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

In the Matter of the Accusation Against:	)	
John Winthrop Pierce, M.D.	)	**Case No. 800-2017-030938**
Physician's and Surgeon's Certificate No. G 45225	)	
Respondent.	)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on December 31, 2019.

IT IS SO ORDERED July 31, 2019.

MEDICAL BOARD OF CALIFORNIA

By: Kimberly Kirchmeyer
Executive Director

XAVIER BECERRA
Attorney General of California
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Supervising Deputy Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **JOHN WINTHROP PIERCE, M.D.** 2480 Mission Street, Ste 329 San Francisco, CA 94110 Physician's and Surgeon's Certificate No. G 45225 Respondent.	Case No. 800-2017-030938 OAH No. 2019030645 **STIPULATED SURRENDER OF LICENSE AND 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 (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Jane Zack Simon, Supervising Deputy Attorney General.

2. John Winthrop Pierce, M.D. (Respondent) is represented in this proceeding by Dexter B. Louie of Hassard Bonnington LLP, 275 Battery Street Suite 1600, San Francisco, CA 94111-3370.

3. On July 6, 1981, the Board issued Physician's and Surgeon's Certificate No. G 45225 to John Winthrop Pierce, M.D. The Physician's and Surgeon's Certificate was in full force and

effect at all times relevant to the charges brought in Accusation No. 800-2017-030938 and will expire on April 30, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-030938 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent, who timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2017-030938 is attached as Exhibit A.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-030938. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

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

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

CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2017-030938, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation and that those charges constitute cause for discipline.

Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

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

CONTINGENCY

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

12. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Surrender of License and Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

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

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 45225, issued to Respondent John Winthrop Pierce, M.D., is surrendered and accepted by the Board.

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

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

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

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2017-030938 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2017-030938 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

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

DATED: 7/19/19

JOHN WINTHROP PIERCE, M.D.
Respondent

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

DATED: 7/19/19

DEXTER B. LOUIE
Attorney for Respondent

ENDORSEMENT

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

DATED: 7/19/19

Respectfully submitted,

XAVIER BECERRA
Attorney General of California

JANE ZACK SIMON
Supervising Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-030938

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

In the Matter of the Accusation Against: **John Winthrop Pierce, M.D.** 2480 Mission Street, Ste. 329 San Francisco, CA 94110 Physician's and Surgeon's Certificate No. G 45225, Respondent.	Case No. 800-2017-030938 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about July 6, 1981, the Medical Board issued Physician's and Surgeon's Certificate Number G 45225 to John Winthrop Pierce, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2019, unless renewed.

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DISCIPLINARY HISTORY

3. On January 9, 2008, the Board filed an Accusation against Respondent in Medical Board Case No. 03-2006-172261 that alleged causes for discipline for unprofessional conduct (Bus. & Prof. Code §2234), failure to maintain adequate records (Bus. & Prof. Code §2266), and aiding and abetting the unlicensed practice of medicine (Bus. & Prof. Code §2264). The allegations in the Accusation involved Respondent's medical care, acts and omissions, rendered to one patient.

4. On November 25, 2008, the Board issued a Decision and Order in Accusation Case No. 03-2006-172261, which became effective on December 24, 2008. Based on the Decision, Respondent's Physician's and Surgeon's Certificate No. G45225 was disciplined with a public reprimand and Respondent was required to complete a Professional Boundaries Program and courses in Medical Record Keeping and in Ethics.

JURISDICTION

5. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

6. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

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

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

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

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

7. Section 2234 of the Code states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

8. Section 2242 states, in pertinent part:

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

9. 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."

10. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

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

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

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

PERTINENT CONTROLLED SUBSTANCES/DANGEROUS DRUGS

11. Adderall, a trade name for a combination of mixed salts of a single-entity amphetamine product (dextroamphetamine sulphate, dextroamphetamine saccharate, amphetamine sulfate, amphetamine aspartate), is a central nervous system (CNS) stimulant. It is a Schedule II controlled substance as defined by section 11055 of the Health and Safety Code and a dangerous drug as defined in Business and Professions Code section 4022. Adderall is indicated for the treatment of attention deficit hyperactivity disorder (ADHD) and of narcolepsy.

12. Ambien, a trade name for zolpidem tartrate, is a non-benzodiazepine hypnotic of the imidasopyridine class. It is a Schedule IV controlled substance under Health and Safety Code section 11057(d)(32) and is a dangerous drug as defined in Business and Professions Code section 4022. It is indicated for the short-term treatment of insomnia. It is a central nervous system (CNS) depressant and should be used cautiously in combination with other CNS depressants. Any CNS depressant could potentially enhance the CNS depressive effects of Ambien. It should be administered cautiously to patients exhibiting signs or symptoms of depression because of the risk of suicide. Because of the risk of habituation and dependence, individuals with a history of addiction to or abuse of drugs or alcohol should be carefully monitored while receiving Ambien.

13. Effexor XR, a trade name for venlafaxine hydrochloride, is an anti-depressant of the group of drugs called selective serotonin and norepinephrine reuptake inhibitors (SSNRIs). It is indicated for the treatment of major depressive disorder, anxiety, and panic disorder. It is a dangerous drug as defined in Business and Professions Code section 4022.

14. Fentanyl is an opioid analgesic which can be administered by an injection, through a transdermal patch (known as Duragesic). It is a Schedule II controlled substance as defined by

section 11055 of the Health and Safety Code and by Section 1308.12 of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022. Fentanyl's primary effects are anesthesia and sedation. It is a strong opioid medication and is indicated only for treatment of chronic pain (such as that of malignancy) that cannot be managed by lesser means and that requires continuous opioid administration. Fentanyl presents a risk of serious or life-threatening hypoventilation. Use of fentanyl together with other central nervous system depressants, including alcohol, can result in increased risk to the patient.

15. Hydrocodone bitartrate with acetaminophen, which is known by the trade names Norco or Vicodin, is a semi-synthetic opioid analgesic. Since October 2016, it is a Schedule II controlled substance as defined by section 11055, subdivision (b) of the Health and Safety Code, and by section 1308.13(e) of Title 21 of the Code of Federal Regulations[1], and is a dangerous drug as defined in Business and Professions Code section 4022.

16. Lisinopril is an angiotensin converting enzyme (ACE) inhibitor that is indicated for the treatment of high blood pressure (hypertension) and also congestive heart failure. It is a dangerous drug as defined in Business and Professions Code section 4022.

17. Methadone hydrochloride is a synthetic opioid analgesic with multiple actions quantitatively similar to those of morphine. Methadone may be administered as an injectable liquid or in the form of a tablet, disc, or oral solution. It is a Schedule II controlled substance as defined by section 11055, subdivision (c) of the Health and Safety Code, and by Section 1308.12 (c) of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022. Methadone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Methadone should be used with caution and in reduced dosage in patients who are concurrently receiving other opioid analgesics.

18. Morphine sulfate, known by the trade name MS Contin, is an opioid pain medication indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. Morphine is a

[1] Effective October 6, 2014, all hydrocodone combination products were re-scheduled from Schedule III to Schedule II controlled substances by the Federal Drug Enforcement Agency ("DEA"), section 1308.12 (b)(1)(vi) of Title 21 of the Code of Federal Regulations.

Schedule II controlled substance as defined by section 11055, subdivision (b) of the Health and Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022. Morphine is a highly addictive drug which may rapidly cause physical and psychological dependence and, as a result, creates the potential for being abused, misused, and diverted.

19. OxyIR and OxyContin are trade names for oxycodone hydrochloride controlled-release tablets. Oxycodone is a white odorless crystalline powder derived from an opium alkaloid. It is a pure agonist opioid whose principal therapeutic action is analgesia. Other therapeutic effects of oxycodone include anxiolysis, euphoria, and feelings of relaxation. OxyContin is a Schedule II controlled substance as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and by Section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022.

20. Phenobarbital is a barbiturate that is indicated to treat or prevent seizures. It may also be used as a short-term sedative. It is a Schedule IV controlled substance under Health and Safety Code section 11057(d)(26) and is a dangerous drug as defined in Business and Professions Code section 4022.

21. Promethazine with codeine cough syrup is a combination of promethazine hydrochloride, phenylephrine hydrochloride, and codeine phosphate. It is an anti-emetic, anti-histamine, and antitussive indicated for the temporary relief of cough and other upper respiratory symptoms. It is a Schedule V controlled substance under Health and Safety Code section 11058 and section 1308.15 of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022. Phenergan may significantly affect the actions of other drugs. It may increase, prolong, or intensify the sedative action of CNS depressants.

22. Soma, a trade name for carisoprodol, is a muscle-relaxant and sedative. It is a Schedule III controlled substance as defined by section 11056, subdivision (e) of the Health and Safety Code and by section 1308.13 (e) of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022. Since the effects of carisoprodol and alcohol or carisoprodol and other central nervous system depressants or

psychotropic drugs may be addictive, appropriate caution should be exercised with patients who take more than one of these agents simultaneously.

23. Tylenol No. 4, a trade name for a combination of acetaminophen (300 mg.) and codeine (60 mg.), is an opioid pain medication. It is a combination opioid analgesic that is used to relieve mild to moderately severe pain. It is a Schedule III controlled substance under Health and Safety Code section 11056 and is a dangerous drug as defined in Business and Professions Code section 4022.

24. Valium, a trade name for diazepam, is a psychotropic drug used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code and section 1308.14 of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022. Diazepam can produce psychological and physical dependence and it should be prescribed with caution particularly to addiction-prone individuals (such as drug addicts and alcoholics) because of the predisposition of such patients to habituation and dependence.

25. Xanax is a trade name for alprazolam, a psychotropic triazolo-analogue of the benzodiazepine class of central nervous system-active compounds. Xanax is used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a Schedule IV controlled substance as defined by section 11057, subdivision (d) of the Health and Safety Code, and by section 1308.14 (c) of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code section 4022. Xanax has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol and other CNS depressant drugs during treatment with Xanax.

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FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient A: Gross Negligence and/or Repeated Negligent Acts and/or Excessive Prescribing and/or Prescribing without Appropriate Examination/Medical Indication.)

26. Respondent is subject to disciplinary action for unprofessional conduct under sections 2234 subd. (b) and/or 2234 subd. (c) and/or 725 and/or 2242 subd. (a) in that Respondent's overall conduct, acts and/or omissions, with regard to Patient A constitutes gross negligence and/or repeated negligent acts and/or excessive prescribing and/or prescribing without an appropriate prior examination and a medical indication, as more fully described herein below.

27. On or about March 1, 2013, Patient A, a 55-year-old male, saw Respondent and re-established care after a period of at least 4 years, having been a patient of Respondent for many years before 2008 or 2009. Patient A presented with a history of heavy tobacco use, anxiety disorder, coronary artery disease, recent aorto-left subclavian bypass, cervical fusion, left renal (artery) stent placement, left carotid endarterectomy. The patient was on home supplemental oxygen and used a finger oximeter. Respondent's documented impressions at this visit included: coronary artery disease, chronic obstructive pulmonary disease, hypertension, peripheral vascular disease, and chronic anxiety. Respondent's impressions were not supported by any documented objective findings. No vital signs were documented. There was no documented impression of pain, either chronic or acute. Respondent noted that the patient presented with "non-stop talking" and that the patient had no limitation of movement. Respondent's plan was to continue the patient's medications and Respondent prescribed the following controlled substances: #180 Norco 10/325 with one refill, and #90 Soma 350 mg. with one refill. Respondent noted a follow-up visit in 2 months.

28. On March 1, 2013, blood lab work for Patient A was collected. Respondent received the results on or about March 4, 2013. Most notable was a very high triglyceride level of 1301 mg./dL.

29. On or about April 3, 2013, Patient A obtained refills of #180 Norco 10/325 mg. and #90 Soma 350 mg.

30. On or about May 10, 2013, Patient A returned to Respondent's office and was seen by Respondent's physician assistant. No examination was documented and there was no documentation that the abnormal lab results were discussed with the patient. Under physical exam, the only note was "Very talkative." There was no documentation of the patient's complaints of pain, history of present illness, no details of physical features/symptoms, and no vital signs were taken. The patient's chief complaint noted was: "Says wine kills his pain." The impressions listed were coronary artery disease and anxiety with no documented findings to support those diagnoses. Respondent issued prescriptions for #180 Norco 10/325 with one refill, #90 Soma 350 mg. with one refill, and added #90 Alprazolam 1 mg. with one refill. Patient A was to have follow-up visit in 2 months.

31. The monthly amount of Norco (hydrocodone with acetaminophen) prescribed to Patient A by Respondent constitutes a high level of a morphine-equivalent daily dose.

32. On or about May 20, 2013, Patient A was found dead at his apartment. A necropsy showed a potentially toxic level of hydrocodone (0.61 mg./L). No autopsy was performed. It was noted that a caregiver reported that the patient was oxygen dependent, a smoker, and that he abused alcohol and was a heavy wine drinker. The caregiver also reported that, the night before the patient died, he was drinking whiskey and taking medications.

33. At an interview on January 7, 2018 with the Medical Board's investigator, Respondent stated that it was his practice pattern to continue his patients with the pain medications that they were taking at the time of their first visit with him, as long as the medications controlled the pain. Respondent would not change or try to de-escalate the pain medications and did not offer pain management alternatives.

34. Respondent's overall conduct, acts and/or omissions, with regard to Patient A, as set forth in paragraphs 26 through 33 herein, constitutes unprofessional conduct and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient A as follows:

a. Respondent prescribed controlled substances to Patient A without documenting an appropriate examination and medical indications.

b. Respondent failed to document informed consent, advising the patient of the risks and potential adverse effects of the controlled substances prescribed.

c. Respondent failed to enter into a controlled substances agreement with Patient A that established boundaries for the on-going prescribing of controlled substances.

d. Respondent issued prescriptions of Norco without documentation of the patient's pain and the basis for the continued prescribing of opiates. For example, there was no documentation of the patient's response to the opiates that were prescribed on March 1, 2013. There were no details documented of the patient's complaints of pain. There was also no documented examination and evaluation of the lumbar/back region, the head, and/or the abdomen.

e. Respondent failed to inform Patient A of the abnormal blood test results indicating severe hypertriglyceridemia and of the symptoms and risks of pancreatitis, which may present as back pain.

f. Respondent failed to document an appropriate treatment plan.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient B: Gross Negligence and/or Repeated Negligent Acts and/or Excessive Prescribing and/or Prescribing without Appropriate Examination/Medical Indication.)

35. Respondent is subject to disciplinary action for unprofessional conduct under sections 2234 subd. (b) and/or 2234 subd. (c) and/or 725 and/or 2242 subd. (a) in that Respondent's overall conduct, acts and/or omissions, with regard to Patient B constitutes gross negligence and/or repeated negligent acts and/or excessive prescribing and/or prescribing without an appropriate prior examination and a medical indication, as more fully described herein below.

36. On or about December 21, 2011, Respondent saw Patient B who had no new complaints. Respondent's impressions noted were chronic leg edema, fatigue, and hypogonadism. There were no findings or other details documented related to pain. On that day, Patient B filled a prescription from Respondent for #20 Fentanyl 100 mcg/1 Hr. transdermal patches. Respondent also continued to regularly prescribe morphine sulfate and Xanax to the patient.

37. Respondent continued to see Patient B on approximately a monthly basis through 2012 and continued to prescribe the basically same combination of controlled substances: morphine sulfate and Fentanyl transdermal patches without documenting findings to support the prescribing.

38. On or about May 14, 2012, Respondent saw Patient B and documented under "Impression" diagnoses that included fatigue, pressure sore, and ankle/lower leg edema. Respondent added a prescription for #40 Adderall 10 mg. for Patient B without any documented medical indication. There was no appropriate examination and no documentation of symptoms or of a diagnosis of Attention Deficit Hyperactivity Disorder. There was also no documentation of specific findings related to the patient's level or type of pain.

39. On or about July 16, 2012, Respondent saw Patient B and noted that the patient was released 9 days ago from the hospital. In addition to the chronic prescriptions for Fentanyl patches, morphine, and Xanax, Respondent prescribed to Patient B a high starting dose of Alprazolam (1 mg. QID), without a documented medical indication and without specific findings or a diagnosis to support the prescription. The impression listed for that visit was only "bilateral flank pain."

40. On or about September 10, 2012, Patient B saw Respondent's physician assistant who gave him a B12 injection. Although the impression listed for the visit was "anemia", there was no documentation in the chart that a vitamin B12 deficiency was the cause of the patient's anemia.

41. On or about December 6, 2013, Respondent saw Patient B and, without documenting any examination or symptoms, noted the following prescriptions refills: #20 Fentanyl patches 100 mcg./hr. (dated December 20, 2013); #60 Morphine sulfate IR 30 mg. (dated December 8, 2013 and December 23, 2013); and #120 Alprazolam 0.5 mg. (dated December 26, 2013).

42. Respondent continued to see Patient B on approximately a monthly basis through 2014 and 2015. Respondent continued to prescribe the basically same combination of controlled substances: Morphine sulfate, Fentanyl transdermal patches, and Alprazolam, without documented findings to support the prescribing.

43. On or about August 1, 2016, Respondent created a visit note that he saw the patient for a routine visit, that the patient had run out of medications one day before the due date of July 30, 2016. Respondent noted that Patient B "appears his usual self." Respondent noted that Patient was "seen at my place of residence July 30, 2016." Respondent also noted that he issued, on July 30, prescriptions for an unspecified quantity of Fentanyl patches and for #120 Oxy IR 30 mg. tablets. No specific examination or findings to support the prescribing were documented.

44. On or about August 30, 2016, Respondent noted that Patient B "stays in various places including my home when I am out of the country."

45. During the course of Respondent's care and treatment, Patient B had multiple episodes of withdrawals related to the prescribed controlled substances. For example:

a. August 2, 2012: Alprazolam withdrawal was noted.

b. October 16, 2012: narcotic withdrawal was noted.

c. August 27, 2014: "polysubstance withdrawal" was noted.

d. February 2, 2015: "Ran out of narcotics a few days ago" was noted.

e. April 14, 2017: "opioid dependence with withdrawal" was noted.

f. May 15, 2017: "Pt has been out of pain medication for 4 days . . . opioid dependence with withdrawal" was noted.

46. During the course of Respondent's care and treatment, Patient B reported on several occasions that his controlled substances were stolen. Respondent failed to consider the potential risk of diversion and failed to conduct urine toxicology screens.

47. During at least four visits (May 23, 2012, November 7, 2016, November 11, 2016, and May 15, 2017), Respondent noted that Patient B had suicidal ideation and once even had a plan.

48. Respondent's overall conduct, acts and/or omissions, with regard to Patient B, as set forth in paragraphs 35 through 47 herein, constitutes unprofessional conduct and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient B as follows:

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a. Respondent prescribed a combination of two long-acting potent opioids (morphine and Fentanyl patches) to Patient B for many years without documenting an appropriate examination and a medical indication for the prescribing. Respondent also made no attempt to de-escalate the use of the combination of morphine and Fentanyl.

b. Respondent also failed to document performing appropriate evaluations and specific medical indications to support his prescribing of other controlled substances, such as methadone, Adderall, Alprazolam, and Zolpidem.

c. Respondent failed to document obtaining informed consent, advising the patient of the risks and potential adverse effects of the controlled substances prescribed.

d. Respondent failed to enter into a controlled substances/opioid agreement with Patient B that established boundaries for the on-going prescribing of controlled substances for chronic pain.

e. Respondent prescribed Methadone to Patient B while also prescribing Morphine and Fentanyl patches, which would be contra-indicated, without documenting an appropriate medical indication for the prescribing.

f. Respondent prescribed long-acting opioids to Patient B without offering alternatives to the patient for pain management, both pharmacologic and non-pharmacologic.

g. When the patient presented with multiple episodes of withdrawals, Respondent did not evaluate and make adjustments to the prescribing (dose, frequency, type) in pursuit of the goal to use the lowest effective total daily dose of medication.

h. Respondent failed to consider the significant clinical impact that his prescribed medications had on Patient B, who had a history of depression, (implied) obstructive sleep apnea, multiple episodes of withdrawals, and a psychiatric hospitalization that Respondent briefly noted on June 30, 2016 as having occurred 2 – 3 years prior.

i. During the course of his treatment of the chronic prescribing of controlled substances to Patient B, Respondent failed to document an appropriate treatment plan, conduct periodic review, failed to consider the potential risk of diversion, and failed to conduct random urine toxicology screens.

j. On several occasions during the course of his care and treatment of Patient B, Respondent failed to recognize a life-threatening psychiatric condition and failed to immediately refer Patient B to a psychiatric/mental health specialist.

k. Respondent demonstrated a lack of knowledge by failing to recognize that Patient B's multiple substance withdrawals (opioid and benzodiazepine) were indications of the patient's polysubstance abuse and not merely of dependence.

l. Respondent failed to refer, or to offer a referral to, Patient B to a formal Chemical Dependency Program.

m. Respondent failed to maintain professional boundaries by allowing Patient B to visit and to reside at Respondent's home.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient C: Gross Negligence and/or Repeated Negligent Acts and/or Excessive Prescribing and/or Prescribing without Appropriate Examination/Medical Indication.)

49. Respondent is subject to disciplinary action for unprofessional conduct under sections 2234 subd. (b) and/or 2234 subd. (c) and/or 725 and/or 2242 subd. (a) in that Respondent's overall conduct, acts and/or omissions, with regard to Patient C constitutes gross negligence and/or repeated negligent acts and/or excessive prescribing and/or prescribing without an appropriate prior examination and a medical indication, as more fully described herein below.

50. On or about March 13, 2014, Respondent first saw Patient C, a 25-year-old male with a history of depression, anxiety, Post Traumatic Stress Disorder, fractured facial bone in 2006, tobacco use, and tattoos. Respondent noted that Patient C said a dry cough "bothers him at night." Respondent's assessment was Depression/Anxiety. Respondent prescribed an unspecified amount of Promethazine with codeine cough syrup and Effexor XR 225 mg. daily plus 5 refills. Respondent did not document an appropriate examination, findings, and medical indications for his treatment. Respondent did not assess the cause of the cough. His prescription

of the Promethazine with codeine cough syrup does not appear in the Controlled Substance Utilization Review and Evaluation System.[2]

51. At the next visit on April 8, 2014, Respondent noted that Patient C attributed his cough to his exposure to mold in his apartment. Respondent again prescribed an unspecified amount of Promethazine with codeine cough syrup, which does not appear in the CURES report. Respondent noted that Patient C wanted anxiety medicine, said that he had taken some of his aunt's Xanax, and "it helped." Respondent prescribed #30 Xanax/Alprazolam 0.5 mg. as a ten-days supply. Respondent also issued another prescription for Effexor XR. Respondent's chart notes do not document a complaint, examination, and diagnosis of back pain although it was noted: "back exercises shown to patient."

52. On or about May 14, 2014, Respondent saw Patient C who reported that his "back went out recently" and that he was recently held up at gunpoint. Respondent noted that the patient was his "usual self" and did not document any specifics about the patient's back pain complaint. Respondent did not perform and document an examination of the back. Respondent prescribed #30 Norco 10/325 and again prescribed an unspecified amount of Promethazine "Elixir" with one refill. Respondent almost tripled the dose of Xanax to 4 mg. daily and he refilled the prescription for Effexor XR. Respondent's assessment at the visit was PTSD/Anxiety but there was no documentation with specific findings to support the diagnoses. Respondent did not attempt to refer Patient C to psychiatry. Respondent's prescriptions for this visit do not appear in the CURES report.

53. On or about June 19, 2014, Respondent saw Patient C and prescribed #60 Norco 10/325 to Patient C, which was a doubled increase of the prior dose, without a documented medical indication.

54. On or about July 21 2014, Respondent saw Patient C who appeared as "his usual self." Respondent's assessment was chronic low back pain but Respondent did not document any specific findings to support the diagnosis, except for left leg sciatica noted at the prior June visit.

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[2] The Controlled Substance Utilization Review and Evaluation System (CURES) is a database of Schedule II, III and IV controlled substance prescriptions.

Respondent increased the dosage and prescribed #90 Norco 10/325 to Patient C. The patient was still being prescribed Xanax as well.

55. Respondent also noted at the July 21, 2014 visit that Patient C's mother said that her son served in the military less than one year and never went to Afghanistan. She reported that Patient C was on methadone after he was put on high doses of OxyContin.

56. On or about August 19, 2014, Respondent noted that Patient C was arrested on August 15, 2014, had his car impounded with the meds in a backpack in the trunk. He said that he was with a friend and police found cocaine in a search of his car. Respondent did not prescribe Norco but prescribed Effexor XR and #30 Xanax 2 mg. Respondent did not perform or order a urine toxicology screen.

57. On or about September 2, 2014, two weeks later, Respondent saw Patient C and prescribed #60 Norco 10/325 and #60 Xanax 2 mg. Respondent did not document an examination or specific findings, medical indications to support his prescribing.

58. A month later, on or about October 3, 2014, Respondent saw Patient C and noted that two prescriptions had been issued to Patient C by another physician in Oakland on September 29, 2014, one for Promethazine with codeine cough syrup and one for Amoxicillin. Respondent issued prescriptions for Patient C for #100 Norco 10/325, #60 Xanax, and an unspecified amount of Promethazine with codeine cough syrup. There is not documentation of an examination, specific findings or medical indications to support the prescribing.

59. On or about January 6, 2015, Respondent increased the prescription to #120 Norco 10/325 without documenting a medical indication.

60. On November 2, 2015, Respondent's note of Patient C's visit states that he prescribed #240 Methadone 10 mg. and #120 Diazepam 10 mg. (dated November 15, 2015 with 3 refills). It is unclear whether these prescriptions were issued or dispensed to Patient C because the prescriptions do not appear in the CURES report. There is no documented findings and medical indications to support the prescribing.

61. From 2015 through at least December 2016, Respondent continued to see Patient C on approximately a monthly basis and prescribed a combination of Norco 10/325, Xanax, and

Promethazine with codeine cough syrup, without documenting appropriate examinations and medical indications.

62. Starting in February 2015, Respondent regularly billed his office visits with Patient C under a "99213" CPT[3] code, which is not supported by his documentation.

63. Respondent's overall conduct, acts and/or omissions, with regard to Patient C, as set forth in paragraphs 49 through 62 herein, constitutes unprofessional conduct and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient C as follows:

a. Respondent failed to document performing appropriate evaluations and specific medical indications to support his prescribing of controlled substances, his rapid dose escalation of hydrocodone, and his prescribing a combination of codeine, opiates, and benzodiazepines.

b. Respondent failed to document obtaining informed consent, advising Patient C of the risks and potential adverse effects of the controlled substances prescribed, particularly the potential side effects of opiates in combination with other prescribed controlled substances.

c. Respondent failed to enter into a controlled substances agreement with Patient C that established boundaries for the on-going prescribing of controlled substances for chronic pain.

d. Respondent prescribed long-acting opioids to Patient C without attempting to taper the medications and/or without offering alternatives to the patient for pain management, both pharmacologic and non-pharmacologic.

e. During the course of his treatment of chronic prescribing of controlled substances, Respondent failed to document a treatment plan and conduct periodic reviews, either by reviewing the CURES or pharmacy profiles for Patient C and/or by obtaining random urine drug toxicology screens, particularly when the patient demonstrated suspicious aberrant behavior.

f. Respondent prescribed and rapidly escalated the prescribing of a short-acting benzodiazepine to Patient C who had a history of depression and anxiety.

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[3] This code is part of a family medical billing codes described by the numbers 99211-99215. CPT 99213 represents the middle (level 3) office or other outpatient established office patient visit and is part of the Healthcare Common Procedure Coding System (HCPCS).

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient D: Gross Negligence and/or Repeated Negligent Acts and/or Excessive Prescribing and/or Prescribing without Appropriate Examination/Medical Indication.)

64. Respondent is subject to disciplinary action for unprofessional conduct under sections 2234 subd. (b) and/or 2234 subd. (c) and/or 725 and/or 2242 subd. (a) in that Respondent's overall conduct, acts and/or omissions, with regard to Patient D constitutes gross negligence and/or repeated negligent acts and/or excessive prescribing and/or prescribing without an appropriate prior examination and a medical indication, as more fully described herein below.

65. On or about August 19, 2011, Respondent saw Patient D, a 44-year-old male maintenance worker, after a gap of about 3 years. Patient D presented with a history of left knee arthroscopy (five years ago) for left Anterior Cruciate Ligament tear with left medial and lateral meniscal tear, septoplasty, marked transient hypertriglyceridemia, alcoholic hepatitis, erectile dysfunction, gout with hyperuricemia, bilateral epicondylitis, chronic depression, hypertension, and tobacco use. Patient D reported that he had stopped drinking 18 months ago. Respondent's impressions were gout, hypertension, erectile dysfunction, and chronic depression. Routine labs and uric acid test were ordered. A discussion about an orthopedic referral is noted without any specifics. Respondent prescribed #100 Vicodin ES with five refills.

66. During his treatment of Patient D, Respondent prescribed hydrocodone (Vicodin/Norco) on a monthly basis.

67. On or about May 24, 2012, Respondent increased the dosage and prescribed #120 Norco with 2 refills. Also on that day, Respondent noted that he was contacted by a pharmacist who questioned the high amounts of acetaminophen being prescribed to Patient D.

68. On or about June 7, 2012, Respondent noted that the patient was "apprehensive" about surgery and needs health insurance. Respondent increased the prescription to #180 Norco for that month.

69. On or about February 20, 2015, Respondent increased the dosage and prescribed #240 Norco to Patient D.

70. Respondent continued to prescribe #240 Norco monthly for Patient D through at least December 2016.

71. On or about September 18, 2015, Respondent received the results of Patient D's blood test that were abnormal, indicating unreconciled erythrocythemia, aka polycythemia. Respondent did not document the reason for ordering the lab work and did not document taking any action based on the abnormal results. Respondent did not inform the patient of the risks and did not obtain any subsequent lab tests to monitor the condition and evaluate the cause of the abnormal results.

72. On or about December 23, 2015, Patient D complained of nocturia and dysuria after sex. Respondent did not conduct an appropriate medical examination to address the patient's urinary symptoms and did not perform any follow-up.

73. Respondent's overall conduct, acts and/or omissions, with regard to Patient D, as set forth in paragraphs 64 through 72 herein, constitutes unprofessional conduct and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient D as follows:

a. Respondent failed to document obtaining informed consent, advising the patient of the risks and potential adverse side effects of the controlled substances prescribed on a chronic basis, particularly the potential side effects of opiates in combination with other prescribed controlled substances and the risks regarding the amount of acetaminophen.

b. Respondent prescribed long-acting opioids to Patient D without attempting to taper the medications, particularly the hydrocodone, and/or without offering alternatives to the patient for pain management, both pharmacologic and non-pharmacologic.

c. Respondent prescribed excessive amounts of acetaminophen to Patient D, who had a substantial history of alcohol use, without an appropriate medical indication and without monitoring the patient's liver function.

d. Respondent prescribed a short-acting benzodiazepine (Xanax/Alprazolam) to Patient D without documenting an appropriate examination and medical indication. Respondent's

prescribing Alprazolam in combination with opiates created a high risk for complications in Patient D who had a history of alcohol hepatitis.

e. During the course of his treatment of chronic prescribing of controlled substances to Patient D, Respondent failed to document a treatment plan and conduct periodic reviews, such as by obtaining random urine drug toxicology screens.

f. Respondent failed to enter into a controlled substances agreement with Patient D that established boundaries for the on-going prescribing of controlled substances for chronic pain.

g. Respondent failed to appropriately evaluate and follow-up with the patient's urinary complaints from at least December 2015 to February 2016.

h. Respondent failed to appropriately evaluate and follow-up with Patient D's abnormal and unreconciled elevated hemoglobin blood test results in September 2015.

i. Respondent billed his office visits with Patient D under a "99213" CPT code, which is not supported by his documentation.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient E: Gross Negligence and/or Repeated Negligent Acts and/or Excessive Prescribing and/or Prescribing without Appropriate Examination/Medical Indication.)

74. Respondent is subject to disciplinary action for unprofessional conduct under sections 2234 subd. (b) and/or 2234 subd. (c) and/or 725 and/or 2242 subd. (a) in that Respondent's overall conduct, acts and/or omissions, with regard to Patient E constitutes gross negligence and/or repeated negligent acts and/or excessive prescribing and/or prescribing without an appropriate prior examination and a medical indication, as more fully described herein below.

75. On or about November 9, 2010, Respondent saw Patient E, a 68-year-old male, and noted that the patient had a history that included Chronic Obstructive Pulmonary Disease (COPD), hypertension, "heavy drinker" in remission, tobacco use, who had been seeing a psychiatrist "for years."

76. Respondent saw Patient E regularly, about every two months.

77. On or about April 24, 2014, Respondent saw Patient E and noted that the patient had been prescribed phenobarbital by a psychiatrist who was about to retire, and Patient E wanted Respondent to now prescribe phenobarbital. Respondent issued to Patient E prescriptions for #100 phenobarbital 16.2 mg. with 5 refills and for #45 Tylenol with codeine with 3 refills.

78. After April 24, 2014, Respondent prescribed, on a monthly basis, either #100 or #90 phenobarbital to Patient E in combination with prescriptions for Tylenol with codeine.

79. Respondent's medical records are inaccurate and conflicting for what appears to be two separate visits on October 16, 2014. The first chart note indicates that the patient's hands are hurting, with swollen joints, and a referral to Rheumatology. The second chart note for that same date indicates no hand swelling and the assessment was "Essentially Normal Exam" with no specialist referral. The note also states that Patient E never consumed alcohol and did not have HIV risk factors yet the patient had a history of excessive alcohol use.

80. Between at least February 2015 and September 2015 and also March 31, 2016 and June 5, 2017, Respondent regularly billed his office visits with Patient E under a "99213" CPT code, which is not supported by his documentation.

81. Although Respondent generally noted diagnoses that included back pain and/or chronic pain, Respondent did not provide sufficient information of an adequate history and examination with a description of the patient's symptoms, the location, character, and duration of the pain and of the alleviating, precipitating, or associated factors, and/or whether there was any relief or relieving factors.

82. In the chart note for a visit on April 12, 2016, Respondent noted that Patient E was seen in the hospital ER on April 3 with back pain and anxiety.

83. During the course of treatment with Respondent, Patient E reported depression, e.g. on September 7, 2012, October 16, 2014, October 23, 2015, and May 5, 2017. Respondent, however, did not document performing an appropriate evaluation, treatment plan, or referral in response to the patient's depression.

84. At multiple visits, Patient E complained of constipation and had significant weight loss, particularly from November 2013 to May 2017.

85. On or about December 23, 2016, Respondent saw Patient E for a post-ER visit. He noted that the ER visit was because the patient had a "panic attack." No further evaluation was documented. Respondent noted that the patient's drug plan would not pay for phenobarbital. Respondent prescribed #90 Diazepam 10 mg. TID with 3 refills, for "generalized anxiety disorder." This initial dose of Diazepam was 30 mg. daily, for the first four months. Respondent also increased the prescribed amount of Tylenol #4 from #120 pills monthly to #180 pills monthly without a documented medical indication.

86. Respondent's overall conduct, acts and/or omissions, with regard to Patient E, as set forth in paragraphs 74 through 85 herein, constitutes unprofessional conduct and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient E as follows:

a. Respondent failed to document performing appropriate evaluations and specific medical indications to support his prescribing of controlled substances, particularly opiates/hydrocodone and phenobarbital.

b. Respondent failed to document obtaining informed consent, advising the patient of the risks and potential adverse effects of the controlled substances prescribed, particularly the potential side effects of opiates in combination with other prescribed controlled substances and the risks of high levels of acetaminophen.

c. Respondent failed to enter into a controlled substances agreement with Patient E that established boundaries for the on-going prescribing of controlled substances for chronic pain.

d. Respondent prescribed long-acting opioids to Patient E without attempting to taper the medications, particularly the hydrocodone. Respondent did not evaluate and make adjustments to the prescribing (dose, frequency, type) in pursuit of the goal to used the lowest effective total daily dose of medication. Respondent did not offer alternatives to the patient for pain management, both pharmacologic and non-pharmacologic.

e. Respondent prescribed an initial dose of Diazepam, a benzodiazepine, to Patient E for generalized anxiety disorder without documented consideration of the risks, benefits, alternatives and potential adverse effects and/or without a referral to a psychiatrist.

f. During the course of his treatment of chronic prescribing of controlled substances, Respondent failed to document a treatment plan and conduct periodic reviews, by obtaining random urine drug toxicology screens.

g. Respondent billed his office visits with Patient E under a "99213" CPT code, which is not supported by his documentation.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient F: Gross Negligence and/or Repeated Negligent Acts)

87. Respondent is subject to disciplinary action for unprofessional conduct under sections 2234 subd. (b) and/or 2234 subd. (c) in that Respondent's overall conduct, acts and/or omissions, with regard to Patient F constitutes gross negligence and/or repeated negligent acts, as more fully described herein below.

88. On or about August 12, 2011, Respondent saw Patient F, a 59-year-old female, whose care was being transferred from her family practitioner. Respondent noted that Patient F had a history that included a motor vehicle accident 20 years prior, back pain for which she had been prescribed Vicodin, and tobacco use (half-pack a day). Patient F was taking Vicodin for back pain, Simvastatin for dyslipidemia, Lexapro for depression, and Ducosate for constipation. Respondent's impressions were spinal stenosis, hyperlipidemia, depression, and constipation.

89. During almost six years of care for Patient F, Respondent ordered four CBC tests: August 12, 2011; December 2, 2013; September 21, 2015; and, November 11, 2016. All four CBC lab results showed a hemoglobin level below the cited normal range. Respondent never acknowledged or documented informing Patient F of the abnormal results and never took action to address the medical issue.

90. During almost six years of care for Patient F (October 2011 through July 2017), Respondent documented repeated readings of high blood pressure. Respondent, however, did not measure and document the patient's blood pressure at each visit. Respondent also never documented informing the patient about blood pressure goals, treatment alternatives, and potential risks and complications related to high blood pressure.

91. On or about July 10, 2017, Respondent saw Patient F and recorded a blood pressure reading of 160/90. Respondent prescribed #30 Lisinopril 10 mg. daily plus 11 refills, without documenting that he informed the patient of the major side effects of the prescribed treatment. Respondent also prescribed #120 Norco 10/325.

92. During almost six years of care for Patient F (August 2011 to January 2017), Patient F reported and/or Respondent noted depression as a diagnosis during at least 7 visits. Respondent, however, did not address the Patient F's depression until January 10, 2017. At that visit, Respondent noted that Patient F reported that she still has depression and that she used to take anti-depressants but stopped in 2011 when she started seeing Respondent. Respondent prescribed #90 Lexapro 10 mg. with 3 refills.

93. Respondent's overall conduct, acts and/or omissions, with regard to Patient F, as set forth in paragraphs 87 through 92 herein, constitutes unprofessional conduct and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient F as follows:

a. Respondent failed to document informed consent, advising Patient F of the risks and potential adverse effects of the controlled substances prescribed, particularly the side effects of constipation with chronic opiate use, and the clinically significant adverse effects (behavioral and addictive) of the chronic use of opiates.

b. During the course of his treatment of chronic prescribing of controlled substances, Respondent failed to document a treatment plan and conduct periodic reviews. Respondent prescribed long-acting opioids to Patient F without attempting to taper the medications, particularly the hydrocodone. Respondent did not evaluate and make adjustments to the prescribing (dose, frequency, type) in pursuit of the goal to used the lowest effective total daily dose of medication.

c. Respondent failed to enter into a controlled substances agreement with Patient F that established boundaries for the on-going prescribing of controlled substances for chronic pain.

d. Respondent failed to appropriately evaluate, interpret, and take action based on the test results indicating hemoglobin below the normal range, between August 12, 2011 and November 11, 2016.

e. Respondent failed to appropriately and timely address the patient's high blood pressure, early hypertension, for almost six years.

f. Respondent failed to appropriately evaluate and attempt to treat the patient's chronic constipation, which was attributed to the chronic use of opiates.

g. Respondent failed to appropriately assess and address Patient F's reports of depression for almost six years. Respondent failed to consider that patients using opiates on a chronic basis have an increased risk for depressive symptoms.

SEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient G: Gross Negligence and/or Repeated Negligent Acts)

94. Respondent is subject to disciplinary action for unprofessional conduct under sections 2234 subd. (b) and/or 2234 subd. (c) in that Respondent's overall conduct, acts and/or omissions, with regard to Patient G constitutes gross negligence and/or repeated negligent acts, as more fully described herein below.

95. On or about June 27, 2014, Respondent assumed care of Patient G, a 54-year-old male with a history of advanced prostate cancer who had a total prostatectomy in 2011. Patient G had developed side effects from the treatment and his systemic chemotherapy had been discontinued.

96. On or about September 17, 2014, Respondent saw Patient G who reported developing back pain a month prior to the visit. Respondent documented only that there was tenderness over the lumbosacral area and that "exercise makes it worse." No specific examination and assessment were documented. Respondent prescribed #100 Oxy IR 20 mg., every 4 hours as needed. Respondent ordered a bone scan, which showed no metastasis.

97. On or about October 7, 2014, Respondent saw Patient G and the assessment was prostate cancer. Respondent increased the prescription to #120 OxyIR 30 mg.

98. Starting in or about September 2014, Patient G received controlled substances prescriptions from two providers: short-acting oxycodone from Respondent, and short-acting hydrocodone from an oncologist.

99. On or about February 9, 2015, Respondent prescribed to Patient G a long-acting opioid, #60 Morphine 60 mg. along with #120 OxyIR 30 mg. tablets.

100. Respondent's overall conduct, acts and/or omissions, with regard to Patient G, as set forth in paragraphs 94 through 99 herein, constitutes unprofessional conduct and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient G as follows:

a. Respondent failed to document performing appropriate evaluations and specific medical indications to support his prescribing of controlled substances, particularly for non-specific back pain in 2014. Respondent failed to offer alternatives to treatment with controlled substances.

b. Respondent failed to document obtaining informed consent from Patient G, advising the patient of the risks and potential adverse effects of the controlled substances prescribed on a chronic basis.

c. Respondent failed to enter into a controlled substances agreement with Patient G that established boundaries for the on-going prescribing of controlled substances for chronic pain.

EIGHTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Repeated Negligent Acts re Patients A, B, C, D, E, F, and/or G)

101. In the alternative, Respondent is subject to disciplinary action for unprofessional conduct, jointly and severally, under section 2234(c) for repeated negligent acts with regard to his acts and/or omissions with regards to Patient A and/or Patient B and/or Patient C and/or Patient D and/or Patient E and/or Patient F and/or Patient G, as alleged in paragraphs 26 through 100, which are incorporated herein by reference as if fully set forth.

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NINTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct re: Inadequate Medical Record Keeping: Patients A, B, C, D, E, F, and/or G)

102. Respondent is subject to disciplinary action for unprofessional conduct under section 2266 for failure to maintain adequate and accurate records relating to the provision of services to Patient A and/or Patient B and/or Patient C and/or Patient D and/or Patient E and/or Patient F and/or Patient G, as alleged in paragraphs 26 through 100, which are incorporated herein by reference as if fully set forth.

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 G 45225, issued to John Winthrop Pierce, M.D.;

2. Revoking, suspending or denying approval of John Winthrop Pierce, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering John Winthrop Pierce, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and,

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

DATED: August 31, 2018

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

SF2018501026