

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

In the Matter of the Accusation)
Against:)
)
)
Nathan H. Thuma, M.D.)
)
Physician's and Surgeon's)
Certificate No. G58451)
)
Respondent)
_____)

Case No. 800-2014-008551

DECISION

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

This Decision shall become effective at 5:00 p.m. on November 8, 2019.

IT IS SO ORDERED: October 9, 2019.

MEDICAL BOARD OF CALIFORNIA



**Kristina D. Lawson, J.D., Chair
Panel B**

1 XAVIER BECERRA
Attorney General of California
2 JANE ZACK SIMON
Supervising Deputy Attorney General
3 LYNNE K. DOMBROWSKI
Deputy Attorney General
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7 *Attorneys for Complainant*

8
9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

13 **NATHAN H. THUMA, M.D.**
14 1030 Main Street Suite 210
St. Helena, CA 94574
15 Physician's and Surgeon's Certificate
16 No. G58451

17 Respondent.

Case No. 800-2014-008551

OAH No. 2019070969

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

18
19
20 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
21 entitled proceedings that the following matters are true:

22 **PARTIES**

23 1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board
24 of California (Board). She brought this action solely in her official capacity and is represented in
25 this matter by Xavier Becerra, Attorney General of the State of California, by Lynne K.
26 Dombrowski, Deputy Attorney General.

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1 CULPABILITY

2 9. Respondent understands and agrees that the charges and allegations in Accusation
3 No. 800-2014-008551; if proven at a hearing, constitute cause for imposing discipline upon his
4 Physician's and Surgeon's Certificate.

5 10. For the purpose of resolving the Accusation without the expense and uncertainty of
6 further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual
7 basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest
8 those charges.

9 11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to
10 discipline and he agrees to be bound by the Board's probationary terms as set forth in the
11 Disciplinary Order below.

12 CONTINGENCY

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

23 13. The parties understand and agree that Portable Document Format (PDF) and facsimile
24 copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile
25 signatures thereto, shall have the same force and effect as the originals.

26 14. Respondent agrees that if he ever petitions for early termination or modification of
27 probation, or if an accusation and/or petition to revoke probation is filed against him before the
28 Board, all of the charges and allegations contained in Accusation No. 800-2014-008551 shall be

1 deemed true, correct, and fully admitted by Respondent for purposes of any such proceeding or
2 any other licensing proceeding involving Respondent in the State of California.

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

6 **DISCIPLINARY ORDER**

7 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G58451 issued
8 to Respondent Nathan H. Thuma, M.D. is revoked. However, the revocation is stayed and
9 Respondent is placed on probation for four (4) years on the following terms and conditions.

10 1. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO
11 RECORDS AND INVENTORIES. Respondent shall maintain, for his private outpatient practice,
12 a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by
13 Respondent, and any recommendation or approval which enables a patient or patient's primary
14 caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within
15 the meaning of Health and Safety Code section 11362.5, during probation, showing all of the
16 following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of
17 controlled substances involved; and 4) the indications and diagnosis for which the controlled
18 substances were furnished.

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

23 2. EDUCATION COURSE. Within 60 calendar days of the effective date of this
24 Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee
25 for its prior approval educational program(s) or course(s) which shall not be less than 40 hours
26 per year, for each year of probation. The educational program(s) or course(s) shall pertain to
27 addiction medicine and shall be Category I certified. The educational program(s) or course(s)
28 shall be at Respondent's expense and shall be in addition to the Continuing Medical Education

1 (CME) requirements for renewal of licensure. Following the completion of each course, the
2 Board or its designee may administer an examination to test Respondent's knowledge of the
3 course. Respondent shall provide proof of attendance for 65 hours of CME, of which 40 hours
4 were in satisfaction of this condition.

5 3. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective
6 date of this Decision, Respondent shall enroll in a course in prescribing practices approved in
7 advance by the Board or its designee. Respondent shall provide the approved course provider
8 with any information and documents that the approved course provider may deem pertinent.
9 Respondent shall participate in and successfully complete the classroom component of the course
10 not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully
11 complete any other component of the course within one (1) year of enrollment. The prescribing
12 practices course shall be at Respondent's expense and shall be in addition to the Continuing
13 Medical Education (CME) requirements for renewal of licensure.

14 A prescribing practices course taken after the acts that gave rise to the charges in the
15 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board
16 or its designee, be accepted towards the fulfillment of this condition if the course would have
17 been approved by the Board or its designee had the course been taken after the effective date of
18 this Decision.

19 Respondent shall submit a certification of successful completion to the Board or its
20 designee not later than 15 calendar days after successfully completing the course, or not later than
21 15 calendar days after the effective date of the Decision, whichever is later.

22 4. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective
23 date of this Decision, Respondent shall enroll in a course in medical record keeping approved in
24 advance by the Board or its designee. Respondent shall provide the approved course provider
25 with any information and documents that the approved course provider may deem pertinent.
26 Respondent shall participate in and successfully complete the classroom component of the course
27 not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully
28 complete any other component of the course within one (1) year of enrollment. The medical

1 record keeping course shall be at Respondent's expense and shall be in addition to the Continuing
2 Medical Education (CME) requirements for renewal of licensure.

3 A medical record keeping course taken after the acts that gave rise to the charges in the
4 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board
5 or its designee, be accepted towards the fulfillment of this condition if the course would have
6 been approved by the Board or its designee had the course been taken after the effective date of
7 this Decision.

8 Respondent shall submit a certification of successful completion to the Board or its
9 designee not later than 15 calendar days after successfully completing the course, or not later than
10 15 calendar days after the effective date of the Decision, whichever is later.

11 5. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the
12 Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the
13 Chief Executive Officer at every hospital where privileges or membership are extended to
14 Respondent, at any other facility where Respondent engages in the practice of medicine,
15 including all physician and locum tenens registries or other similar agencies, and to the Chief
16 Executive Officer at every insurance carrier which extends malpractice insurance coverage to
17 Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15
18 calendar days. This condition shall apply to any change(s) in hospitals, other facilities or
19 insurance carrier.

20 6. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE
21 NURSES. During probation, Respondent is prohibited from supervising physician assistants and
22 advanced practice nurses.

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

26 8. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations
27 under penalty of perjury on forms provided by the Board, stating whether there has been

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1 compliance with all the conditions of probation. Respondent shall submit quarterly declarations
2 not later than 10 calendar days after the end of the preceding quarter.

3 9. GENERAL PROBATION REQUIREMENTS.

4 Compliance with Probation Unit

5 Respondent shall comply with the Board's probation unit.

6 Address Changes

7 Respondent shall, at all times, keep the Board informed of Respondent's business and
8 residence addresses, email address (if available), and telephone number. Changes of such
9 addresses shall be immediately communicated in writing to the Board or its designee. Under no
10 circumstances shall a post office box serve as an address of record, except as allowed by Business
11 and Professions Code section 2021(b).

12 Place of Practice

13 Respondent shall not engage in the practice of medicine in Respondent's or patient's place
14 of residence, unless the patient resides in a skilled nursing facility or other similar licensed
15 facility.

16 License Renewal

17 Respondent shall maintain a current and renewed California physician's and surgeon's
18 license.

19 Travel or Residence Outside California

20 Respondent shall immediately inform the Board or its designee, in writing, of travel to any
21 areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty
22 (30) calendar days.

23 In the event Respondent should leave the State of California to reside or to practice
24 ,Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of
25 departure and return.

26 10. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be
27 available in person upon request for interviews either at Respondent's place of business or at the
28 probation unit office, with or without prior notice throughout the term of probation.

1 11. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or
2 its designee in writing within 15 calendar days of any periods of non-practice lasting more than
3 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is
4 defined as any period of time Respondent is not practicing medicine as defined in Business and
5 Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct
6 patient care, clinical activity or teaching, or other activity as approved by the Board. If
7 Respondent resides in California and is considered to be in non-practice, Respondent shall
8 comply with all terms and conditions of probation. All time spent in an intensive training
9 program which has been approved by the Board or its designee shall not be considered non-
10 practice and does not relieve Respondent from complying with all the terms and conditions of
11 probation. Practicing medicine in another state of the United States or Federal jurisdiction while
12 on probation with the medical licensing authority of that state or jurisdiction shall not be
13 considered non-practice. A Board-ordered suspension of practice shall not be considered as a
14 period of non-practice.

15 In the event Respondent's period of non-practice while on probation exceeds 18 calendar
16 months, Respondent shall successfully complete the Federation of State Medical Boards's Special
17 Purpose Examination, or, at the Board's discretion, a clinical competence assessment program
18 that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model
19 Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

20 Respondent's period of non-practice while on probation shall not exceed two (2) years.

21 Periods of non-practice will not apply to the reduction of the probationary term.

22 Periods of non-practice for a Respondent residing outside of California will relieve
23 Respondent of the responsibility to comply with the probationary terms and conditions with the
24 exception of this condition and the following terms and conditions of probation: Obey All Laws;
25 General Probation Requirements; and Quarterly Declarations.

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1 12. COMPLETION OF PROBATION. Respondent shall comply with all financial
2 obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the
3 completion of probation. Upon successful completion of probation, Respondent's certificate shall
4 be fully restored.

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

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

22 15. PROBATION MONITORING COSTS. Respondent shall pay the costs associated
23 with probation monitoring each and every year of probation, as designated by the Board, which
24 may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of
25 California and delivered to the Board or its designee no later than January 31 of each calendar
26 year.

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1 ACCEPTANCE

2 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully
3 discussed it with my attorney, Paul R. Baleria. I understand the stipulation and the effect it will
4 have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and
5 Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the
6 Decision and Order of the Medical Board of California.

7
8 DATED: 8-30-19

N. Thuma MD
9 NATHAN H. THUMA, M.D.
10 *Respondent*

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12
13 I have read and fully discussed with Respondent Nathan H. Thuma, M.D. the terms and
14 conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order.

15 I approve its form and content.

16 DATED: 8-30-19


17 PAUL R. BALERIA
18 LOW MCKINLEY BALERIA & SALENKO, LLP
19 *Attorney for Respondent*
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ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: 09/04/2019

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General


LYNNE K. DOMBROWSKI
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2014-008551

1 XAVIER BECERRA
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2 JANE ZACK SIMON
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7 *Attorneys for Complainant*

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO MAY 24 2017
BY: [Signature] ANALYST

8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:
12 **Nathan H. Thuma, M.D.**
1030 Main Street Suite 210
13 St. Helena, CA 94574
14 Physician's and Surgeon's Certificate
No. G58451,
15
16 Respondent.

Case No. 800-2014-008551
ACCUSATION

18 Complainant alleges:

19 **PARTIES**

- 20 1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official
21 capacity as the Executive Director of the Medical Board of California, Department of Consumer
22 Affairs (Board).
- 23 2. On or about August 25, 1986, the Medical Board issued Physician's and Surgeon's
24 Certificate Number G58451 to Nathan H. Thuma, M.D. (Respondent). The Physician's and
25 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein
26 and will expire on August 31, 2018, unless renewed.
- 27 3. During all times alleged herein, Respondent was board-certified as a psychiatrist and
28 as a DEA-approved prescriber of buprenorphine.

1 **JURISDICTION**

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

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

8 6. Section 2234 of the Code states:

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

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

14 "(b) Gross negligence.

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

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

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

25 "(d) Incompetence.

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

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

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

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

8 7. Section 2242 of the Code states, in pertinent part:

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

12 8. Section 2266 of the Code states: “The failure of a physician and surgeon to maintain
13 adequate and accurate records relating to the provision of services to their patients constitutes
14 unprofessional conduct.”

15 9. Section 725 of the Code states:

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

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

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

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

6 **PERTINENT CONTROLLED SUBSTANCES/DANGEROUS DRUGS**

7 10. Abilify, a trade name for aripiprazole, is an anti-psychotic medication that is used to
8 treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder (manic
9 depression). It may also be used together with other medications to treat major depressive
10 disorder in adults. It is a dangerous drug as defined in Business and Professions Code section
11 4022. Taking Abilify with other drugs that induce sleepiness may worsen the effect.

12 11. Adderall, a trade name for amphetamine and dextroamphetamine, is a central nervous
13 system stimulant indicated for use in the treatment of Attention Deficit Hyperactivity Disorder
14 (ADHD) and narcolepsy. It is a Schedule II controlled substance as defined by section 11055
15 (d)(1) of the Health and Safety Code and by Section 1308.12 of Title 21 of the Code of Federal
16 Regulations and is a dangerous drug as defined in Business and Professions Code section 4022.

17 12. Ambien, a trade name for zolpidem tartrate, is a non-benzodiazepine hypnotic of the
18 imidazopyridine class. It is a Schedule IV controlled substance as defined by section
19 11057(d)(32) of the Health and Safety Code and is a dangerous drug as defined in Business and
20 Professions Code section 4022. It is a central nervous system (CNS) depressant that is indicated
21 for the short-term treatment of insomnia.

22 13. Ativan, a trade name for lorazepam, is a benzodiazepine and central nervous system
23 (CNS) depressant used in the management of anxiety disorder for short-term relief from the
24 symptoms of anxiety or anxiety associated with depressive symptoms. It is a Schedule IV
25 controlled substance as defined by section 11057 of the Health and Safety Code and by section
26 1308.14 of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in
27 Business and Professions Code section 4022. Long-term or excessive use of Ativan can cause
28 dependency. Concomitant use of alcohol or other CNS depressants may have an additive effect.

1 14. Dexedrine, a trade name for dextroamphetamine sulfate, is a central nervous system
2 stimulant. It is used to treat Attention Deficit Hyperactivity Disorder (ADHD) and to treat
3 narcolepsy. It is a Schedule II controlled substance as defined by section 11055(d) of the Health
4 and Safety Code and is a dangerous drug as defined in Business and Professions Code section
5 4022.

6 15. Dilaudid, a trade name for hydromorphone hydrochloride, is a hydrogenated ketone of
7 morphine and an opioid analgesic whose principal therapeutic use is for relief of pain. It is a
8 Schedule II controlled substance as defined by section 11055, subdivision (d) of the Health and
9 Safety Code, and by Section 1308.12 (d) of Title 21 of the Code of Federal Regulations, and is a
10 dangerous drug as defined in Business and Professions Code section 4022.

11 16. Endocet is a trade name for the combination of oxycodone and acetaminophen.
12 Oxycodone is a semisynthetic narcotic analgesic with multiple actions qualitatively similar to
13 those of morphine. It is a Schedule II controlled substance as defined by section 11055,
14 subdivision (b)(1) of the Health and Safety Code, and section 1308.12 (b)(1) of Title 21 of the
15 Code of Federal Regulations, and is a dangerous drug as defined in Business and Professions
16 Code section 4022.

17 17. Fentanyl is an opioid analgesic which can be administered by an injection, through a
18 transdermal patch (known as Duragesic), as an oral lozenge (known as Actiq), or in tablet form
19 (known as Fentora). It is a Schedule II controlled substance as defined by section 11055 of the
20 Health and Safety Code and by Section 1308.12 of Title 21 of the Code of Federal Regulations,
21 and is a dangerous drug as defined in Business and Professions Code section 4022. Fentanyl's
22 primary effects are anesthesia and sedation. It is a strong opioid medication and is indicated only
23 for treatment of chronic pain (such as that of malignancy) that cannot be managed by lesser means
24 and that requires continuous opioid administration. Fentanyl presents a risk of serious or life-
25 threatening hypoventilation. When patients are receiving fentanyl, the dosage of central nervous
26 system depressant drugs should be reduced. Use of fentanyl together with other central nervous
27 system depressants, including alcohol, can result in increased risk to the patient.

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1 18. Fioricet is the trade name for the combination of butalbital (a barbiturate),
2 acetaminophen, and caffeine. It has a sedating effect and is used in the treatment of headaches. It
3 is a dangerous drug as defined in Business and Professions Code section 4022.

4 19. Geodon is the trade name for ziprasidone hydrochloride. It is an anti-psychotic drug
5 that is used in the treatment of schizophrenia and of the manic symptoms of bipolar disorder. It is
6 a dangerous drug as defined in Business and Professions Code section 4022.

7 20. Hydrocodone bitartrate with acetaminophen, known by the trade names Norco or
8 Vicodin, is a semi-synthetic opioid analgesic. It is indicated for the relief of moderate to severe
9 acute and chronic pain. It is a Schedule II controlled substance as defined by section 11055,
10 subdivision (b) of the Health and Safety Code, and is a Schedule II controlled substance as
11 defined by section 1308.13 (e) of Title 21 of the Code of Federal Regulations¹ and is a dangerous
12 drug as defined in Business and Professions Code section 4022.

13 21. Klonopin, a trade name for clonazepam, is an anti-convulsant of the benzodiazepine
14 class of drugs. It is a Schedule IV controlled substance under Health and Safety Code section
15 11057(d)(7) and is a dangerous drug as defined in Business and Professions Code section 4022. It
16 produces CNS depression and should be used with caution with other CNS depressant drugs.

17 22. Morphine Sulfate, known by the trade name MS Contin, is an opioid pain medication
18 indicated for the management of moderate to severe acute and chronic pain. Morphine is a
19 Schedule II controlled substance as defined by section 11055, subdivision (b) of the Health and
20 Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022.

21 23. OxyContin and Oxycodone IR are both trade names for oxycodone hydrochloride, a
22 pure agonist opioid that is used to treat moderate to severe pain lasting for an extended period of
23 time. It is a Schedule II controlled substance as defined by section 11055, subdivision (b)(1) of
24 the Health and Safety Code and by Section 1308.12 (b)(1) of Title 21 of the Code of Federal
25 Regulations and is a dangerous drug as defined in Business and Professions Code section 4022.

26 _____
27 ¹ Effective 10/06/2014, all hydrocodone combination products were re-scheduled from
28 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.

1 24. Risperdal, a trade name for Risperidone, is an anti-psychotic agent and a
2 benzisoxazole derivative indicated for the management of the manifestations of psychotic
3 disorders. It is a dangerous drug as defined by Business and Professions Code section 4022.

4 25. Ritalin, a trade name for methylphenidate hydrochloride, is a central nervous system
5 stimulant. It is indicated for the treatment of Attention Deficit Disorder (ADD), Attention Deficit
6 Hyperactivity Disorder (ADHD), and narcolepsy. It is a Schedule II controlled substance as
7 defined by section 11055, subdivision (d) of the Health and Safety Code and is a dangerous drug
8 as defined in Business and Professions Code section 4022.

9 26. Seroquel, a trade name for quetiapine, is an anti-psychotic drug indicated for the
10 management of the manifestations of psychotic disorders, such as schizophrenia and bipolar
11 disorder. It may be used in conjunction with anti-depressant medications to treat major
12 depressive disorder. It is a dangerous drug as defined in Business and Professions Code section
13 4022.

14 27. Suboxone (Buprenorphine and naloxone) and Subutex (Buprenorphine) are both trade
15 names for drugs containing buprenorphine, an opioid (narcotic) partial agonist-antagonist that
16 works by binding receptors in the brain and nervous system to help prevent withdrawal symptoms
17 in someone who has stopped taking narcotics (e.g., heroin, oxycodone). Buprenorphine is used as
18 part of an office-based opiate maintenance treatment. It is a Schedule III controlled substance as
19 defined by section 11056 of the Health and Safety Code and is a dangerous drug as defined in
20 Business and Professions Code section 4022. Under the Drug Addiction Treatment Act (DATA)
21 codified at 21 U.S.C. 823(g), prescription use of Suboxone in the treatment of opioid dependence
22 is limited to physicians who meet certain qualifying requirements, who have notified the Secretary
23 of Health and Human Services (HHS) of their intent to prescribe this product for the treatment of
24 opioid dependence, and who have been assigned a unique identification number that must be
25 included on every prescription.

26 28. Tylenol with Codeine No. 3 and Tylenol with Codeine No. 4 are trade names for
27 acetaminophen with codeine. They contain a combination of 300 mg. of acetaminophen with
28 either 30 mg. (No. 3) or 60 mg. (No. 4) of codeine. It is a combination opioid analgesic that is

1 used to relieve mild to moderately severe acute and chronic pain. It is a Schedule III controlled
2 substance under Health and Safety Code section 11056 and is a dangerous drug as defined in
3 Business and Professions Code section 4022.

4 29. Valium, a trade name for diazepam, is a psychotropic drug used for the management
5 of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a Schedule IV
6 controlled substance as defined by section 11057 of the Health and Safety Code and by section
7 1308.14 of Title 21 of the Code of Federal Regulations, and is a dangerous drug as defined in
8 Business and Professions Code section 4022. Diazepam can produce psychological and physical
9 dependence and it should be prescribed with caution particularly to addiction-prone individuals
10 (such as drug addicts and alcoholics) because of the pre-disposition of such patients to habituation
11 and dependence.

12 30. Vyvanse, a trade name for lisdexamfetamine, is a central nervous system stimulant
13 that affects chemicals in the brain and nerves that contribute to hyperactivity and impulse control.
14 It is used to treat Attention Deficit Hyperactivity Disorder (ADHD) and is also used to treat
15 moderate to severe binge eating disorder. It should not be taken in the evening because it may
16 cause sleep problems (insomnia). It is a Schedule II controlled substance as defined by section
17 11055 of the Health and Safety Code and is a dangerous drug as defined in Business and
18 Professions Code section 4022.

19 31. Wellbutrin, a trade name for bupropion, is an anti-depressant medication that is used
20 to treat major depressive disorder and seasonal affective disorder. Drinking alcohol with
21 bupropion may increase the risk of seizures. It is a dangerous drug within the meaning of
22 Business and Professions Code section 4022.

23 32. Xanax, a trade name for Alprazolam, is used in the management of anxiety and panic
24 disorders. It is a psychotropic triazolo-analogue of the benzodiazepine class of central nervous
25 system-active compounds. It is a Schedule IV controlled substance as defined by section 11057,
26 subdivision (d) of the Health and Safety Code, and by section 1308.14 (c) of Title 21 of the Code
27 of Federal Regulations, and is a dangerous drug as defined in Business and Professions Code
28

1 section 4022. It has a central nervous system depressant effect and patients should be cautioned
2 about the simultaneous ingestion of alcohol and other CNS depressant drugs.

3 **FIRST CAUSE FOR DISCIPLINE**

4 **(Unprofessional Conduct: Patient A²: Gross Negligence, Incompetence, Prescribing Without
5 Appropriate Prior Examination and Medical Indication, Excessive Prescribing)**

6 33. Respondent Nathan H. Thuma, M.D. is subject to disciplinary action under sections
7 2234(b) and/or 2234(d) and/or 2242 and/or 725 in that Respondent's overall conduct, acts and/or
8 omissions, with regard to Patient A constitutes gross negligence and/or incompetence and/or
9 prescribing without an appropriate prior examination and a medical indication and/or excessive
10 prescribing, as more fully described herein below.

11 34. In or about May 1998, Respondent first saw Patient A for outpatient mental health
12 treatment. At the time, Patient A was a 29-year-old female with a history of sexual abuse as a
13 child, a long history of emotional problems, recurrent depression and psychosis, multiple suicide
14 attempts, and severe alcohol and poly-substance abuse. Patient A reported having just completed
15 a residential drug recovery program. The patient also reported using methamphetamine with her
16 boyfriend.

17 35. After May 1998, Respondent saw and treated Patient A on a regular basis up until
18 about December 1999. Respondent diagnosed Patient A with severe ADHD, without
19 documenting a full examination and assessment. During the course of Respondent's treatment,
20 the patient's addiction was active with multiple relapses. Respondent prescribed Dexedrine, a
21 controlled substance, along with other prescription drugs, with no clear positive response from the
22 patient regarding the treatment.

23 36. In or about December 1999, Patient A was hospitalized for four days. Respondent
24 was asked by the patient's outpatient substance abuse program counselor to withdraw from the
25 case so that the patient could see someone closer to home who would not prescribe Dexedrine.
26

27 ² To protect the patients' privacy, they will be referred to by letter designations.
28 Respondent will be provided with the full names of the patients through discovery.

1 37. On or about January 31, 2006, after an absence of about six years, Patient A returned
2 to see Respondent. The patient reported that for the past three years she was on SSDI and was
3 unable to work because she could not stay sober for more than 90 days. The patient also reported
4 that she was currently taking methadone and Zoloft that was prescribed by a primary care
5 physician. Respondent prescribed Dexedrine to the patient, although the patient had a history of
6 being addicted to Dexedrine.

7 38. By February 2007, Respondent was prescribing Dexedrine, Geodon, Zoloft, along
8 with two additional benzodiazepine sedatives: Xanax and Klonopin. Respondent was aware that
9 the patient was also getting methadone from another physician for back pain.

10 39. On or about December 10, 2010, Respondent spoke by telephone with the patient who
11 reported another severe vodka relapse from which she was just recovering. Respondent
12 prescribed the antipsychotic drug Geodon to be given intramuscularly (IM) and faxed a
13 prescription for Geodon IM 20 mg. prn #3 doses plus 11 refills. Respondent noted that the patient
14 liked the idea of Geodon IM because it "reminded her of prior heroin use." Although it is unclear
15 from Respondent's records, it appears that he prescribed Geodon as a take-home medication to be
16 self-injected. Respondent also issued refill prescriptions for Xanax (#90 with 11 refills) and
17 Dexedrine (#210).

18 40. In or about January 2011, the patient was hospitalized and was in the ICU for alcohol
19 withdrawal, septic shock, lactic acidosis, and acute respiratory failure. The patient had also
20 swallowed a few coins.

21 41. On or about April 29, 2011, Respondent added Suboxone (buprenorphine) to the
22 prescribing regimen, which included Geodon, Zoloft, Xanax, and Dexedrine.

23 42. In or about July 2011, the patient was heavily intoxicated, found in her bed lying in
24 her own feces and urine, and was brought to a hospital Emergency Department, placed on an
25 involuntary psychiatric hold, and treated for alcohol withdrawal.

26 43. During another hospitalization in 2012, the patient's liver function was determined to
27 be poor and it was attributed to alcohol-related hepatitis.

28

1 44. During the course of treatment, Respondent was aware that Patient A had been “fired”
2 by a pharmacist, by her pain doctor, and by her substance rehabilitation program due to her
3 multiple relapses and behavior.

4 45. During the course of treatment, the patient kept relapsing and demonstrated
5 increasingly serious consequences of addiction: increased depression, poor hygiene, bedwetting,
6 sedation, nausea, vomiting, ataxia (trouble with balance), repeated falls, bone fractures, a DUI
7 charge, a motor vehicle accident, withdrawal symptoms, a withdrawal seizure, repeat
8 hospitalizations, one ICU stay, broken ribs, amnesia, and incarceration. Yet, Respondent did not
9 re-evaluate the effectiveness of his treatment. He instead escalated the doses of controlled
10 substances.

11 46. On April 20, 2013, a neighbor found Patient A dead at home. The Marin County
12 Coroner’s report found that the immediate cause of death was acute alcohol intoxication and that
13 the death was an accident. Other causes of death listed were: chronic alcoholism with fibrosis and
14 severe steatosis of the liver, chronic obstructive pulmonary disease. In addition to alcohol, the
15 patient died with controlled substances (benzodiazepines) in her system.

16 47. Respondent’s overall conduct, acts and/or omissions with regard to Patient A, as set
17 forth in paragraphs 33 through 46 herein, constitutes unprofessional conduct through gross
18 negligence and/or incompetence and/or prescribing without an appropriate prior examination and
19 a medical indication and/or excessive prescribing, pursuant to Business and Professions Code
20 Sections 2234 subdivisions (b) and/or (d) and/or section 2242 and/or section 725, and is therefore
21 subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct
22 with regard to Patient A as follows:

23 a. Respondent treated Patient A with controlled substances without ever performing a
24 complete psychiatric history and assessment, including a complete medical, substance abuse, and
25 social history.

26 b. Respondent failed to document a clear and comprehensive treatment plan and
27 periodic review of the effectiveness of the treatment.
28

1 c. Respondent failed to document legitimate medical indications for the prescribing and
2 the escalating of doses of multiple controlled substances for long-term use, particularly to an
3 alcoholic and addict such as Patient A.

4 d. Respondent demonstrated gross negligence and/or a lack of knowledge in prescribing
5 buprenorphine to Patient A concurrently with sedatives and other controlled substances.

6 e. Respondent failed to maintain clear and complete progress notes, and failed to
7 maintain a clear and updated list of all of the concurrent psychoactive central nervous system
8 medications that Patient A was taking.

9 f. Respondent failed to consult with the patient's other medical providers and/or failed
10 to ask for and obtain collateral records. Respondent failed to obtain contemporaneous hospital
11 and rehabilitation center records after the patient had repeated medical hospitalizations and
12 multiple relapses with stays at rehabilitation centers.

13 g. Respondent failed to document that he obtained informed consent from Patient A for
14 treatment with multiple psychiatric medications, controlled substances. There was no
15 documentation that Respondent discussed the risks, benefits, and possible complications of
16 treatment with psychiatric medications, discussed the risk of treatment vs. no treatment, and the
17 alternatives to psychiatric medicines, and/or discussed the risk of relapse when prescribing
18 multiple controlled substances to an addict.

19 h. Respondent prescribed controlled substances to an addict without proper
20 consideration and monitoring.

21 i. Respondent failed to order initial baseline screening lab tests and to conduct follow-
22 up lab tests, or to document why such testing was not needed.

23 j. Respondent failed to conduct random urine or blood toxicology screenings, especially
24 when the patient admitted to relapsing and/or requested early refills of her prescription
25 medications.

26 k. Respondent failed to perform a suicide risk assessment on Patient A, initially and
27 whenever there was a clinical change in the patient's condition, e.g. after an overdose, after a
28 relapse, or when the patient reported taking increased quantities of medications.

1 1. Respondent demonstrated gross negligence and/or a lack of knowledge in prescribing
2 Geodon IM to Patient A for self-injection.

3 **SECOND CAUSE FOR DISCIPLINE**

4 **(Unprofessional Conduct: Patient B: Gross Negligence, Incompetence, Prescribing Without**
5 **Appropriate Prior Examination and Medical Indication, Excessive Prescribing)**

6 48. Respondent Nathan H. Thuma, M.D. is subject to disciplinary action under sections
7 2234(b) and/or 2234(d) and/or 2242 and/or 725 in that Respondent's overall conduct, acts and/or
8 omissions, with regard to Patient B constitutes gross negligence and/or incompetence and/or
9 prescribing without an appropriate prior examination and a medical indication and/or excessive
10 prescribing, as more fully described herein below.

11 49. On or about January 5, 2006, Patient B, a 29-year-old female, began to see
12 Respondent for treatment after she was discharged from a psychiatric hospital. Patient B was an
13 addict and had multiple health problems, including chronic pain. Patient B had a history of being
14 sexually abused as a child by a family member. By the age of fifteen, Patient B was addicted to
15 prescription opiates, poly-substances, and had multiple relapses. The patient had a significant
16 history of impulsivity and self-harm behavior with multiple suicide attempts (overdosing),
17 multiple admissions to drug treatment centers and crisis centers, along with other hospitalizations.
18 In 2003, Patient B spent four months in jail for stealing prescription medications from her
19 mother. The patient had not worked since 2002. She reported that she lost her driver's license
20 four years prior because she had fainted while driving. The patient reported that she was trying to
21 get an appointment to see a pain specialist. Respondent diagnosed Patient B with Bipolar
22 Affective Disorder, Type II, Post-Traumatic Stress Disorder, Borderline Personality Disorder,
23 Opiate Dependence, and mild Autism. Respondent prescribed Haldol, Lamictal, Cogentin,
24 Ambien, and Lorazepam.

25 50. Respondent did not complete a thorough psychiatric evaluation and history at the time
26 of the initial visit and/or during the course of treatment. A comprehensive list of all the patient's
27 substances of abuse was not documented.

28

1 51. Within less than one month after starting treatment, Respondent began to prescribe
2 Subutex (buprenorphine) to the patient.

3 52. Within months of starting treatment, Respondent began prescribing opiates and
4 sedatives in addition to the buprenorphine, escalating the doses during the course of treatment,
5 without documented medical indications.

6 53. Starting in or about September 2012, Respondent began to prescribe opiates on a
7 chronic basis for pain, in escalating doses, without documented medical indications.

8 54. Respondent treated Patient B with multiple controlled substances and other dangerous
9 drugs, including: Tylenol with codeine, Norco/Vicodin, Dilaudid, Fentanyl patches, Morphine
10 sulfate, OxyContin, Buprenorphine (Subutex/Suboxone), Fioricet, Ambien, Xanax, Ativan,
11 Endocet, and Lyrica.

12 55. During the course of treatment, Patient B missed scheduled appointments and made
13 frequent phone calls to Respondent, not all of which were documented by Respondent.
14 Respondent also would talk on the phone with Patient B in place of an office visit.

15 56. Patient B frequently requested early refills or increased doses of controlled substances
16 and also frequently reported losing her prescriptions or reported them stolen. Respondent
17 frequently noted that the patient was non-compliant with the medications and did not follow the
18 dosing directions, often taking extra doses. Yet, Respondent granted the patient's requests for
19 early refills and for increased doses, without documenting a medical indication.

20 57. Respondent continued to prescribe Fentanyl patches for daily use even after the
21 patient reported that she had problems keeping the patch on her arm and that she would instead
22 suck the patch.

23 58. During the course of treatment, Respondent would call in or fax prescriptions to
24 several different pharmacies or Respondent would mail the prescriptions for controlled substances
25 directly to the patient. Patient B used multiple pharmacies to obtain her prescriptions and would
26 often change the pharmacy.

27 ///

28 ///

1 59. During the course of treatment, Respondent was aware that Patient B was also being
2 treated by other physicians and was aware that the patient went to the hospital emergency room to
3 get opiate injections.

4 60. During the course of treatment, Patient B was chronically suicidal and had a history of
5 multiple hospitalizations, cutting and burning herself, and a history of overdosing. The patient
6 also reported physical withdrawal symptoms, multiple falls, and multiple seizures. Respondent
7 documented the following symptoms: auditory hallucinations, insomnia, depression, suicidal
8 ideation, irritability, temper tantrums, visual hallucinations, and nightmares.

9 61. Respondent's overall conduct, acts and/or omissions, with regard to Patient B, as set
10 forth in paragraphs 48 through 60 herein, constitutes unprofessional conduct through gross
11 negligence and/or incompetence and/or prescribing without an appropriate prior examination and
12 a medical indication and/or excessive prescribing, pursuant to Business and Professions Code
13 Sections 2234 subdivisions (b) and/or (d) and/or section 2242 and/or section 725, and is therefore
14 subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct
15 with regard to Patient B as follows:

16 a. Without ever performing a complete psychiatric history and assessment of the patient,
17 including a complete medical, substance abuse, and social history, Respondent treated the patient
18 with controlled substances and other prescription medications.

19 b. During the course of treatment of Patient B, Respondent failed to maintain clear and
20 complete progress notes, and failed to maintain a clear and updated list of all of the concurrent
21 psychoactive central nervous system medications that the patient was taking.

22 c. Respondent did not seek to obtain records from collateral sources. Respondent failed
23 to order collateral hospital records for the patient's repeated medical hospitalizations and
24 emergency room visits.

25 d. Respondent failed to document a clear and comprehensive treatment plan and failed
26 to document periodic review of the effectiveness of the treatment.

27 e. Respondent failed to document that he obtained informed consent from the patient
28 with regard to his treatment of multiple controlled substances, that he discussed the risks, benefits

1 and possible complications of the psychiatric medications, and the alternatives to psychiatric
2 medicines, and/or discussed the risk of relapse when prescribing multiple controlled substances to
3 an addict.

4 f. Respondent failed to order initial and follow-up lab tests and/or failed to document
5 why testing was not needed.

6 g. Respondent failed to perform routine and/or random urine or blood toxicology
7 screening for this patient who admitted to relapsing and/or who had requested early refills of
8 prescriptions.

9 h. Respondent demonstrated gross negligence and/or incompetence in the prescribing of
10 buprenorphine to Patient B.

11 i. Respondent demonstrated gross negligence and/or incompetence in the prescribing to
12 Patient B of multiple controlled substances (such as Fentanyl, Oxycodone, Hydromorphone,
13 Hydrocodone, Codeine, Ambien, and Lorazepam) at escalating doses and for long term use.

14 j. Respondent prescribed controlled substances to an addict without proper
15 consideration and monitoring.

16 k. Respondent's prescribing of opiates, other than buprenorphine, on a chronic basis to
17 Patient B, who was a psychiatric patient, was outside of Respondent's scope of practice and
18 constitutes gross negligence and/or incompetence.

19 THIRD CAUSE FOR DISCIPLINE

20 **(Unprofessional Conduct: Patient C: Gross Negligence, Incompetence, Prescribing Without** 21 **Appropriate Prior Examination and Medical Indication, Excessive Prescribing)**

22 62. Respondent Nathan H. Thuma, M.D. is subject to disciplinary action under sections
23 2234(b) and/or 2234(d) and/or 2242 and/or 725 in that Respondent's overall conduct, acts and/or
24 omissions, with regard to Patient C constitutes gross negligence and/or incompetence and/or
25 prescribing without an appropriate prior examination and a medical indication and/or excessive
26 prescribing, as more fully described herein below.

27 63. On or about December 24, 2010, Patient C, a 19-year-old male, saw Respondent to
28 begin treatment for opiate addiction using Suboxone. Patient C had a history of addiction to

1 opiates and methamphetamines. The patient was living with his parents. His family history
2 included drug and alcohol abuse. He had sold drugs to maintain his habit and had been arrested
3 twice for methamphetamine-related charges. At the time of the initial visit, Patient C reported
4 using 200 mg of OxyContin daily and he stated that he had taken six Vicodin prior to the visit.
5 The patient reported that he was currently in a court-ordered drug rehabilitation program and that
6 he had to switch groups because of a dirty test. Respondent's diagnosis, based on the clinical
7 interview of the patient, was panic disorder, opiate dependence, and anti-social traits. Respondent
8 prescribed #30 Suboxone (buprenorphine). Respondent did not order any urine or blood
9 toxicology screens.

10 64. Respondent continued to see Patient C approximately every month. At a visit on
11 February 4, 2011, the patient reported running out of Suboxone a few days before. The patient
12 reported that he took the Suboxone "erratically" and that some of it may have been stolen. The
13 patient also asked for Wellbutrin and mentioned that he was starting to have health insurance
14 through Kaiser. Respondent noted in the chart that he prescribed: #60 Suboxone film, #30 Paxil
15 20 mg., and #30 Wellbutrin XL, plus three refills each for the Paxil and the Wellbutrin XL.

16 65. On or about April 1, 2011, the patient requested Adderall and Respondent added
17 Adderall to the treatment, prescribing #60 Adderall IR 20 mg. bid.

18 66. On or about April 29, 2011, Respondent noted that Patient C claimed that he had been
19 without Adderall for the last week because he had left the bottle of pills at his mother's house.
20 Without any documented medical indication, Respondent increased the Adderall prescribed to
21 #80 Adderall 20 mg, to be taken three times a day, and also prescribed #60 Subutex 8 mg., along
22 with Paxil.

23 67. In the progress note for May 27, 2011, Respondent noted again that the patient was
24 not compliant with his prescription medications. The patient reported that he recently went five
25 days without Adderall and buprenorphine and that he "did okay." Respondent continued to
26 prescribe #60 Adderall IR and #60 Subutex 8 mg., plus one refill for each.

27 68. For the remainder of 2011, the patient saw Respondent only twice: in July and in
28 November. During that time, the patient reported running out of Adderall and of someone

1 stealing his buprenorphine. Respondent continued to issue prescriptions, with refills, for Adderall
2 IR and for Subutex (buprenorphine).

3 69. In or about 2012, Respondent saw the patient about every two or three months. The
4 patient continuously reported running out of Adderall and he claimed that his parents were
5 “dipping into his Adderall.” Respondent continued to prescribed Adderall IR and Subutex
6 (buprenorphine) with refills, in addition to other prescription medications.

7 70. In the progress note for July 6, 2012, Respondent noted that the patient had just turned
8 21 years of age. The patient stated that he had run out of Adderall awhile back, that he had tried
9 his mother’s Abilify and “liked it.” Respondent gave the patient samples of Abilify 5 mg.
10 samples and issued prescriptions, with two refills each, for #60 Adderall IR 30 mg. and #60
11 Buprenorphine 8 mg.

12 71. On or about January 4, 2013, Respondent noted that the patient said that he quit
13 Adderall a month ago and ran out of Subutex five days ago but was able to get a refill of an old
14 prescription through CVS. Respondent prescribed Xanax and Subutex, with two refills.

15 72. On or about April 5, 2013, Respondent saw Patient C who reported that his mother
16 gave him Klonopin at times and that he wanted Xanax for chronic social anxiety. The patient
17 reported now getting care from Kaiser. Respondent prescribed #30 Xanax 1 mg. with two refills,
18 along with a #30 Buprenorphine 8 mg. with two refills.

19 73. On or about May 4, 2013, the patient requested to double the dose of Xanax and
20 Respondent agreed, without documenting a medical indication for the increased dose.

21 74. On or about August 2, 2013, the patient saw Respondent and reported that he was
22 taking more Subutex than prescribed, 12 mg. daily instead of 8 mg. The patient also said that he
23 was getting Klonopin from his mother to smooth out the Xanax. Respondent also noted that the
24 patient was getting prescriptions for Effexor and Wellbutrin from Kaiser. Respondent prescribed
25 Klonopin (clonazepam) in addition to prescriptions for #60 Xanax 2 mg. and #120 Subutex 8 mg.,
26 with refills plus an extra prescription.

27 75. On or about October 8, 2013, the patient reported that he was using more medications
28 than prescribed, that he was taking too much Xanax and Klonopin, and he admitted that he had

1 lied to Respondent about having a brother home from prison. Respondent continued to prescribe:
2 #60 Subutex 8 mg., #90 Clonazepam 1 mg., and #90 Tegretol 200 mg., with a refill for each
3 prescription.

4 76. A week later, on October 15, 2013, the patient made an unannounced visit to
5 Respondent's office. The patient stated that he had run out of Xanax. Respondent issued
6 prescriptions for #90 Xanax 2 mg. with one refill and #90 Seroquel 100 mg. with two refills.

7 77. During the course of treatment in 2014, Respondent was aware that the patient was
8 not compliant with his prescription medications, that he took more medication than prescribed,
9 and was requesting early refills. Yet, Respondent continued to grant the patient's refill requests
10 and to issue sequential and refill prescriptions.

11 78. On or about April 1, 2014, Respondent increased the quantities and prescribed #120
12 Xanax 2 mg. and #120 Clonazepam 2 mg. with one refill. There was no documentation of any
13 medical indication for the increased dosages.

14 79. On or about September 23, 2014, the patient stopped by Respondent's office for an
15 early refill. Respondent noted that he had called in a refill the day before for #30 Subutex. The
16 patient reported that he was taking 4 mg. each of Xanax and Klonopin in the morning.
17 Respondent also noted that the patient reported that he was going to start attending an outpatient
18 substance abuse program at Kaiser. Respondent wrote in the chart that the patient was an "abject
19 drug addict."

20 80. Respondent's records for Patient C include a letter dated September 24, 2014 from
21 Kaiser (TPMG) informing him that the patient had entered the Kaiser Chemical Dependency
22 Recovery Program in Vallejo and that the patient was to begin supervised medical detoxification
23 from benzodiazepines.

24 81. On or about December 23, 2014, Respondent noted that the patient completed the
25 Kaiser Outpatient Chemical Recovery Program and was off all benzodiazepines. The patient
26 reported getting Suboxone from Kaiser but wanted to increase his dose of buprenorphine and
27 wanted to resume taking Adderall. Respondent prescribed: #60 Buprenorphine 8 mg. and #60
28 Adderall IR 15 mg.

1 82. On or about April 21, 2015, the patient reported to Respondent that the Medical
2 Board was investigating Respondent. Respondent noted in the patient's chart that "for awhile
3 there he got too many benzos from me."

4 83. In or about June 2015, the patient reported relapsing on benzodiazepines (Klonopin,
5 Xanax) along with smoking cannabis at night. Respondent prescribed Klonopin in weekly doses
6 for eight weeks and Buprenorphine with two refills.

7 84. In or about June 2015, Patient C reported that he had relapsed on benzodiazepines.
8 As a result, his mother kicked him out of the home and he was homeless for a period of time.

9 85. In or about August or September 2015, Respondent saw Patient C, who was living
10 with his grandparents. Respondent noted in the chart that the patient abuses Klonopin even
11 though he is prescribed just enough for one week at a time. The patient also reported smoking
12 marijuana at night. Respondent increased the Klonopin and the Wellbutrin, for which he wrote
13 prescriptions in two different strengths, along with prescriptions for Buprenorphine, Effexor, and
14 Lamictal.

15 86. During the course of treatment in 2016, Patient C continued to request early refills of
16 both Xanax and Klonopin, which Respondent mostly granted. The patient also was still being
17 prescribed psychiatric medications and was using cannabis.

18 87. On or about March 15, 2016, Respondent noted that the patient "wants Adderall
19 again." Respondent prescribed Ritalin IR 20 mg., in addition to Buprenorphine and Klonopin.
20 But on March 18, 2016, the patient stopped by Respondent's office and Respondent wrote a
21 prescription for #60 Adderall IR 10 mg. because the patient "dislikes Ritalin." Then on or about
22 April 26, 2016, the patient stated that he preferred Ritalin to Adderall and Respondent prescribed
23 #60 Ritalin 20 mg., along with Klonopin and Buprenorphine.

24 88. During the course of treatment, Patient C demonstrated multiple behaviors that were
25 indicative of prescription drug misuse.

26 89. Through at least September 2016, Respondent continued to prescribe to Patient C, on
27 an approximately monthly basis, Clonazepam, Buprenorphine, and Ritalin (methylphenidate
28 hydrochloride).

1 90. Respondent's overall conduct, acts and/or omissions with regard to Patient C, as set
2 forth in paragraphs 62 through 89 herein, constitutes unprofessional conduct through gross
3 negligence and/or incompetence and/or prescribing without an appropriate prior examination and
4 a medical indication and/or excessive prescribing, pursuant to Business and Professions Code
5 Sections 2234 subdivisions (b) and/or (d) and/or section 2242 and/or section 725, and is therefore
6 subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct
7 with regard to Patient C as follows:

8 a. Without ever performing a complete psychiatric history and assessment of the patient,
9 including a complete medical, substance abuse, and social history, Respondent treated the patient
10 with controlled substances (opiates, sedatives, and stimulants).

11 b. During the course of treatment of Patient C, Respondent failed to maintain clear and
12 complete progress notes, and failed to maintain a clear and updated list of all of the concurrent
13 psychoactive central nervous system medications that the patient was taking.

14 c. Respondent did not seek to obtain records from collateral sources. Respondent failed
15 to order collateral records for the patient's treatments with other health care providers.

16 d. Respondent failed to document a clear and comprehensive treatment plan and failed
17 to document periodic review of the effectiveness of the treatment.

18 e. Respondent failed to document that he obtained informed consent from Patient C with
19 regard to his treatment of multiple controlled substances, that he discussed the risks, benefits and
20 possible complications of the psychiatric medications and alternatives to the treatment using
21 multiple controlled substances, and/or discussed the risk of relapse when prescribing multiple
22 controlled substances to an addict.

23 f. Respondent failed to order initial and follow-up lab tests and/or failed to document
24 why testing was not needed.

25 g. Respondent failed to perform routine and/or random urine or blood toxicology
26 screening for this patient who admitted to relapsing and/or who had requested early refills of
27 prescriptions.
28

1 h. Respondent prescribed controlled substances to an addict without proper
2 consideration and monitoring.

3 i. Respondent demonstrated a lack of knowledge in prescribing buprenorphine and then
4 adding other controlled substances, such as Xanax and/or Klonopin.

5 j. Respondent prescribed multiple controlled substances for long-term use, and at
6 escalating doses, to an addict without documenting a reasonable medical indication.

7 **FOURTH CAUSE FOR DISCIPLINE**

8 **(Unprofessional Conduct: Patient D: Gross Negligence, Incompetence, Prescribing Without
9 Appropriate Prior Examination and Medical Indication, Excessive Prescribing)**

10 91. Respondent Nathan H. Thuma, M.D. is subject to disciplinary action under sections
11 2234(b) and/or 2234(d) and/or 2242 and/or 725 in that Respondent's overall conduct, acts and/or
12 omissions, with regard to Patient D constitutes gross negligence and/or incompetence and/or
13 prescribing without an appropriate prior examination and a medical indication and/or excessive
14 prescribing, as more fully described herein below.

15 92. On or about February 13, 2010, Patient D, a 59-year-old male, saw Respondent for
16 opiate maintenance treatment using Suboxone. Patient D had a history of chronic foot pain and
17 was prescription opiate abuse. The patient reported that he was taking OxyContin for peripheral
18 neuropathy pain. He was seeing a primary care physician, a neurologist, and pain management
19 doctor. He had a family history of alcoholism. Respondent prescribed Suboxone
20 (buprenorphine), Cymbalta, and Vyvanse.

21 93. Within about two weeks of starting the Suboxone, however, the patient aborted the
22 Suboxone treatment. Respondent prescribed Oxycodone IR 80 mg. and increased the dose of
23 Vyvanse.

24 94. On or about April 23, 2010, Respondent began to prescribe to Patient D both
25 OxyContin ER 80 mg. and Oxycodone IR 15 mg. along with the Vyvanse. There was no
26 documentation of a medical indication for this prescribing in the patient's chart.

27 95. By July 2010, Respondent's prescribing of opiates had escalated so that the patient
28 was getting monthly about #150 Oxycodone IR 15 mg., #120 OxyContin 80 mg., in addition to

1 Vyvanse, a stimulant. There was no documentation in the records of medical indications, a
2 treatment plan, periodic review, and/or monitoring.

3 96. On or about August 17, 2010, Respondent added, without documenting a medical
4 indication, a prescription for Xanax (a benzodiazepine) to the combination of opiates and
5 Vyvanse.

6 97. During the course of Respondent's treatment, Patient D frequently reported mis-use
7 of opiates. He requested early refills or increased doses. Respondent would grant early refill
8 requests and increase the dosages without documenting medical indications and without any
9 monitoring of the patient. Respondent noted several times in the chart that the patient would
10 come in late and leave early so that he could get to the pharmacy.

11 98. In or about 2012, Respondent was prescribing on a monthly basis between #300 -
12 #450 Oxycodone IR 30 mg., #60 Xanax, plus Vyvanse to Patient D.

13 99. During the course of Respondent's treatment, Patient D had increasing medical issues
14 and complications. The patient had a neuro-stimulator placed by the end of 2011. In or about
15 November 2012, the patient reported having suffered a stroke. In December 2012, he was in a car
16 accident.

17 100. Starting in or about March 2013, Respondent was prescribing monthly to Patient D
18 between #680 to #800 Oxycodone 30 mg.; #90 Xanax; and Vyvanse.

19 101. In 2014, Respondent noted in the chart that the patient's condition was getting worse.
20 Yet, Respondent continued to issue monthly prescriptions for #800 Oxycodone, #90 Xanax, and
21 Vyvanse.

22 102. During the course of treatment, Patient D demonstrated multiple behaviors that were
23 indicative of prescription drug misuse. In April 2014, Respondent noted that all the patient cared
24 about were the drugs. Yet, when the patient reported losing his prescription for Oxycodone less
25 than three weeks after a visit, Respondent issued another prescription.

26 103. On or about May 27, 2014, Respondent issued two prescriptions for #375 Oxycodone
27 IR 30 mg. plus one prescription for #75 Oxycodone IR 30 mg. along with a prescription for #90
28 Xanax.

1 104. On or about June 10, 2014, Respondent saw Patient D and noted that the Oxycodone
2 was being discontinued. Respondent wrote a prescription for Suboxone with three refills. The
3 patient was a no-show for his next appointment and he did not return to see Respondent. He did,
4 however, fill the Suboxone prescriptions.

5 105. Respondent's overall conduct, acts and/or omissions, with regard to Patient D, as set
6 forth in paragraphs 91 through 104 herein, constitutes unprofessional conduct through gross
7 negligence and/or incompetence and/or prescribing without an appropriate prior examination and
8 a medical indication and/or excessive prescribing, pursuant to Business and Professions Code
9 Sections 2234 subdivisions (b) and/or (d) and/or section 2242 and/or section 725; and is therefore
10 subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct
11 with regard to Patient D as follows:

12 a. Without ever performing a complete psychiatric history and assessment of the patient,
13 including a complete medical, substance abuse, and social history, Respondent treated Patient D
14 with controlled substances.

15 b. Respondent failed to document legitimate medical indications for the prescribing and
16 escalating of doses of multiple controlled substances for long-term use, particularly to an addict
17 such as Patient D.

18 c. During the course of treatment of Patient D, Respondent failed to maintain clear and
19 complete progress notes, and failed to maintain a clear and updated list of all of the concurrent
20 psychoactive medications and controlled substances that the patient was taking.

21 d. Respondent did not seek to obtain records from collateral sources regarding the
22 patient's repeated medical hospitalizations and emergency room visits.

23 e. Respondent failed to document a clear and comprehensive treatment plan and failed
24 to document periodic review of the effectiveness of the treatment.

25 f. Respondent failed to document that he obtained informed consent from the patient
26 with regard to his treatment of multiple controlled substances, that he discussed the risks, benefits
27 and possible complications of the psychiatric medications, and alternatives to the treatment using
28

1 multiple controlled substances, and/or discussed the risk of relapse when prescribing multiple
2 controlled substances to an addict.

3 g. Respondent failed to order initial and follow-up lab tests and/or failed to document
4 why testing was not needed.

5 h. Respondent failed to perform routine and/or random urine or blood toxicology
6 screening for this patient who admitted to mis-use of the medications and requested early refills of
7 prescriptions.

8 i. Respondent prescribed controlled substances to an addict without proper
9 consideration and monitoring.

10 j. Respondent demonstrated a lack of knowledge and was practicing outside the scope
11 of his practice by prescribing long-term opiates for chronic pain to Patient D.

12 k. Respondent prescribed multiple controlled substances for long-term use, and at
13 escalating doses, to an addict without documenting a reasonable medical indication.

14 **FIFTH CAUSE FOR DISCIPLINE**

15 **(Unprofessional Conduct: Patient E: Gross Negligence and/or Incompetence)**

16 106. Respondent Nathan H. Thuma, M.D. is subject to disciplinary action under sections
17 2234(b) and/or 2234(d) in that Respondent's overall conduct, acts and/or omissions with regard to
18 Patient E constitutes gross negligence and/or incompetence, as more fully described herein below.

19 107. On or about January 9, 2015, Patient E, a 36-year old female who was under the
20 temporary conservatorship of Solano County Mental Health, was transferred and admitted to
21 Crestwood Mental Health Rehabilitation Center (Crestwood) in Angwin. Crestwood in Angwin
22 is a 52-bed locked Mental Health Rehabilitation Center. At all times alleged herein, Respondent
23 was the Medical Director of Crestwood in Angwin, a position that he has held since about 1995.
24 Respondent was present at the facility only on Wednesday mornings but was available "on-call"
25 at all times.

26 108. Patient E had been involuntarily hospitalized at another Crestwood facility in Vallejo
27 from December 23, 2014 until January 9, 2015. Patient E had a history of bipolar disorder and
28 methamphetamine abuse. She had a history of non-compliance, drug use, and homelessness. She

1 had repeated psychiatric hospitalizations in 2014. The diagnoses at the time of transfer were
2 Bipolar disorder, borderline personality disorder, and methamphetamine abuse. She was admitted
3 on a temporary conservatorship for further stabilization and to find placement.

4 109. On or about January 14, 2015, Respondent first saw Patient E and noted that she had
5 been diagnosed with schizoaffective disorder and polysubstance use disorder. The current
6 medications were listed as: Lithium 600 mg. bid; Neurontin 300 mg. am and Neurontin 600 mg.
7 at hs; Risperidone 3 mg. bid; Seroquel 50 mg. qis and Seroquel 400 mg. qhs. It was noted that the
8 patient kept stopping her psychiatric medicines. Respondent's impression was schizoaffective
9 disorder bipolar type, and methamphetamine and cannabis use disorder. His plan was to replace
10 the Neurontin with Depakote 750 mg. bid, to change the dosages of Seroquel and of Lithium, to
11 decrease the Risperidone, and to add Clonazepam and Propranolol.

12 110. On or about January 20, 2015, it was noted by a licensed psychiatric technician that
13 Patient E was over-sedated and was walking around in a stupor and was difficult to understand.
14 Respondent was called and ordered that the Clonazepam be reduced to 1 mg. and that the
15 Seroquel be decreased to 400 mg. qhs.

16 111. On or about January 21, 2015, the program director at Crestwood Angwin was
17 informed that the patient's writ had been granted by the court and that her conservatorship was
18 terminated. The patient was discharged from the facility and was picked up by her sister later that
19 day.

20 112. Respondent signed the Physician's Discharge Summary about two weeks after
21 discharge, on or about February 4, 2015. Respondent had not been present at the time of the
22 patient's discharge. The Discharge Summary did not provide a clear and detailed discharge
23 treatment plan with recommendations and instructions, and it did not list the medications
24 provided at discharge. It appears that there were no written follow-up instructions provided to the
25 patient.

26 113. Respondent's overall conduct, acts and/or omissions, with regard to Patient E, as set
27 forth in paragraphs 106 through 112 herein, constitutes unprofessional conduct through gross
28 negligence and/or incompetence pursuant to Business and Professions Code Sections 2234

1 subdivisions (b) and/or (d) and is therefore subject to disciplinary action. More specifically,
2 Respondent is guilty of unprofessional conduct with regard to Patient E as follows:

3 a. Respondent discharged the patient with prescription medications, including lithium
4 carbonate pills, without providing the patient with a clear and comprehensive discharge
5 medication list that included the medications and dosages, indication, and written follow-up
6 treatment.

7 b. Respondent signed the discharge summary two weeks after the patient's discharge
8 and the discharge summary was deficient. It did not contain the necessary elements, such as a
9 discharge plan with the pertinent psychiatric part of the treatment course, follow-up treatment
10 recommendations, a list of discharge medications, and written follow-up instructions.

11 **SIXTH CAUSE FOR DISCIPLINE**

12 **(Unprofessional Conduct: Repeated Negligent Acts: Patients A, B, C, D, and/or E)**

13 114. In the alternative, Respondent is subject to disciplinary action for unprofessional
14 conduct under section 2234(c) for repeated negligent acts, jointly and severally, with regard to his
15 acts and/or omissions with regards to Patient A and/or Patient B and/or Patient C and/or Patient D
16 and/or Patient E, as alleged in paragraphs 33 through 113, which are incorporated herein by
17 reference as if fully set forth.

18 **SEVENTH CAUSE FOR DISCIPLINE**

19 **(Unprofessional Conduct: Inadequate/Inaccurate Medical Records)**

20 115. Respondent Nathan H. Thuma, M.D. is subject to disciplinary action, jointly and
21 severally, for unprofessional conduct under section 2266 for failure to maintain adequate and
22 accurate records relating to the provision of services to Patient A and/or Patient B and/or Patient
23 C and/or Patient D and/or Patient E, as alleged in paragraphs 33 through 113, which are
24 incorporated herein by reference as if fully set forth.

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PRAAYER

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 G58451, issued to Nathan H. Thuma, M.D.;
2. Revoking, suspending or denying approval of Nathan H. Thuma, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code, and advanced practice nurses;
3. Ordering Nathan H. Thuma, 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: May 24, 2017


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

SF2016202369