comprehensive Assessment program comprised of
6 a two-day assessment of respondent's physical and mental health; basic clinical and
7 communication skills common to all clinicians; and medical knowledge, skill and judgment
8 pertaining to respondent's specialty or sub-specialty, and at minimum, a 40 hour program of
9 clinical education in the area of practice in which respondent was alleged to be deficient and
10 which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any
11 other information that the Division or its designee deems relevant. Respondent shall pay all
12 expenses associated with the clinical training program.

13 Based on respondent's performance and test results in the assessment and clinical
14 education, the Program will advise the Division or its designee of its recommendation(s) for the
15 scope and length of any additional educational or clinical training, treatment for any medical
16 condition, treatment for any psychological condition, or anything else affecting respondent's
17 practice of medicine. Respondent shall comply with Program recommendations.

18 At the completion of any additional educational or clinical training, respondent
19 shall submit to and pass an examination. The Program's determination whether or not
20 respondent passed the examination or successfully completed the Program shall be binding.

21 Respondent shall complete the Program not later than six months after
22 respondent's initial enrollment unless the Division or its designee agrees in writing to a later time
23 for completion.

24 If respondent fails to successfully complete the clinical training program within
25 the designated time period, respondent shall cease the practice of medicine within 72 hours after
26 being notified by the Division or its designee that respondent failed to successfully complete the
27 clinical training program.

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1 Failure to participate in and complete successfully all phases of the clinical
2 training program outlined above is a violation of probation.

3 6. MONITORING - PRACTICE Within 30 calendar days of the effective
4 date of this Decision, respondent shall submit to the Division or its designee for prior approval as
5 a practice monitor, the name and qualifications of one or more licensed physicians and surgeons
6 whose licenses are valid and in good standing, and who are preferably American Board of
7 Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or
8 personal relationship with respondent, or other relationship that could reasonably be expected to
9 compromise the ability of the monitor to render fair and unbiased reports to the Division,
10 including, but not limited to, any form of bartering, shall be in respondent's field of practice, and
11 must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

12 The Division or its designee shall provide the approved monitor with copies of the
13 Decision and Second Amended Accusation, and a proposed monitoring plan. Within 15 calendar
14 days of receipt of the Decision, Second Amended Accusation, and proposed monitoring plan, the
15 monitor shall submit a signed statement that the monitor has read the Decision and the Second
16 Amended Accusation, and fully understands the role of a monitor, and agrees or disagrees with
17 the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the
18 monitor shall submit a revised monitoring plan with the signed statement.

19 Within 60 calendar days of the effective date of this Decision, and continuing
20 throughout probation, respondent's office practice shall be monitored by the approved monitor.
21 Respondent shall make all records available for immediate inspection and copying on the
22 premises by the monitor at all times during business hours, and shall retain the records for the
23 entire term of probation.

24 The monitor shall submit a quarterly written report to the Division or its designee
25 which includes an evaluation of respondent's performance, indicating whether respondent's
26 practices are within the standards of practice of medicine or billing, or both, and whether
27 respondent is practicing medicine safely, billing appropriately or both.

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1 It shall be the sole responsibility of respondent to ensure that the monitor submits
2 the quarterly written reports to the Division or its designee within 10 calendar days after the end
3 of the preceding quarter.

4 If the monitor resigns or is no longer available, respondent shall, within 5 calendar
5 days of such resignation or unavailability, submit to the Division or its designee, for prior
6 approval, the name and qualifications of a replacement monitor who will be assuming that
7 responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement
8 monitor within 60 days of the resignation or unavailability of the monitor, respondent shall be
9 suspended from the practice of medicine until a replacement monitor is approved and prepared to
10 assume immediate monitoring responsibility. Respondent shall cease the practice of medicine
11 within 3 calendar days after being so notified by the Division or designee.

12 Failure to maintain all records, or to make all appropriate records available for
13 immediate inspection and copying on the premises, or to comply with this condition as outlined
14 above is a violation of probation.

15 7. PROHIBITED PRACTICE During probation, respondent is prohibited
16 from providing care, treatment or management to any patient with chronic pain or to any patient
17 experiencing "intractable pain" as defined in Business and Professions Code section 2241.5.
18 After the effective date of this Decision, the first time that a patient seeking the prohibited
19 services makes an appointment, respondent shall orally notify the patient that respondent does
20 not provide care, treatment or management to patients with chronic or intractable pain.
21 Respondent shall maintain a log of all patients to whom the required oral notification was made.
22 The log shall contain the: 1) patient's name, address and phone number; 2) patient's medical
23 record number, if available; 3) the full name of the person making the notification; 4) the date the
24 notification was made; and 5) a description of the notification given. Respondent shall keep this
25 log in a separate file or ledger, in chronological order, shall make the log available for immediate
26 inspection and copying on the premises at all times during business hours by the Division or its
27 designee, and shall retain the log for the entire term of probation. Failure to maintain a log as

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1 defined in the section, or to make the log available for immediate inspection and copying on the
2 premises during business hours is a violation of probation.

3 In addition to the required oral notification, after the effective date of this
4 Decision, the first time that a patient who seeks the prohibited services presented to respondent,
5 respondent shall provide a written notification to the patient stating that respondent does not
6 provide care, treatment or management to patients with chronic or intractable pain. Respondent
7 shall maintain a copy of the written notification in the patient's file, shall make the notification
8 available for immediate inspection and copying on the premises at all times during business
9 hours by the Division or its designee, and shall retain the notification for the entire term of
10 probation. Failure to maintain the written notification as defined in the section, or to make the
11 notification available for immediate inspection and copying on the premises during business
12 hours is a violation of probation.

13 8. NOTIFICATION Prior to engaging in the practice of medicine, the
14 respondent shall provide a true copy of the Decision and Second Amended Accusation to the
15 Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership
16 are extended to respondent, at any other facility where respondent engages in the practice of
17 medicine, including all physician and locum tenens registries or other similar agencies, and to the
18 Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage
19 to respondent. Respondent shall submit proof of compliance to the Division or its designee
20 within 15 calendar days.

21 This condition shall apply to any change in hospitals, other facilities or insurance
22 carrier.

23 9. SUPERVISION OF PHYSICIAN ASSISTANTS During probation,
24 respondent is prohibited from supervising physician assistants.

25 10. OBEY ALL LAWS Respondent shall obey all federal, state and local
26 laws, all rules governing the practice of medicine in California, and remain in full compliance
27 with any court ordered criminal probation, payments and other orders.

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1 11. QUARTERLY DECLARATIONS Respondent shall submit quarterly
2 declarations under penalty of perjury on forms provided by the Division, stating whether there
3 has been compliance with all the conditions of probation. Respondent shall submit quarterly
4 declarations not later than 10 calendar days after the end of the preceding quarter.

5 12. PROBATION UNIT COMPLIANCE Respondent shall comply with the
6 Division's probation unit. Respondent shall, at all times, keep the Division informed of
7 respondent's business and residence addresses. Changes of such addresses shall be immediately
8 communicated in writing to the Division or its designee. Under no circumstances shall a post
9 office box serve as an address of record, except as allowed by Business and Professions Code
10 section 2021, subdivision (b).

11 Respondent shall not engage in the practice of medicine in respondent's place of
12 residence. Respondent shall maintain a current and renewed California physician's and
13 surgeon's license.

14 Respondent shall immediately inform the Division, or its designee, in writing, of
15 travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last,
16 more than 30 calendar days.

17 13. INTERVIEW WITH THE DIVISION, OR ITS DESIGNEE Respondent
18 shall be available in person for interviews either at respondent's place of business or at the
19 probation unit office, with the Division or its designee, upon request at various intervals, and
20 either with or without prior notice throughout the term of probation.

21 14. RESIDING OR PRACTICING OUT-OF-STATE In the event respondent
22 should leave the State of California to reside or to practice, respondent shall notify the Division
23 or its designee in writing 30 calendar days prior to the dates of departure and return. Non-
24 practice is defined as any period of time exceeding 30 calendar days in which respondent is not
25 engaging in any activities defined in sections 2051 and 2052 of the Business and Professions
26 Code.

27 All time spent in an intensive training program outside the State of California
28 which has been approved by the Division or its designee shall be considered as time spent in the

1 practice of medicine within the State. A Board-ordered suspension of practice shall not be
2 considered as a period of non-practice. Periods of temporary or permanent residence or practice
3 outside California will not apply to the reduction of the probationary term. Periods of temporary
4 or permanent residence or practice outside California will relieve respondent of the responsibility
5 to comply with the probationary terms and conditions with the exception of this condition and
6 the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance;
7 and Cost Recovery.

8 Respondent's license shall be automatically canceled if respondent's periods of
9 temporary or permanent residence or practice outside California total two years. However,
10 respondent's license shall not be canceled as long as respondent is residing and practicing
11 medicine in another state of the United States and is on active probation with the medical
12 licensing authority of that state, in which case the two year period shall begin on the date
13 probation is completed or terminated in that state.

14 15. FAILURE TO PRACTICE MEDICINE - CALIFORNIA RESIDENT

15 In the event respondent resides in the State of California and for any reason
16 respondent stops practicing medicine in California, respondent shall notify the Division or its
17 designee in writing within 30 calendar days prior to the dates of non-practice and return to
18 practice. Any period of non-practice within California, as defined in this condition, will not
19 apply to the reduction of the probationary term and does not relieve respondent of the
20 responsibility to comply with the terms and conditions of probation. Non-practice is defined as
21 any period of time exceeding 30 calendar days in which respondent is not engaging in any
22 activities defined in sections 2051 and 2052 of the Business and Professions Code.

23 All time spent in an intensive training program which has been approved by the
24 Division or its designee shall be considered time spent in the practice of medicine. For purposes
25 of this condition, non-practice due to a Board-ordered suspension or in compliance with any
26 other condition of probation, shall not be considered a period of non-practice.

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Respondent's license shall be automatically canceled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

16. COMPLETION OF PROBATION Respondent shall comply with all financial obligations not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

17. VIOLATION OF PROBATION Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

18. LICENSE SURRENDER Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Division or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

19. PROBATION MONITORING COSTS Respondent shall pay the costs associated with probation monitoring each and every year of probation which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to

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1 the Division or its designee no later than January 31 of each calendar year. Failure to pay costs
2 within 30 calendar days of the due date is a violation of probation.

3 ACCEPTANCE

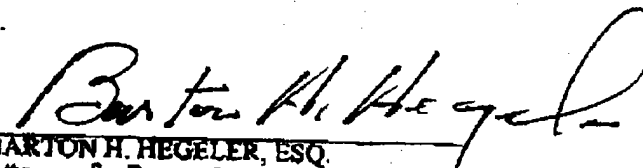
4 I have carefully read the above Stipulated Settlement and Disciplinary Order and
5 have fully discussed it with my attorney, Barton H. Hegeler, Esq. I understand the stipulation
6 and the effect it will have on my Physician's and Surgeon's Certificate No. G42884. I enter into
7 this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and
8 agree to be bound by the Decision and Order of the Division of Medical Quality, Medical Board
9 of California, Department of Consumer Affairs, State of California.

10
11 DATED: 9/12/07

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13 
14 JAMES SANTIAGO GRISOLIA, M.D.
15 Respondent

16 I have read and fully discussed with respondent James Santiago Grisolia, M.D.,
17 the terms and conditions and other matters contained in the above Stipulated Settlement and
18 Disciplinary Order. I approve its form and content.

19 DATED: 9.13.07

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22 BARTON H. HEGELER, ESQ.
Attorney for Respondent

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ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Division of Medical Quality, Medical Board of California, Department of Consumer Affairs, State of California.

DATED: 9/13/07

EDMUND G. BROWN JR., Attorney General
of the State of California

THOMAS S. LAZAR
Supervising Deputy Attorney General



SAMUEL K. HAMMOND
Deputy Attorney General

Attorneys for Complainant

DOJ Matter ID: SD2005701247
80162134.wpd

Exhibit A

Second Amended Accusation No. 10-2004-154474

1 EDMUND G. BROWN JR, Attorney General
of the State of California
2 THOMAS S. LAZAR
Supervising Deputy Attorney General
3 SAMUEL K. HAMMOND, State Bar No. 141135
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8 Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO September 11, 20 07
BY Walter Moore ANALYST

10 **BEFORE THE**
11 **DIVISION OF MEDICAL QUALITY**
12 **MEDICAL BOARD OF CALIFORNIA**
13 **DEPARTMENT OF CONSUMER AFFAIRS**
14 **STATE OF CALIFORNIA**

13 In the Matter of the Second Amended
Accusation Against:

14 **JAMES SANTIAGO GRISOLIA, M.D.**
15 4033 Third Avenue, #410
San Diego, CA 92103

16 Physician's and Surgeon's
17 Certificate No. G 42884

18 Respondent.

Case No. 10-2004-154474

OAH Case No. L-2006110388

SECOND AMENDED ACCUSATION

(Gov. Code, § 11503)

20 Complainant Barbara Johnston, as causes for disciplinary action, alleges:

21 **PARTIES**

22 1. Complainant is the Executive Director of the Medical Board of California,
23 Department of Consumer Affairs, State of California (hereinafter the "Board"), and makes and
24 files this Second Amended Accusation solely in his official capacity.

25 2. At all times mentioned herein, James Santiago Grisolia, M.D., (hereinafter
26 "Respondent") has been licensed by the Medical Board under Physician's and Surgeon's
27 Certificate No. G 42884. Said certificate was issued by the Board on August 4, 1980, and will
28 expire on April 30, 2008, unless renewed.

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1 conduct which is unbecoming to a member in good standing of the medical profession, and
2 which demonstrates an unfitness to practice medicine.^{2/}

3 7. Section 2238 of the Code provides that a violation of any federal statute or
4 federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or
5 controlled substances constitutes unprofessional conduct.

6 8. Section 2241.5 of the Code, also known as the "Intractable Pain Act"
7 provides, in pertinent part, that:

8 "(f) This section shall not affect the power of the Board to deny,
9 revoke, or suspend the license of any physician and surgeon who does any of the
10 following:

11 "(1) Prescribes or administers a controlled substance or treatment that is
12 non-therapeutic in nature or non-therapeutic in the manner the controlled
13 substance or treatment is administered or prescribed or is for a non-therapeutic
14 purpose in a non-therapeutic manner.

15 "(2) Fails to keep complete and accurate records of purchases and
16 disposals of substances listed in the California Controlled Substances Act or of
17 controlled substances scheduled in, or pursuant to the federal Comprehensive
18 Drug Abuse Prevention and Control Act of 1970.

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

22 "(4) Prescribes, administers, or dispenses in a manner not consistent
23 with public health and welfare controlled substances listed in the California
24 Controlled Substances Act or scheduled in the federal Comprehensive Drug
25 Abuse Prevention and Control Act of 1970.

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27
28 2. *Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.

1 “(5) Prescribes, administers, or dispenses in violation of either
2 Chapter 4 (commencing with Section 11150) or Chapter 5 (commencing with
3 Section 11210) of Division 10 of the Health and Safety Code or this chapter.”

4 9. Section 2242 of the Code provides, in pertinent part, that the prescribing,
5 dispensing, or furnishing dangerous drugs, as defined in section 4022 of the Code, without a
6 good faith examination and medical indication therefor, constitutes unprofessional conduct.

7 10. Section 2262 of the Code provides that the altering or modifying of the
8 medical record of any person, with fraudulent intent, or creating any false medical record, with
9 fraudulent intent, constitutes unprofessional conduct.

10 11. Section 2266 of the Code provides that the failure of a physician and
11 surgeon to maintain adequate and accurate records relating to the provision of services to their
12 patients constitutes unprofessional conduct.

13 **FIRST CAUSE FOR DISCIPLINARY ACTION**

14 (Gross Negligence)

15 12. Respondent has subjected his Physician's and Surgeon's Certificate
16 No. G 42884 to disciplinary action under sections 2227 and 2234 as defined by 2234,
17 subdivision (b) of the Code, in that he was grossly negligent in the medical care he rendered to
18 patients L.G., I.G., W.W., D.D., J.L. and A.S. The circumstances are as follows:

19 Patient L.G.

20 A. Patient L.G. was respondent's spouse. She died on October 23,
21 2003, at the age of 52, at the home she shared with respondent. An autopsy determined
22 the cause of death to be accidental due to intoxication from morphine, Vicodin, Celexa,
23 Benadryl, and Restoril. The coroner concluded L.G.'s death was attributed to the
24 combined effect of multiple sedative prescription medications. Toxicological studies
25 revealed that the levels of some of the drugs found in L.G.'s system were above the usual
26 therapeutic range.

27 B. Respondent and L.G. were married in or about 1990. Prior to their
28 marriage, and dating back to at least 1987, L.G. had been diagnosed with a variety of

1 medical conditions that included syncopal episodes and drop attacks for which she had
2 been taking Dilantin, an anticonvulsant medication. She also had been diagnosed with
3 migraine headaches and complex partial seizures, both also controlled with Dilantin.
4 These conditions, including a post-traumatic headache disorder, dated back to a minor
5 head injury in or about 1987. In addition to these conditions, L.G. had been diagnosed
6 with difficulty in sleeping, arthritis, anxiety disorder, chronic allergies, and possible
7 depression.

8 C. Respondent, a neurologist by specialty, participated in L.G.'s
9 medical care prior to and following their marriage, including prescribing medications for
10 her various medical conditions. In addition to respondent, L.G. also received medical
11 care from several other physicians as well from 1987 through 2003.

12 D. Respondent's medical records for L.G. were virtually non-existent
13 and consist of only five pages of notes, dated between April 9, 1987³ through October 20,
14 2003, three days before L.G.'s death. There are no notes consistent with an initial
15 evaluation of L.G., either dictated or handwritten. There are gaps in the evaluations that
16 do exist between May 21, 1987, to September 20, 1988, and from November 3, 1988, to
17 May 2, 1989, with a final note on June 5, 1999. Thereafter, there are no more notes until
18 the two final notes shortly before the patient's death, one dated March 8, 2003, and the
19 other dated October 20, 2003. Respondent's brief medical records that do exist for L.G.
20 indicate that respondent assumed the primary responsibility for L.G.'s medical care in or
21 about May 1998, based on a chart notation that L.G., then respondent's wife, trusted
22 respondent to take care of her and that she did not want to see any other physician.

23 E. Respondent's chart note for L.G., dated March 8, 2003, states that
24 L.G.'s headaches and seizures were well controlled.

25 F. Respondent's chart note for L.G., dated October 20, 2003, three
26 days before her death, is quite extensive and appears to be the longest note in
27

28 3. Statements pertaining to treatment respondent provided to this patient prior to 1999 are
informational only and are not the basis for discipline.

1 respondent's chart with respect to the care he provided to L.G. In this note, respondent
2 indicated that L.G. had a single seizure, typical epileptic drop with postictal confusion
3 witnessed by him. L.G. had not been taking Neurontin for two days and had sleep loss
4 from her trip back home. She had the onset of right hip pain four days prior to the note,
5 and she was given morphine sulfate 30 mg. every four hours from an old prescription that
6 respondent had at his home. Also, respondent gave L.G. Prednisone. On the evening
7 prior to L.G.'s death, respondent admitted giving L.G. Benadryl, Restoril, and morphine
8 sulfate.

9 G. Respondent prescribed many medications to L.G. during the years
10 he treated her. Specifically, between July 13, 2001, and October 20, 2003, respondent
11 prescribed multiple prescriptions for Vicodin, as well as prescriptions for Restoril,
12 Prempro, Xenical, Beconase, Celexa, Indocin, Fioricet, Diflucan, Advair, chromalin
13 sodium, Retin-4 Motrin, Compazine, Septra, Azmacort, clindamycin, and Alupent. In
14 addition, at various other times, respondent also prescribed to L.G. Benadryl, morphine
15 sulfate, Valium, hydrocodone, Esgic, Effexor, and Neurontin. In addition, L.G. was also
16 receiving Lorazepam and morphine prescribed by other doctors as well.

17 Patient I.G.

18 H. On or about July 7, 1999, patient I.G., then 49 years old, made a
19 visit to respondent's clinic with complaints of neck pain radiating to both extremities and
20 cramping in both hands. As medical history, patient I.G. stated that he suffered a
21 ruptured disc from an automobile accident in 1996, that a cervical MRI was performed at
22 the San Diego VA Hospital and that he was taking 4-10 tablets of Percocet^{4/} a day.
23 Respondent examined the patient. His impression included cervical strain and bilateral
24 carpal tunnel syndrome. He ordered a cervical MRI and prescribed 60 tablets of Percocet
25 and Prednisone for the patient. On or about July 13, 1999, patient I.G. made a return visit

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28 4. Percocet (oxycodone and acetaminophen) is a Schedule II controlled substance as defined in
section 11055, subdivision (b)(1)(N) of the Health and Safety Code.

1 during which respondent reviewed the MRI films and prescribed 200 tablets of Percodan
2 for the patient.

3 I. Beginning in August 1999 and continuing until about September
4 2001, patient I.G. made nearly monthly visits to respondent's clinic. With some
5 exceptions, respondent prescribed 200 tablets of Percocet 5 mg. for patient I.G. on each
6 visit.⁵ On most of these visits, respondent noted the patient's complaint as "increased
7 neck pain" or "no change." During this period, patient I.G. was also receiving treatment
8 and other medications from the Pain Clinic at the San Diego VA Hospital. Beginning in
9 October 2001, patient I.G.'s visits changed to every other month. Between about
10 October 1, 2001 and about January 23, 2002, respondent prescribed 400 tablets of
11 Percocet 5 mg. every other month for patient I.G. However, beginning with the visit on
12 or about March 18, 2002, respondent increased the dosage to 600 tablets of Percocet
13 5 mg. every other month. Respondent continued to prescribe 600 tablets of Percocet
14 5 mg. every other month until patient I.G.'s final visit on or about August 3, 2005.
15 Despite the large amount of controlled substances prescribed, there is no documentation
16 of ongoing physical examination of patient I.G. during the period of treatment, and there
17 is no documentation of an established treatment plan of treatment of the patient's cervical
18 and neck pain. Moreover, respondent failed to obtain and note patient I.G.'s informed
19 consent for the prolonged treatment with narcotics, failed to discuss and/or note he
20 discussed other pain treatment modalities with the patient, and failed to conduct periodic
21 reviews to determine the effectiveness of large amounts of controlled substances he was
22 prescribing for the patient.

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27 5. For example, respondent prescribed 300 tablets of Percocet 5 mg. for the patient on the visit on
28 or about October 19, 1999.

Patient W.W.

J. On or about November 16, 1993,^{6/} patient W.W., a 45-year-old male, made a visit to respondent's clinic with a complaint of low back pain. As medical history, the patient W.W. stated he underwent a lumbar laminectomy at the UCSD Medical Center in about 1991, and was again hospitalized at the San Diego VA hospital in October 1993. Patient W.W. also stated that he abused street drugs for 15 years but stopped in about 1991, and that he was on Motrin 75 mg. daily. Respondent examined the patient. His impression was "arachnoiditis." Respondent wrote a prescription for several medications including 30 tablets of Tylenol #4^{7/} for the patient. On patient W.W.'s next visit, respondent noted the patient's pain was unchanged and he prescribed 50 tablets of Tylenol #4 for the patient. On or about January 3, 1994, respondent was informed that a pharmacy had denied patient W.W.'s request for 60 tablets of Tylenol #4.

K. On or about March 27, 1995, the patient W.W. presented with lower back pain radiating to both lower extremities. On this visit, the patient specifically requested the drug Doriden.^{8/} Respondent prescribed 30 tablets of Doriden to the patient on this visit. Thereafter, patient W.W. made monthly visits during 1995. On all of these visits, respondent wrote prescriptions for Dilaudid^{9/} and Valium^{10/} for the patient. On the visit of about November 8, 1995, respondent noted patient W.W. had forged a prescription to obtain Tylenol #3 at UCSD. Patient W.W. made nearly monthly visits

6. Statements pertaining to treatment respondent provided to this patient and patients W.W., J.L., D.D. and A.S. prior to 2000 are informational only and are not the basis for discipline.

7. Tylenol #4, acetaminophen and codeine, is a Schedule III controlled substance under section 11056, subdivision (e)(3) of the Health and Safety Code. It is indicated for treatment to severe pain.

8. Doridan is a drug that is highly desired by drug abusers. It is said to reproduce the sensation of intravenous heroin when combined with Tylenol #4. On the "streets," the combination is referred to as "Doors and Fours."

9. Dilaudid, hydromorphone and hydrochloride, are Schedule II controlled substances under section 11055, subdivision (b)(1)(K) of the Health and Safety Code.

10. Valium, a brand name for Diazepam, is a Schedule IV controlled substance under Health and Safety Code section, subdivision 11057(d)(7).

1 during 1996, 1997 and 1998. On most of these visits, respondent noted the patient's back
2 pain was worsening. On most visits he prescribed 200 tablets of Dilaudid, 100 tablets of
3 Tylenol #4 and 100 tablets of Valium for the patient. On or about April 2, 1998,
4 respondent noted patient W.W.'s house had burned down. On or about May 12, 1998,
5 patient W.W. reported he was assaulted by "gang members" and suffered a "minor
6 traumatic brain injury." On the visit on or about August 3, 1998, patient W.W. reported
7 that someone attempted to obtain drugs from a pharmacy by impersonating the patient.
8 On the visit on or about September 2, 1998, respondent commenced prescribing
9 Methadone 80 mg. instead of the Dilaudid drug. Thereafter and continuing through about
10 December 1999, respondent monthly prescription for patient W.W. included Methadone,
11 Tylenol #4 and Valium.

12 L. Patient W.W. made monthly visits from January 2000 to
13 November 2000. During this period, respondent continued to prescribe 250 tablets of
14 Methadone 10 mg., 100 tablets of Valium and 100 tablets of Tylenol #4 on each visit for
15 treatment of patient W.W.'s back pain. During this period, patient W.W. was also been
16 treated at the San Diego VA Hospital where he was diagnosed with Post Traumatic Stress
17 Syndrome. On or about April 4, 2001, patient W.W. checked himself to the ER at
18 Scripps Mercy Hospital complaining he was being poisoned at the hotel in which he
19 resided.

20 M. Patient W.W. resumed his visits to respondent's clinic on or about
21 August 20, 2003, when he complained of "left upper extremity swelling." On this visit,
22 respondent noted patient W.W. "went to Mercy Hospital" and "was followed (sic) by San
23 Diego VA Hospital" and "was on Methadone 10 mg. up to 20 per day." Respondent
24 wrote a prescription for medications that included 600 tablets of Morphine Sulphate (MS)
25 30 mg.,^{11/} 100 tablets of Valium 10 mg. On patient W.W.'s follow-up visit on or about
26 September 22, 2003, respondent prescribed 600 tablets of long acting Morphine Sulphate

27 11. Morphine Sulphate is a Schedule II controlled substance under section 11055, subdivision
28 (b)(1)(M) of the Health and Safety Code.

1 (MSIR) 30 mg. and 600 tablets of Methadone 10 mg. for the patient. Respondent
2 repeated this prescription on the patient's visits on October 20, 2003, December 2, 2003,
3 and December 23, 2003. There is no notation of the medical justification for the
4 morphine sulphate medications.

5 N. Patient W.W. continued his monthly visits throughout 2004, and
6 from January 2005 until the final visit on or about September 13, 2005. On most visits,
7 respondent noted "low back pain" or "increased back pain" as the patient's complaint.
8 On nearly all visits, respondent prescribed 600 tablets of MS 30 mg., 600 tablets of
9 Methadone 10 mg. and 100 tablets of Valium 5 mg. for patient W.W. On or about
10 March 18, 2004, respondent noted he had received a telephone call from a police officer
11 stating patient W.W. was "delusional, confused and paranoid." On the visit on or about
12 June 21, 2005, respondent noted patient W.W. underwent a psychological evaluation at
13 UCSD. His impression on this visit was patient W.W. suffered a "paranoid reaction."

14 O. Respondent prescribed large amounts of controlled substances to
15 patient W.W. over a prolonged period without performing and documenting adequate
16 ongoing physical examinations and without establishing and documenting a treatment
17 plan for the patient's lower back pain. Respondent also failed to obtain and note the
18 patient W.W.'s informed consent for the prolonged treatment with narcotics, failed to
19 discuss and/or note he discussed other pain treatment modalities with the patient.
20 Respondent also failed to conduct periodic reviews to determine the effectiveness of large
21 amounts of controlled substances he was prescribing for patient W.W. In spite of the
22 clear signs of addiction, respondent failed to take and note steps he took to determine
23 whether patient W.W. was addicted to pain medication, and failed to obtain a pain
24 specialist or an addictionologist consult for the patient at any time during the period of
25 treatment.

26 Patient J.L.

27 P. On or about August 11, 1994, at the request of her attorney,
28 patient J.L., then 39 years old, consulted with respondent for a "neurologic disability"

1 evaluation in connection with a breast implant litigation. Patient J.L. reported, among
2 other things, that she underwent a cervical laminectomy procedure in 1983 and a bilateral
3 silicone breast implantation in 1987, and that in 1991, she began to suffer pain in her
4 shoulders and neck, left arm tingling and numbness, memory loss, chronic fatigue and
5 depression. Patient J.L. denied taking any medications for her medical problems, denied
6 smoking or drinking and denied using recreational drugs. After evaluating the patient,
7 respondent reported his impressions and diagnosis in a Neurologic Comprehensive
8 Evaluation report addressed to the patient's attorney. His impressions and diagnosis
9 included "Atypical Neurologic Disease Syndrome," polyneuropathy, arthralgias,
10 myalgias, sustained balance disturbance and progressive memory loss. Respondent
11 concluded patient J.L. was unable to perform any vocational or avocational activities and
12 has been disabled since 1992.

13 Q. On or about August 31, 1994, patient J.L. returned to respondent's
14 clinic complaining of increased neck pain. Respondent prescribed Prednisone 20 mg.
15 Patient J.L. made a return visit in which she reported the Prednisone medication caused
16 anxiety, sweatiness and tachycardia. Respondent prescribed Klonopin^{12/} for the patient.
17 On the visit on or about November 7, 1994, respondent noted patient J.L. could not afford
18 Klonopin. On this date, respondent prescribed Ativan, Valium and 10 refills of Vicodin.
19 Thereafter, the patient J.L. made roughly monthly visits through 1996 during which the
20 patient received prescriptions for Vicodin and Valium. On most visits, respondent noted
21 patient J.L. complained of pain in the neck, headaches and auditory and visual
22 hallucinations. In 1995, in the course of its disability evaluation, the Department of
23 Social Services (DDS) found that patient J.L. suffered from both depressive and anxiety
24 disorders. In March 1996, DDS noted patient J.L. carried a diagnosis of personality
25 disorder and active alcohol abuse. On patient J.L.'s visit on or about April 19, 1996,
26 respondent noted the patient was drinking beer to relieve the pain. In 1997, patient J.L.

27 12. Klonopin (Clonazepam) is a Schedule IV controlled substance under section 11057,
28 subdivision (d)(6) of the Health and Safety Code.

1 made approximately 16 visits, and in 1998, she made approximately 18 visits.
2 Respondent prescribed Vicodin and Valium for the patient on nearly every visit, and on
3 some visits, respondent added prescriptions for Zoloft, Klonopin, Ritalin and Zyprexa.¹³
4 On patient J.L.'s visit on or about February 12, 1997, respondent noted the patient
5 requested more Vicodin which was denied. On the visit on or about October 23, 1998,
6 respondent noted patient J.L. was using marijuana. In November 1998, respondent began
7 prescribing Fentanyl for patient J.L. Patient J.L. was admitted to the hospital on
8 numerous occasions during 1996 through 1998.

9 R. Patient J.L. made approximately 22 office visits during 1999. On
10 most of the visits, respondent continued to prescribe Vicodin, Valium, Trazadone,
11 Ritalin, Fentanyl and Klonopin for the patient. In February, April, June and October,
12 patient J.L. was hospitalized for visual and auditory hallucinations and for exacerbation
13 of her dymelination autoimmune disorder. Patient J.L. was noted to have a history of
14 schizophrenia and schizoaffective disorder during these hospitalizations. Beginning in
15 December 1999, respondent commenced prescribing Oxycontin for the patient. There is
16 no notation that patient J.L. complained of pain on any of the visits in 1999.

17 S. Patient J.L. made approximately 27 office visits during 2000.
18 Respondent prescribed Oxycontin (160 mg. per day), Valium, Klonopin for the patient
19 throughout the year. With the exception of 5 visits (visits on March 20 and 29, June 14,
20 August 7 and November 1) there is no notation patient J.L. complained of pain during
21 these visits. On the visit on or about April 10, 2000, respondent noted patient J.L. was
22 "hearing increased voices" telling her to "kill herself." On or about May 9, 2000,
23 respondent noted that patient J.L. had checked herself into the detox facility at Charter
24 Hospital for Valium detoxification. At the hospital, patient J.L. admitted she had been
25 obtaining Valium from Mexico. On the visit on or about August 7, 2000, respondent
26 noted patient J.L. "threw out" her Oxycontin medication, and on the December 29, 2000,
27

28 13. Zyprexa is indicated for the treatment of schizophrenia.

1 visit, respondent noted patient J.L. "threw away" all her prescription drugs upon
2 observing her brother use IV drugs.

3 T. Patient J.L. made approximately 30 office visits during 2001.
4 Respondent prescribed Oxycontin, Klonopin and Valium for the patient during this
5 period. On or about April 4, 2001, patient J.L. reported her Oxycontin medication was
6 seized by a US Border Patrol agent as she crossed the border. In May of 2001,
7 respondent increased the Oxycontin dosage to 240 mg. a day. On or about June 18, 2001,
8 respondent noted patient J.L. fell and hit her head while riding her bicycle. On or about
9 August 8, 2001, respondent noted patient J.L. fell in a river. On or about August 30,
10 2001 patient J.L. reported that her friend had been "pressuring" her for prescription drugs
11 and that some of the patient's drugs were missing. On or about September 12, 2001,
12 respondent noted patient J.L. crashed her bike.

13 U. Patient J.L. made approximately 28 office visits in 2002.
14 Respondent prescribed Oxycontin 240 mg. per day for the patient on nearly every visit.
15 He also continued the prescriptions for Valium and Klonopin. On or about June 25,
16 2002, respondent's staff noted patient J.L. called the office claiming she lost two days of
17 medications. This same day, another physician called the respondent's office and
18 instructed respondent's staff that patient J.L. should not be prescribed any medication
19 because her "story was unbelievable." On or about November 11, 2002, respondent noted
20 he prescribed Klonopin for patient J.L. so the patient would no longer use marijuana, and
21 on December 9, respondent noted patient J.L. was "staying away from marijuana."

22 V. Patient J.L. made approximately 30 office visits in 2003.
23 Respondent prescribed Oxycontin 240 mg. per day for the patient on nearly every visit.
24 Respondent also continued the prescription for Klonopin, and on some occasions, added
25 Prednisone. On the visit on or about February 24, 2003, patient J.L. reported her friend
26 had stolen her medication. Respondent wrote another prescription for Oxycontin on this
27 visit. On or about March 24, 2003, patient J.L. called respondent's staff requesting more
28 medication because she spilled water on her medications. On the April 23 visit, patient

1 J.L. reported that her friend had stolen and used "a lot" of the patient's medication. On or
2 about May 12, 2003, patient J.L. called respondent's office requesting an early refill of
3 her Klonopin medication claiming the Klonopin had been "washed" away. Respondent
4 ordered a refill of the Klonopin medication. On the visit on or about May 20, 2003,
5 patient J.L. again reported she "lost" her Klonopin. On or about June 23, 2003, patient
6 J.L. called respondent's office requesting an early refill claiming she "accidentally" took
7 double the prescribed dosage. On the visit on or about September 22, 2003, respondent
8 prescribed 50 tablets of Percocet for patient J.L. in addition to the Oxycontin medication.
9 On the visit on or about November 11, 2003, respondent noted that patient J.L. was
10 "desperate," "confused" and "psychotic" and that he instructed the patient to "slow down
11 on Oxycontin."

12 W. Patient J.L. made approximately 25 office visits in 2004. Patient
13 J.L.'s complaints were related to her psychiatric problems on most of these visits.
14 Respondent prescribed Oxycontin for patient J.L. on nearly every visit. He also
15 prescribed Klonopin, Ambien Seroquel, Stratera and Neurontin for the patient during the
16 year. On the visit on or about January 20, 2004, respondent noted patient J.L. had
17 "increasing psychosis and paranoia." On the visit on or about March 11, 2004, patient
18 J.L. reported she fell and hit her head and neck. On the visit on or about April 20, 2004,
19 respondent noted patient J.L. was using less marijuana. On or about July 30, 2004,
20 patient J.L. called respondent's staff claiming she "lost" all her medications. On the visit
21 on or about August 3, 2004, respondent increased the Oxycontin dosage to 480 mg. per
22 day, and on the visit on or about August 13, 2004, he increased the Oxycontin dosage to
23 640 mg. per day. Thereafter, respondent prescribed 640 mg. per day for patient J.L. on
24 each visit. On the visit on or about November 17, 2004, respondent noted patient J.L.
25 stated she was "disintegrating and falling apart." On the visit on or about December 15,
26 2004, patient J.L. reported she fell on her head five days before the visit.

27 X. Patient J.L. made approximately 19 visits in 2005, and made her
28 final visit on or about September 23, 2005. Patient J.L.'s complaints on most visits

1 related to her psychiatric problems. Respondent prescribed Oxycontin 640 mg. per day
2 for patient J.L. on each visit. He also continued to prescribe Klonopin, Percocet, Xanax
3 and other drugs for the patient during the year. On the visit on or about January 11, 2005,
4 patient J.L. reported she "threw away" her Klonopin medication. On or about March 30,
5 2005, patient J.L. reported all her medications had been destroyed in a "wash." On the
6 visit on or about May 12, 2005, respondent noted patient J.L. was "holding marijuana."
7 In or about July or August 2005 patient J.L. called respondent's staff requesting refill of
8 her Klonopin prescription 12 days earlier than ordered. On or about September 9, 2005,
9 respondent's staff noted patient J.L. reported her house had been broken into and her
10 medication had been stolen.

11 Y. Respondent prescribed large amounts of controlled substances to
12 patient J.L. over a prolonged period without performing and documenting adequate
13 ongoing physical examinations, and without establishing and documenting a treatment
14 plan for the patient's pain. Respondent also failed to obtain and note patient J.L.'s
15 informed consent for the prolonged treatment with narcotics, failed to discuss and/or note
16 he discussed other pain treatment modalities with the patient. Respondent also failed to
17 conduct periodic reviews to determine the effectiveness of large amounts of controlled
18 substances he was prescribing for patient J.L. In spite of the clear signs of addiction,
19 respondent failed to take any steps to determine whether patient J.L. was addicted to pain
20 medication and failed to obtain a pain specialist or addictionologist consultation for the
21 patient. Further, in spite of the clear evidence patient J.L. was obtaining other
22 prescription drugs and marijuana from other sources, respondent failed take and note
23 steps he took to determine the patient was not abusing prescription medications and
24 "street" drugs.

25 Patient D.D.

26 Z. On or about December 11, 1995, patient D.D., then 40 years old,
27 consulted with respondent. Patient D.D. complained of excruciating pain in the back and
28 legs and a headache. She stated the pain was controlled by large amounts Vicodin and

1 Valium. On or about May 17, 1995, patient D.D. made a follow-up visit at which time
2 respondent reviewed the patient's medical records including an MRI, and formulated the
3 impression of cervical multiple sclerotic lesion. Thereafter, patient D.D. made regular
4 office visits during 1996 through 1999. Respondent's standard prescriptions for the
5 patient during this period included Oxycontin, Vicodin and Valium. The initial dosage of
6 the Oxycontin was 80 mg. per day. This was increased to 160 mg. per day in 1997, and to
7 240 mg. per day in 1998, and to 480 mg. per day by 1999. Respondent also increased the
8 dosages for the Valium and Vicodin for patient D.D. during this period. During this
9 period, patient D.D. declined to follow respondent's suggestion that she undergo a
10 procedure for the placement of an opiate pump.

11 AA. Patient D.D. made regular office visits between January 2000 and
12 September 2005. During 2000, patient D.D. made approximately eight visits during
13 which respondent continued to prescribe 480 mg. Oxycontin per day, along with 200
14 tablets of Extra Strength Vicodin (Vicodin ES) and 120 tablets of Valium per month.
15 Patient D.D. made monthly visits during 2001. On the January 2001 visit, respondent
16 increased the dosage of the Oxycontin to 600 mg. per day. However, on the following
17 visit on or about February 26, 2001, respondent replaced the Oxycontin with Morphine
18 Sulphate Controlled Release Contin (MS Contin) 150 mg. per day, and this dosage was
19 increased to 210 mg. per day. In addition, respondent prescribed 100 tablets of Vicodin
20 ES and 180 tablets of Valium 10 mg. per month for the patient. Patient D.D. made
21 approximately seven visits in 2002, approximately seven visits in 2003, approximately
22 six visits in 2004 and five visits in 2005. During this period respondent increased the
23 patient's MS Contin to 480 mg. per day in addition to the Vicodin and Valium
24 prescriptions.

25 BB. Respondent prescribed large amounts of controlled substances to
26 patient D.D. over a prolonged period without performing and documenting adequate
27 ongoing physical examinations, and without establishing and documenting a treatment
28 plan for the patient's pain. Respondent also failed to obtain and note patient D.D.'s

1 informed consent for the prolonged treatment with narcotics, failed to discuss and/or note
2 he discussed other pain treatment modalities with the patient. Respondent also failed to
3 conduct periodic reviews to determine the effectiveness of large amounts of controlled
4 substances he was prescribing for patient D.D.

5 Patient A.S.

6 CC. On or about December 12, 2002, patient A.S., then 38 years old,
7 consulted with respondent for evaluation of the patient's chronic headaches. As history,
8 the patient stated her headaches started at age five and had worsened over time, and were
9 occurring almost daily. Patient A.S. reported that she had been followed by several
10 physicians, that multiple CT scans of the head had been normal, that in the past she had
11 been treated with several different medications including Inderol, Neurontin and
12 Depakote, and that her current medications included Wellbutrin, Zoloft and Ultram. On
13 this visit, respondent performed a neurologic examination. His impression was
14 "migrainous headaches disorder."

15 DD. Beginning in January 2003, patient A.S. commenced office visits
16 for treatment. On or about January 6, 2003, patient A.S. made an office visit complaining
17 of "increased headache postpartum." Respondent prescribed one month supply of
18 Tofranil, 30 tablets of Fioricet (with no refills) and 30 tablets of Vicodin (with no refills)
19 for the patient. Patient A.S.'s next contact with respondent's office was on July 16, 2003,
20 when she called respondent's staff requesting early refill of her Vicodin medication. On
21 the visit on or about August 5, 2003, respondent noted the Tofranil and Cardizem
22 medications did not result in an improvement of the headaches. Respondent also noted
23 patient A.S. was obtaining medications such as Wellbutrin and Lortab from other sources.
24 On this visit, respondent prescribed Fioricet, Vicodin and Sansert for patient A.S., and
25 noted he explained the benefits and risks associated with the Sansert medication to the
26 patient. Patient A.S. made visits in October, November and December 2003, during
27 which respondent wrote prescriptions Lortab, Norco, Xanax and Zonergram for the
28 patient. On the visit on or about October 14, 2003, Patient A.S. reported she was unable

1 to obtain the Sansert medication but was taking the drug Ativan. Respondent failed to
2 inquire how the patient obtained the Ativan medication. On the visit on or about
3 December 17, 2003, respondent noted patient A.S. would have to undergo Zonergram
4 detoxification.

5 EE. Patient A.S. made approximately nine office visits during 2004.
6 During this period, respondent prescribed Norco, Xanax and Prednisone for the patient's
7 headaches on nearly every visit. On the visit on or about February 17, 2004, respondent
8 noted patient A.S. would have to undergo Norco detoxification. On or about July 24,
9 2004, respondent's staff noted that a Wal-Mart Pharmacy had denied patient A.S.'s
10 request for a refill of her Norco medication. On or about July 28, 2004, patient A.S.
11 attempted to obtain a refill of her Norco prescription by use of an "old prescription." On
12 the visit on or about November 8, 2004, respondent noted patient A.S. might have to
13 undergo detoxification in the following spring.

14 FF. The patient made approximately three visits in 2005. Respondent
15 added Percocet to the patient's medication during this period. On the visit on or about
16 February 7, 2005, respondent noted he would "hold detox until things blow up." On the
17 visit on or about April 4, 2005, respondent admonished patient A.S. for overusing the
18 Percocet medication. On or about May 6, 2005, respondent's staff noted patient A.S. had
19 attempted to obtain Norco from the Wal-Mart pharmacy through forgery. On or about
20 May 6, 2005, a Sav-On Pharmacy notified respondent that patient A.S. had obtained a
21 refill for Norco without authorization. On patient A.S.'s final visit on or about May 23,
22 2005, respondent noted the patient was obtaining prescriptions from different sources.

23 GG. Respondent prescribed large amounts of controlled substances to
24 patient A.S. over a prolonged period without performing and documenting adequate
25 ongoing physical examinations and without obtaining a definitive diagnosis of the
26 patient's pain. Respondent also failed to establish and document a treatment plan for
27 patient A.S.'s pain, failed to obtain and note patient A.S.'s informed consent for the
28 prolonged treatment with narcotics, and failed to discuss and/or note he discussed other

1 pain treatment modalities with the patient. Respondent also failed to conduct periodic
2 reviews to determine the effectiveness of large amounts of controlled substances he was
3 prescribing for patient A.S. In spite of the clear signs of addiction, respondent failed to
4 take any steps to determine whether patient A.S. was addicted to pain medication, failed
5 to obtain a pain specialist or addictionologist consultation for the patient, and failed to
6 refer the patient to a detox program. Further, in spite of the clear evidence patient A.S.
7 was obtaining other prescription drugs from other sources, respondent failed take and
8 note steps he took to determine whether patient A.S. was not abusing prescription
9 medications drugs.

10 13. Respondent committed gross negligence in his care and treatment of
11 patients L.G., I.G., W.W., J.L., D.D. and A.S. which included, but was not limited to, the
12 following:

13 Patient L.G.

14 A. Paragraphs 12(A) through 12(G) are hereby incorporated by
15 reference as if fully set forth herein.

16 B. Between on or about March 26, 1987 through on or about
17 October 23, 2003, respondent treated L.G. for chronic headaches and epilepsy and failed
18 to obtain and record a full history and physical examination, as well as record any
19 physical findings during his follow-ups until 1989, with no further visits recorded until on
20 or about March 8 and October 20, 2003.

21 C. Between on or about March 26, 1987 and on or about October 23,
22 2003, respondent issued to L.G. in excess of 90 prescriptions for dangerous drugs and/or
23 controlled substances and/or failed to conduct and record a prior good faith examination
24 on each occasion.

25 D. Between on or about March 26, 1987 and on or about October 23,
26 2003, respondent treated L.G. for chronic recurrent headaches and epilepsy and failed to
27 maintain adequate medical records for her.

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1 E. Between on or about March 26, 1987 and on or about October 23,
2 2003, respondent treated L.G. for documented chronic pain and repeatedly failed to abide
3 with the guidelines established by the Intractable Pain Act, as specified in Business and
4 Professions Code section 2241.5.

5 Patient I.G.

6 F. Paragraphs 12(H) through 12(I) are hereby incorporated by
7 reference as though fully set forth.

8 G. Respondent failed to perform and note periodic reviews of his
9 treatment of the patient to determine the effectiveness and appropriateness of the large
10 amount of controlled substances he prescribed for the patient.

11 H. Respondent treated this patient with controlled substances over a
12 prolonged period without establishing and documenting a treatment plan for the patient's
13 cervical and neck pain.

14 I. Respondent treated this patient with controlled substances over a
15 prolonged period without performing and documenting ongoing adequate physical
16 examinations.

17 J. Respondent failed to obtain and document the patient's informed
18 consent for treatment with narcotics over a prolonged period, and failed to discuss and/or
19 note he discussed other treatment modalities with the patient.

20 K. Respondent treated this patient for documented chronic pain and
21 repeatedly failed to abide with the guidelines established by the Intractable Pain Act, as
22 specified in Business and Professions Code section 2241.5.

23 Patient W.W.

24 L. Paragraphs 12(J) through 12(O) are hereby incorporated by
25 reference as if fully set forth herein.

26 M. Respondent failed to perform and note periodic reviews of his
27 treatment of the patient to determine the effectiveness and appropriateness of the large
28 amount of controlled substances he prescribed for the patient.

1 N. Respondent failed refer this patient for treatment by a pain
2 management specialist or an addictionologist at any time during the period of treatment.

3 O. Respondent treated this patient with controlled substances over a
4 prolonged period without performing and documenting ongoing adequate physical
5 examinations.

6 P. Respondent failed to obtain and document the patient's informed
7 consent for treatment with narcotics over a prolonged period, and failed to discuss and/or
8 note he discussed other treatment modalities with the patient.

9 Q. Respondent treated this patient for documented chronic pain and
10 repeatedly failed to abide with the guidelines established by the Intractable Pain Act, as
11 specified in Business and Professions Code section 2241.5.

12 Patient J.L.

13 R. Paragraphs 12(P) through 12(Y) are hereby incorporated by
14 reference as if fully set forth herein.

15 S. Respondent failed to perform and note periodic reviews of his
16 treatment of the patient to determine the effectiveness of the large amount of controlled
17 substances he prescribed for the patient.

18 T. Respondent failed refer this patient for treatment by a pain
19 management specialist or an addictionologist at any time during the period of treatment.

20 U. Respondent treated this patient with controlled substances over a
21 prolonged period without performing and documenting ongoing adequate physical
22 examinations.

23 V. Respondent failed to obtain and document the patient's informed
24 consent for treatment with narcotics over a prolonged period, and failed to discuss and/or
25 note he discussed other treatment modalities with the patient.

26 W. During the period of treatment, respondent failed to take and note
27 steps he took to determine whether the patient was abusing prescription medications and
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1 "street" drugs despite the clear evidence the patient was obtaining other prescription
2 drugs and marijuana from other sources.

3 X. Respondent treated this patient for documented chronic pain and
4 repeatedly failed to abide with the guidelines established by the Intractable Pain Act, as
5 specified in Business and Professions Code section 2241.5.

6 Patient D.D.

7 Y. Paragraphs 12(Z) through 12(BB) are hereby incorporated by
8 reference as if fully set forth herein.

9 Z. Respondent failed to perform and note periodic reviews of his
10 treatment of the patient to determine the effectiveness and appropriateness of the large
11 amount of controlled substances he prescribed for the patient.

12 AA. Respondent treated this patient with controlled substances over a
13 prolonged period without performing and documenting ongoing adequate physical
14 examinations.

15 BB. Respondent failed to obtain and document the patient's informed
16 consent for treatment with narcotics over a prolonged period, and failed to discuss and/or
17 note he discussed other treatment modalities with the patient.

18 CC. Respondent treated this patient for documented chronic pain and
19 repeatedly failed to abide with the guidelines established by the Intractable Pain Act, as
20 specified in Business and Professions Code section 2241.5.

21 Patient A.S.

22 DD. Paragraphs 12(CC) through 12(GG) are hereby incorporated by
23 reference as if fully set forth herein.

24 EE. Respondent failed to perform and note periodic reviews of his
25 treatment of the patient to determine the effectiveness and appropriateness of the large
26 amount of controlled substances he prescribed for the patient.

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1 FF. Respondent failed refer this patient for treatment by a pain
2 management specialist or an appropriate specialist any time during the period of
3 treatment.

4 GG. Respondent treated this patient with controlled substances over a
5 prolonged period without performing and documenting ongoing adequate physical
6 examinations.

7 HH. Respondent failed to obtain and document the patient's informed
8 consent for treatment with narcotics over a prolonged period, and failed to discuss and/or
9 note he discussed other treatment modalities with the patient.

10 II. During the period of treatment, respondent failed to take and note
11 steps he took to determine whether the patient was abusing prescription medications and
12 "street" drugs despite the clear evidence the patient was obtaining other prescription
13 drugs from other sources.

14 JJ. Respondent treated this patient for documented chronic pain and
15 repeatedly failed to abide with the guidelines established by the Intractable Pain Act, as
16 specified in Business and Professions Code section 2241.5.

17 **SECOND CAUSE FOR DISCIPLINE**

18 (Repeated Negligent Acts)

19 14. Respondent has further subjected his Physician's and Surgeon's
20 Certificate No. G 42884 to disciplinary action under sections 2227 and 2234, as defined by
21 section 2234, subdivision (c) of the Code, in that he engaged in for repeated negligent acts in his
22 care and treatment of patients L.G., I.G., W.W., J.L., D.D. and A.S. as more particularly alleged
23 in paragraphs 12 and 13, above, and which are hereby incorporated by reference as if fully set
24 forth.

25 **THIRD CAUSE FOR DISCIPLINE**

26 (Prescribing Without Good Faith Prior Examination)

27 15. Respondent has further subjected his Physician's and Surgeon's Certificate
28 No. G 42884 to disciplinary action under sections 2227 and 2234, as defined by section 2242 of

1 the Code, in that he repeatedly prescribed both dangerous drugs and controlled substances to
2 patients L.G., I.G., W.W., J.L., D.D. and A.S. without a documentation of medical indication and
3 without conducting and documenting a good faith prior medical examination, as more
4 particularly alleged in paragraphs 12 and 13, above, and which are hereby incorporated by
5 reference as if fully set forth.

6 **FOURTH CAUSE FOR DISCIPLINE**

7 (Failure to Maintain Adequate and Accurate Medical Records)

8 16. Respondent has further subjected his Physician's and Surgeon's Certificate
9 No. G 42884 to disciplinary action under sections 2227 and 2234, as defined by section 2266 of
10 the Code, in that he failed to maintain adequate and accurate medical records for patients L.G.,
11 I.G., W.W., J.L., D.D. and A.S. as more particularly alleged in paragraphs 12 and 13, above, and
12 which are hereby incorporated by reference as if fully set forth.

13 **FIFTH CAUSE FOR DISCIPLINE**

14 (Violation of State or Federal Drug Statutes)

15 17. Respondent has further subjected his Physician's and Surgeon's Certificate
16 No. G 42884 to disciplinary action under sections 2227 and 2234, as defined by section 2238 of
17 the Code, in that he has violated state or federal drug statutes in the manner in which he
18 prescribed both dangerous drugs and controlled substances to patients L.G., I.G., W.W., J.L.,
19 D.D. and A.S. as more particularly alleged in paragraphs 12 and 13, above, and which in their
20 entirety are hereby incorporated by reference as if fully set forth.

21 **PRAYER**

22 WHEREFORE, Complainant requests that a hearing be held on the matters
23 alleged herein, and that following the hearing, the Division of Medical Quality, Medical Board of
24 California, issue its Decision and Order:

25 1. Revoking or suspending Physician's and Surgeon's Certificate No.
26 G 42884, heretofore issued by the Board to James Santiago Grisolia, M.D.

27 2. Revoking, suspending or denying respondent's approval authority
28 to supervise physician's assistants pursuant to Code section 3527;

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3. Ordering respondent to pay the costs of probation, if placed on probation; and

4. Taking such other and further action as the Board deems necessary and proper.

DATED: 9/11/07.

Samuel K. Hammond, For
BARBARA JOHNSTON
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

SKH/ Grisolia Second Amended Accusation
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