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

In the Matter of the Accusation Against:	)	
Michael Long Tran, M.D.	)	**Case No. 800-2013-001365**
Physician's and Surgeon's Certificate No. G85353	)	
Respondent	)	

DECISION

The attached Proposed Decision 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 10, 2019.

MEDICAL BOARD OF CALIFORNIA

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

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

In the Matter of the Accusation Against: MICHAEL LONG TRAN, M.D. Physician's and Surgeon's Certificate No. G85353, Respondent.	Case No. 800-2013-001365 OAH No. 2018051293

CORRECTED PROPOSED DECISION

Administrative Law Judge Melissa G. Crowell, State of California, Office of Administrative Hearings, heard this matter January 14-18, 22-25, February 1, 4-6, 8, 11, 14, and 20, 2019, in Oakland, California.

Deputy Attorney General Lynne K. Dombrowski represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California.

Attorneys Mitchell Green and Marvin Firestone, M.D., represented respondent Michael Long Tran, M.D., who was present for most of the hearing.

The record was left open for submission of written argument. Complainant's closing brief was marked for identification as Exhibit 41; respondent's closing brief was marked for identification as Exhibit KK; and complainant's reply brief was marked for identification as Exhibit 42. The record closed and the matter was submitted for decision on May 6, 2019.

FACTUAL FINDINGS

Introduction

1. On July 23, 1999, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. G85353 to respondent Michael Long Tran, M.D. The license is renewed and current.[1]

[1] The license has an expiration date of February 28, 2021.

2. Complainant Kimberly Kirchmeyer is the Executive Director of the Board. On November 18, 2016, complainant issued an accusation against respondent in her official capacity. On May 5, 2017, complainant issued a first amended accusation against respondent. During the hearing, on January 9, 2019, complainant issued a second amended accusation, removing two causes for discipline and factual allegations associated with the removed causes. Some of the allegations in the second amended accusation were withdrawn at hearing.[2]

3. Respondent is an anesthesiologist and pain management specialist. This case pertains to his practice as a pain management specialist.

The second amended accusation alleges that respondent committed unprofessional conduct in providing care to six chronic pain patients. Complainant alleges, among other things, that respondent committed unprofessional conduct in his care and treatment of the patients, prescribed dangerous drugs without an appropriate prior examination and/or medical indication, excessively prescribed controlled substances and maintained inaccurate records. Complainant further alleges that respondent committed unprofessional conduct by failing to adequately supervise physician assistants and nurse practitioners. Respondent disputes all of the allegations. Respondent claims, among other things, that he is not responsible for the treatment provided to the patients by other licensed care providers in the practice, and he argues that the opinion of the Board's expert witness should be disregarded.

Respondent's Training and Employment History

4. Respondent graduated from Oregon Health Services University in Portland, Oregon, in June 1993. From 1993 to 1994, respondent completed an internship in transitional medicine at Good Samaritan/Emanuel Hospitals in Portland. Respondent completed residency training in anesthesiology at Cornell Medical Center in New York from 1994 to 1997. He completed a fellowship in chronic pain at Memorial Sloan-Kettering Cancer Center in New York from July 1997 to July 1998. Respondent is board certified in anesthesiology and pain medicine.

5. Respondent served as an assistant professor at Harvard Medical School and served as an attending physician in anesthesiology and pain management at Beth Israel

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[2] At hearing, complainant stipulated that the dispensing of medications from a pharmacy associated with respondent's medical practice is not at issue in this case. Also not at issue are the recordkeeping practices of the in-house pharmacy. What is at issue is the documentation maintained in the patient records associated with the prescribing of medications filled at that pharmacy. The accusation often refers to dispensing in conjunction with prescribing. To the extent that a factual allegation alleges improper prescribing and dispensing, the term dispensing is deemed withdrawn. Nothing in this decision shall be construed as imposing discipline upon respondent's medical license based on a failure to comply with the regulatory requirements of a pharmacy.

Deaconess Hospital from July 1998 to August 1999. Respondent moved to Santa Rosa, California, in the fall of 1999.

6. Respondent is a diplomat of the National Board of Medical Examiners. He is a Qualified Medical Examiner (QME) as well as a Primary Treating Physician (PTP) approved to treat injured workers in the area of pain management. Many of respondent's patients are referred to him through the workers' compensation Medical Provider Network (MPN).

Structure of the Santa Rosa Practice

7. Respondent opened a private medical practice on Hoen Street in Santa Rosa in late 1999. The pain management aspect of the practice was, and continues to be, referral based; patients are referred to respondent from other specialists and primary care physicians in the community, and through the MPN. Respondent's practice includes performing interventional procedures at numerous local hospital and surgery centers. The patients are almost exclusively adults.

8. As pain management patient referrals to the practice increased over time, respondent employed other pain management physicians to assist him in seeing patients in the clinic, and he spent more time performing interventional procedures. None of the other physicians was a member of the MPN network. According to respondent, none of the physicians had patients referred directly to them. Respondent also employed physician assistants, nurse practitioners, medical assistants, and other staff.

9. In July 2009, respondent incorporated the practice into Acadia Pain Management Group, Inc. (APMG). The type of corporation formed in 2009 is not established by the evidence. None of the documents regarding the formation of the corporation, including the articles of incorporation or the bylaws, is in evidence.[3] Respondent has always been the sole shareholder of APMG. After incorporation, all staff, including the medical providers, were employees of APMG.

10. Respondent obtained a fictitious name permit to operate the practice under the name APMG in December 2014.[4] In the fictitious name permit application he filed with the Board under penalty of perjury, respondent designated APMG as a professional medical

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[3] In respondent closing brief, it is argued that APMG was formed as a "c" corporation and not as a professional medical corporation under the Moscone-Knox Act (Corp. Code, § 13400 et. seq.). As the articles of incorporation and bylaws are not in evidence, the record lacks competent evidence to support this factual claim.

[4] Respondent's brother, Minh Tran, has been the practice's business manager since 2000. He testified that he has been an employee of APMG since that time. Respondent's sister Lisa Tran, R.N., has worked in respondent's practice since 2004. She testified that she has been an employee of APMG since 2004. APMG was not formed, however, until 2009.

corporation, of which he was president, owner and Medical Director. The only type of corporation for which the Board is authorized to issue a fictitious name permit is a professional medical corporation. (Bus. & Prof. Code, §§ 2407, 2285, & 2415.)

RELATIONSHIP WITH OTHER PHYSICIANS IN THE PRACTICE

11. Four physicians in addition to respondent are referenced in the medical records over the course of the care and treatment of the patients in this case: The physicians and their approximate dates in the practice are: Charles Evans, M.D. (2006 to 2011), Thomas Keller, M.D. (2008 to 2010), Michael Yang, M.D. (2010 to 2011), and Toby Leung, M.D. (12/2011 to 3/2015). The number of physicians in the clinic practice varied from one to two, but from April 2015 to August 2016, respondent was the only physician in the practice. None of these physicians was called as a witness in this proceeding.

12. Respondent considered each physician an associate and a peer but the practice was not a group practice, as respondent admitted in his interview with the Board's investigator. The evidence establishes that the patients were respondent's, and he was on call to them "24/7." Respondent "collaborated" with the physicians regarding each patient's ongoing care. Collaboration could take the form of examining the patient with the other physician; or by respondent discussing treatment recommendations after reviewing the patient's record. Respondent often indicated his approval of the treatment plan by initialing the patient record and/or initialing the prescription written by the physician who performed the patient examination. There are examples of respondent signing prescriptions for patients who had been examined by another physician. Respondent did not document the consultation or record review in the patient's record other than by way of initialing the treatment record, initialing the prescription, or signing the prescription.

SUPERVISION OF PHYSICIAN ASSISTANTS

13. There are five physician assistants referenced in the medical records over the course of the care and treatment of the patients in this case. The physician assistants (PA's) and their approximate dates in the practice were: Donald Boone (2004 to 2011), Elizabeth Redick (2010), Rachel Chavez (2012 to 2013), Teresa Martin (2012 to 2013), and James Williams (2014 to present). The only PA's who were with the practice for more than a few months were Boone and Williams. None of the PA's in the practice testified at hearing.

14. Respondent admits that he directly supervised PA's in the practice, but only from April or May 2015 to August 2016, when he was the only physician in the practice. Respondent testified that he had a written delegation of services agreement with the PA in the practice during that time (Williams). A delegation of services agreement between respondent and the PA was not provided to the Board in discovery, and it was not provided in evidence. Respondent testified that, but there is no documentary evidence to support this claim, that he complied with his supervisory obligation to audit patient records.

15. From 2009 to March/April 2015 controlled substances and dangerous drugs were prescribed to Patients B, C, D, E, and F by a PA.[5] Respondent testified that during this time frame, the PA's were supervised by other physicians in the practice, and he believed that each physician had a delegation of service agreement with the PA being supervised. Respondent does not know the parameters of the delegated services agreements, did not participate in their development, and was not a signatory to any of them. Delegated services agreements for this time frame were not provided to the Board in discovery or presented in evidence.

16. Even assuming that delegated services agreements were in place between other physicians and the PA's being supervised, the evidence established that respondent also played a supervisory role to the PA's in the practice during this time period without having his own delegated services agreement. Both Minh Tran and Lisa Tran separately acknowledged that respondent supervised PA's when respondent was in the clinic. In addition, respondent's conduct and admissions supports such a finding. The PA's in the practice often consulted with respondent about the appropriate treatment for patients. Although respondent referred to this as collaboration in the form of a curbside consult, respondent was often present in the treatment room with the PA. Other times, respondent consulted with the PA after the examination was completed, and for these consultations, he reviewed the patient's records before approving the treatment plan. Respondent often signed or co-signed the written prescriptions issued for the visit with the PA, indicating his approval of the treatment plan. Respondent would, at times, initial the progress note written by the PA, also indicating his agreement with the treatment plan.

By any definition, respondent performed a supervisory role to the PA's, and did so without having a delegated service agreement during this time period. Respondent did not audit patient records during this time.[6]

SUPERVISION OF NURSE PRACTITIONERS

17. There are at least seven nurse practitioners (NP) listed in patient records as providing care and treatment to patients. The NP's and their approximate dates in the practice were: Catherine O'Neill-Conover (2014), Gail Senock (2011), Kathy Kladar (2013 to 2014), Maryellen Parker (2014); Jennifer Buescher (2014 to 2015), Shoreh Semati (2014 to 2016), and Thomas Dombrov (2015 to 2017). None of the NP's in the practice testified at hearing.

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[5] Patients are referred to by letter in order to protect their privacy.

[6] Respondent's expert, William Brose, M.D., opined that respondent did not have a supervising relationship by virtue of the fact that he was present in the clinic and available for consultation. But this opinion did not take into consideration respondent's testimony that establishes that these practitioners were not seeing the patients independently of him. For this reason, his testimony is not found persuasive on the question of supervision.

18. Respondent admits that he directly supervised NP's in the practice, but only from April or May 2015 to August 2016, when he was the only physician in the practice. Respondent testified that he had written standardized procedures with each NP in the practice during that time, but the written standardized procedures were not produced to the Board in discovery and were not presented in evidence. With respect to the NP's in the practice at this time, respondent testified he had patient specific protocols, setting forth the types of controlled substances that could be prescribed, and the medical conditions that could be treated in the pain practice.

19. From 2009 to March/April 2015 controlled substances and dangerous drugs were prescribed to Patients B, C, D, E, and F by NP's in the practice. Respondent denies being a supervisor during this time. Respondent testified that the NP's were supervised by other physicians in the practice, and respondent believed that each supervising physician had standardized procedures for the NP's they supervised. Respondent did not know the parameters of the standardized procedures, did not participate in their development, and was not a signatory to any of them. Standardized procedures for this time period were not provided to the Board in discovery and were not presented in evidence.

20. Even assuming that standardized procedures were in place between other physicians and the NP's they supervised, the evidence established that respondent also played a supervisory role to the NP's in the practice from 2009 to April/May 2015, and that he did not have his own standardized protocols with them. Both Minh Tran and Lisa Tran acknowledged that respondent supervised NP's when he was in the clinic. In addition, respondent's conduct and admissions support such a finding. The NP's in the practice often consulted with respondent about the appropriate treatment for these patients. Although respondent referred to this as a collaboration in the form of a curbside consult, in such cases he was either present in the treatment room, or met with the NP after the examination and having reviewed the patient records. Respondent often issued the prescriptions for the NP's appointments, indicating his review, agreement with, and approval of the treatment plan. Respondent would, at times, also initial the progress note written by the examining NP. This also indicated respondent's approval of the treatment plan.

By any definition, respondent performed a supervisory role to NP's, and did so without having written procedures with the NP's he was supervising.

PATIENT-PHYSICIAN RELATIONSHIP

21. The evidence establishes that respondent had an on-going patient-physician relationship with each of the six patients during the treatment years alleged in this case, and that he had an ongoing involvement and responsibility for their overall care and treatment.

The patients were referred to respondent, either through the workers' compensation system as their PTP, or from physicians in the community. Respondent performed most of the patients' initial consultation and examination. He made and concurred in the diagnosis, and he developed the treatment plan. Patients were seen in the clinic on average every 30 to

45 days for medication review. Respondent periodically examined the patients over their course of treatment. Respondent participated in each patient's ongoing treatment in various ways. He conducted periodic follow-up evaluations. He performed interventional pain management procedures at local hospitals and surgery centers.[7] He collaborated and consulted with other physicians, PA's and NP's regarding the patient's care and treatment. Respondent indicated his approval of the treatment plan by initialing the treatment plan and/or the prescription. There are examples of respondent writing prescriptions for patients that had been examined by other practitioners. By initialing the patient's record or prescription, respondent admits that this signifies that he consulted with the practitioner, reviewed the patient's record and was in agreement with the treatment plan. As the PTP, he was often asked by the adjustor to review and approve treatment recommendations made by others in the practice, which he routinely performed. Respondent actively participated in biweekly clinical meetings during which he participated in discussion regarding the appropriate care and treatment for these patients.

Respondent is proud of the personal relationship he developed with each of his patients, and the quality of treatment provided to them. He knew each patient well. He was a devoted physician who was on call to them "24/7."

By his admission to the Board investigator, and more importantly by his actions over the relevant time period of treatment, the evidence establishes that respondent had an ongoing patient-physician relationship with each of these patients. That relationship remained intact and was never formally severed by respondent.

22. The medical records show that on numerous occasions and across the treatment of these patients, respondent issued prescriptions without the treatment record reflecting that he had examined the patient.

At hearing respondent explained his practice was to issue prescriptions on days in which the treatment record does not reflect that he was the examining physician in two scenarios: (1) he had consulted in the treatment room with the practitioner listed on the treatment note[8]: or (2) he had consulted with the practitioner after the examination and after he had reviewed the patient's treatment record. By issuing the prescription, respondent was indicating that he agreed with treatment plan of the physician, PA or NP, and that he was involved in the care and management of the patient on that day. As he admitted at hearing,

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[7] The types of interventional procedures performed by respondent included spinal injections, facet joint injections with radio frequency rhizotomy, sacroiliac joint injections, medial branch nerve blocks injections, and the implanting of spinal cord stimulators and intraspinal pain pumps.

[8] In 2013, the practice began to transition to an electronic medical record. The paper charts in evidence for treatment prior to that time do not always clearly indicate which practitioner performed the examination.

this practice signified that he "remained their primary treating physician, and not others." The progress notes do not reflect on which of these occasions respondent was present in the treatment room. Respondent did not have a standard notation for when he saw the patient personally with another provider, or when he collaborated with the practitioner after the examination. There are some progress notes which carry respondent's initials, in addition to the signature of another practitioner. Respondent's initialing of the progress note does have uniform meaning. It could indicate either of the two scenarios set forth above.

Respondent's recordkeeping practices led to confusion in the record review conducted by the Board's expert when comparing the name of the practitioner in the treatment record with respondent's name on the prescriptions that issued from the examination.

Respondent's testimony regarding his prescribing practices was found credible. It was not established that respondent's practice constitutes prescribing without a prior medication examination in violation of the Medical Practice Act. However, the practice is further evidence of respondent's ongoing involvement over the course of the care and treatment of each of these patients, including on days when patients were examined by other practitioners.

23. As set forth above, the organization of the practice evolved over the years. The business structure of the practice did not alter the patient-physician relationship respondent had with each of these patients. The business structure of the practice did not alter the duties respondent owed to each of these patients by reason of this relationship.[9] Because the evidence establishes that the patients were respondent's, it is found that he is responsible for the overall quality of care provided to them over their course of treatment in the practice pursuant to the Medical Practice Act.

Evolving Treatment of Chronic Pain with Opioids

24. The legislative policies regarding the management of chronic, non-cancer pain, has been evolving in California for many years. As recently as 2006, the focus was not on the risk of opioid death, but on patients receiving appropriate pain relief. This focus was aptly summarized in a 2006 legislative declaration to Assembly Bill No. 2918:

> (a) The investigation and prosecution of pain management cases in California have evolved over the past 15 years.
>
> (b) The Pain Patients' Bill of Rights and the Intractable Pain Treatment Act were created to ensure patients received adequate pain medication and to protect a physician and surgeon from

[9] No opinion is expressed regarding whether respondent had derivative liability for the conduct of other practitioners by reason of his ownership of APMG.

being disciplined solely because of the amounts of controlled substances he or she prescribed or administered.

(c) California recognizes that prescription medication, including controlled substances, can play a critical role in the treatment of pain, and, in and of itself, is an insufficient basis to determine if a physician and surgeon has violated the standard of care in his or her treatment of pain management patients.
(d) Undertreatment of pain, including the use of opioids, is a continuing problem in the State of California, and some terms of the Intractable Pain Treatment Act are outdated and confusing.

(e) In recognition of the Medical Board of California's consumer protection mandates, and in an attempt to provide better treatment of pain patients, as well as protect the public through the appropriate investigation and prosecution of those who violate the standard of care when treating pain patients, the Legislature recognizes that it is time to reflect upon the current state of pain management to aid both those who treat pain patients, as well as those who investigate and prosecute physicians and surgeons.

(Stats. 2006, ch. 350, § 1.)

25. Similarly evolving are the Board's policies regarding the treatment of chronic pain patients with controlled substances. In 1994, the Board formally adopted its first policy statement on Prescribing Controlled Substances for Pain. In 2007, the Board issued updated Guidelines for Prescribing Controlled Substances for Pain.

26. In its November 1, 2011 Morbidity and Mortality Weekly Report, the Centers for Disease Control and Prevention (CDC) reported its finding that between 1999 and 2008, overdose deaths involving opioid analgesics had increased to the point of exceeding deaths involving the use of heroin and cocaine, and was approaching the number of deaths from automobile accidents. The report linked the increase in overdose deaths to wide variations in opioid prescribing, and declared prescription drug abuse to be a nationwide epidemic.

27. The November 2011 pronouncement by the CDC led the Board to issue new Guidelines for Prescribing Controlled Substances for Pain in November 2014. In the Preamble to the guidelines the Board recognized that:

Drug overdose is now the leading cause of accidental death, exceeding deaths caused by automobile accidents. A majority of the overdose deaths involved prescription drugs. The diversion of opioid medications to non-medical uses has also

> contributed to the increased number of deaths, although the problem is not limited to the aberrant, drug-seeking patient. Injuries occurring among the general patient population, with some groups at high risk, (e.g., those with depression). Consequently, the Board called for revision of the [2007] guidelines in which it provided additional direction to physicians who prescribe controlled substances for pain.

The Board's intent in the 2014 guidelines was to assist physicians in improving the outcomes of patient care and to prevent overdose death caused by opioid use in the treatment of patients with chronic pain:

> These guidelines underscore the extraordinary complexity in treating pain and how long-term opioid therapy should only be conducted in practice settings where careful evaluation, regular follow-up, and close supervision are ensured. Since opioids are only one of many options to mitigate pain, and because prescribing opioids carries a substantial level of risk, these guidelines offer several nonopioid treatment alternatives.

The Board has not declared the 2014 prescribing guidelines as mandating the standard of care, recognizing that deviating from the guidelines may be appropriate based on the unique needs of individual patients and based on the type of pain being treated. The Board did not endorse any one treatment option over another, encouraging physicians to "undertake independent research on this continually evolving subject matter." The Board cautioned physicians to document the rationale for each prescribing decision so that when records are reviewed following a quality of care complaint the "totality of the circumstances" can be considered.

28. Following the November 2011 CDC report, medication equivalency formulas were developed. These formulas, known as Morphine Equivalent Dose (MED) or as Morphine Milligram Equivalent (MME), allow for calculation of opioids of varying potency and doses in order to assess the overall amount of opioids being prescribed to the patient. The MME numbers help assess risk in the dosing. There are many different applications available for calculating MME's, and applications can lead to varying calculations of MME's.

29. Appropriate opioid dosing is a matter of clinical judgment. There is no mandated standard of care or ceiling regarding the opioid dosing. With opioids, there are pharmacokinetic and pharmacodynamical variables with each individual patient. Each variable can range fivefold, for a potential of up to a 25-fold variation across patients in response to the same dose of an opioid. A patient's individual variability with respect to medications is part of the determination of the appropriate specific dose for the patient.

30. The Department of Justice maintains the Controlled Substance Utilization Review and Evaluation System (CURES). The system was first created in 1996. In its earliest form, users had to request information by fax, mail, or telephone, and wait a few days in order to receive the information. In 2009, the Department of Justice created the Prescription Drug Monitoring Program (PDMP), an on-line web portal that allowed reregistered users to obtain from CURES real time patient history information regarding controlled substances. The Department of Justice reported in 2013 that only eight percent of licensed providers were registrants in the system.

31. In July 2015, CURES 2.0 was launched with enhancements for user interface, and faster and more reliable service. Licensed practitioners eligible to prescribe Schedule II, III and IV controlled substances may obtain the electronic history of controlled substances dispensed to an individual under his or her care. As of July 1, 2016, all California prescribers are required to register with CURES. Effective October 2, 2018, a prescriber must query the CURES database and run a patient activity report when prescribing a scheduled drug within 24 hours of the first visit, and every four months thereafter. (Health & Saf. Code, § 11165.4.)

Expert Testimony

32. Complainant presented expert testimony from Chante S. Buntin, M.D. Dr. Buntin is licensed to practice medicine in California and Washington, and is board certified in anesthesiology, pain medicine, hospice and palliative care. Dr. Buntin has served as an expert for the Board for five years, and in that time she has reviewed 20 cases, and testified in one case.

Dr. Buntin attended medical school at the University of Utah. She completed a pediatric internship at Kaiser Permanente Medical Center in Oakland, then accepted a one-year National Institute of Health sponsored clinical research fellowship in the Department of Anesthesiology and Neurology at the University of California, San Francisco (UCSF). From 2002 to 2004, Dr. Buntin attended a residency program in anesthesia at Harvard/Brigham and Women's Hospital in Boston, and from 2004 to 2005 she was a resident in the Anesthesia Training Program at the University of Southern California. From 2005 to 2006, Dr. Buntin was a pain management fellow in the Department of Anesthesia and Perioperative Care at UCSF. From 2009 to 2010, Dr. Buntin attended post-graduate training in palliative care through Hope Hospice, in Dublin.

From 2006 to 2008, Dr. Buntin worked as an anesthesiologist and pain management specialist at Santa Clara County Valley Medical Center and then Eden Medical Center. From 2008 to 2009, respondent served as an Assistant Professor of Anesthesiology in the Department of Anesthesiology at the University of Washington. Dr. Buntin returned to California in June 2009. Since that time she has operated her own private practice in anesthesiology, pain medicine, palliative care and hospice in Santa Cruz, and been associated with various community hospitals, clinics, and surgery centers. From 2017 to 2018, Dr. Buntin provided consultant services to Santa Cruz County regarding substance abuse and

harm reduction, pain and symptom management. Dr. Buntin is in the process of closing her private practice.

33. Respondent presented the expert testimony of William G. Brose, M.D. Dr. Brose is licensed to practice medicine in California, and is board certified in anesthesiology, with added qualification in pain management, and in pain medicine. He is a QME in the workers' compensation system.

Dr. Brose attended medical school at Kansas University School of Medicine. He completed an internship in anesthesiology at Santa Clara Valley Medical Center and a residency in anesthesiology at Stanford University School of Medicine. From 1986 to 1987, Dr. Brose completed a fellowship in obstetric anesthesia at Stanford; from 1987 to 1988, he was a chief resident in anesthesia at Stanford; from 1988 to 1999, he served as a Physician Specialist at Stanford. From 1988 to 1989 Dr. Brose completed a clinical research fellowship in chronic pain management in Flinders Medical Centre in South Australia.

Dr. Brose has held a number of academic positions at Stanford University School of Medicine. From 1989 to 1996, Dr. Brose was the director of the Standard Pain Management Service. From 1989 to 1995, he served as an Associate Professor of anesthesia, from 1995 to 1997 he served as an Associate Professor of anesthesia, from 1997 to 2011, he served as an Adjunct Associate Professor of anesthesia, and from 2011 to present he has been an Adjunct Clinical Professor of anesthesia.

Dr. Brose has held numerous clinical positions over the years. From 1998 to 2018, he was president of Alpha Omega Pain Medicine Associates, Inc.; from 2010 to 2018, he was CEO of HELP, Holdings, Inc. and HELP Pain Medical Network; from 2014 to 2018, he was CEO of American Health Medical Group.

Dr. Brose has been awarded two research grants, has published 25 articles in peer-reviewed journals, and has written seven book chapters. Dr. Brose has given numerous presentations to physicians on chronic pain and opioid treatment.

Dr. Brose has provided expert testimony in civil court proceedings, and in two proceedings before the Board. Dr. Brose has never served as an expert reviewer for the Board. Dr. Brose misrepresents on his curriculum vitae that he has served as an expert reviewer for the Board.

34. Dr. Buntin reviewed the following documents in preparation of hearing: the certified medical records submitted to the Board by respondent for each of the patients, respondent's written summary of care for Patient A, the Board's investigative reports; a transcript of the investigative interview with respondent and with Minh Tran;[10] the complaints filed with the Board; and the Board's guidelines for prescribing controlled substances, issued in 1994, 2007 and 2014.

[10] The transcript from the interview with Minh Tran is not in evidence.

Dr. Brose reviewed the same documents, but he was provided medical records that were organized differently than those provided to Dr. Buntin. Dr. Brose was also provided additional medical records that were ruled inadmissible prior to hearing.[11] Dr. Brose also reviewed the expert report of Dr. Buntin.

35. Dr. Buntin and Dr. Brose provided expert opinions on the care and treatment of Patients A, B, C, D, and F. Dr. Buntin provided an expert opinion on the care and treatment of Patient E, Dr. Brose did not provide an expert opinion on the care and treatment of this patient.[12]

36. Dr. Buntin and Dr. Brose provided differing opinions on the standard of care in the managing of chronic pain, and provided significantly different opinions of the quality of care provided to the patients at issue. Respondent argues that the opinions of Dr. Buntin should be rejected in their totality because she lacks the credentials and expertise of Dr. Brose, she has closed her private practice, and her opinions are "idiosyncratic and dogmatic." Complainant argues that the opinions of Dr. Brose should be found untrustworthy because of the misrepresentation on his curriculum vitae regarding his relationship with the Board.

With respect to Dr. Buntin, her expert opinions were based on her review of the patient records in the manner they were received by the Board. The records are not in chronological or subject matter order. The record contained many, but not all, written prescriptions. In this format, record review was extremely challenging.[13] Some of Dr. Buntin's criticisms of respondent are based on assumptions she made from her review of the patient records. Those assumptions were demonstrated to be factually inaccurate at hearing. In light of this, complainant withdrew some serious allegations pertaining to the respondent's practice. This is not found to warrant the wholesale disregard of Dr. Buntin's opinions.

With respect to Dr. Brose, his explanation for misrepresenting his relationship with the Board was neither compelling nor persuasive. This adversely affects his credibility as an expert witness, but it does not warrant the wholesale disregard of Dr. Brose's opinions.

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[11] These documents were ruled untimely disclosed in violation of the Prehearing Conference Order.

[12] Dr. Brose's report and opinion testimony regarding Patient E were ruled inadmissible prior to hearing. (Bus. & Prof. Code, § 2334; Jill Siren Meoni, M.D. (Prec. Decision No. MBC2001001 DMQ).)

[13] The patient records in evidence are in the same disorganized manner as received by the Board. While respondent maintains that his patient records are not maintained in this manner, and are grouped in subject matter (e.g., patient demographics, progress notes, procedures, records from outside providers, authorizations, request for treatment, prescriptions, and diagnostic studies), it is found that the records were received by the Board in this disorganized manner.

Neither expert was found to be persuasive on every point in this complex case. But neither will the opinion of either expert be disregarded in total as argued for by the parties. The disagreement of the experts will be resolved as necessary to each allegation.

37. Each of the patients in this case was treated for chronic pain, not pain associated with cancer, palliative care, or end-of-life care. Each of the patients was prescribed opioids for four years or more, and with treatment commencing prior to the seven-year statute of limitations governing the Board. (Bus. & Prof. Code, § 2230.5, subd. (a).)

38. The patient records in evidence are voluminous and cover many years of ongoing treatment. The records have been thoroughly reviewed and considered. Because of their volume, the medical records can only be summarized in brief form. Finally, the brand name (e.g., MS Contin) and the chemical name (e.g., morphine sulfate) of the drugs referenced in this decision are used interchangeably throughout.

Standard of Care for Prescribing Controlled Substances for Chronic Pain

39. As established by the testimony of Dr. Buntin, at all times relevant to this proceeding, the standard of care for prescribing controlled substances has remained the same since it was established by the Board in its 2007 Guidelines for Prescribing Controlled Substances for Pain. The standard of care requires a physician, when prescribing controlled substances for chronic pain, to do the following:

a. Elicit an appropriate history from the patient and perform an adequate physical examination. This includes an assessment of the patient's pain, physical and psychological function; a substance abuse history; history of prior pain treatment; an assessment of underlying or coexisting diseases or conditions; and documentation of the presence of a recognized medical indication for the use of controlled substances.

b. Establish a treatment plan which states the objectives by which the treatment plan can be evaluated, such as by pain relief and/or by improved physical and psychosocial function, and indicate whether any further diagnostic evaluations or treatments are planned.

c. Obtain the patient's informed consent. This requires the physician to discuss with the patient the risks and benefits of treatment with controlled substances and other treatment modalities.

d. Periodically review the course of pain treatment, and any new information concerning the etiology of the patient's pain or the state of the patient's health. Continuing or modifying the use of controlled substances depends on the physician's evaluation of progress toward the treatment objectives. If the patient's progress is not satisfactory, the physician should assess the appropriateness of continuing the treatment plan, and should consider other treatment modalities.

e. Consider referring the patient, as necessary, for additional evaluation and treatment to achieve the treatment objectives. Physicians should give special attention to those pain patients who are at risk for misusing their medications.

f. Keep accurate and complete records of the matters described above, including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient, and periodic reviews of the treatment plan.

Care and Treatment of Patient A

40. Patient A was a 45-year-old surgical technician at UCSF.[14] Patient A suffered an employment-related lifting injury in February 2003. An MRI in January 2004 showed Patient A had bulging discs at L4-5 and L5-S1, each with protrusion, with facet hypertrophy and possible nerve impingement.

41. Patient A was referred to respondent for evaluation and pain management, and respondent assumed the care of Patient A on March 12, 2004. Patient A was off work with a pending workers' compensation claim. Patient A presented with low back pain, and a tingling numbing sensation that radiated down to the left thigh and calf. Patient A had been receiving conservative treatment for a year, and had been prescribed Vicodin,[15] as needed every four to six hours, for back pain, Celebrex, a non-steroidal anti-inflammatory drug (NSAID) used to treat pain, and Neurontin,[16] a neuropathic pain medication. His recovery from the work injury had plateaued. Respondent's treatment plan recommended epidural steroid injections, physical therapy, and medications as needed.

42. In June 2005, Patient A was referred to respondent for pain complaints associated with injuries sustained in a non-work related automobile accident in October 2004. Patient A reported injury to his neck, right shoulder and right arm, as well as aggravation of his lower back pain. From this accident, Patient A developed complex regional pain syndrome involving his right arm. Over the course of his treatment, medical

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[14] Patient A also worked at Palm Drive Hospital where respondent performed anesthesia services at the time. They knew each other through working at this location.

[15] Vicodin and Norco are trade names for a combination of hydrocodone bitartrate with acetaminophen, a semi-synthetic opioid analgesic. Since 2014 hydrocodone bitartrate has been a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b). (Prior to 2014, hydrocodone combination products were a Schedule III controlled substance.) It is a dangerous drug as defined by Business and Professions Code section 4022.

[16] Neurontin is a trade name for gabapentin which is an anti-convulsant, anti-epileptic. It is a dangerous drug as defined by Business and Professions Code section 4022.

records reflect that Patient A developed other medical conditions not related to his workers' compensation claim, including rheumatoid arthritis, sleep apnea, and exogenous obesity. In 2005, Patient A was diagnosed with depressive disorder. During the course of treatment by respondent, Patient A underwent medical procedures that included cervical neck fusion, and right shoulder surgery in 2006.

43. Patient A was seen in the practice on approximately a monthly basis from March 2004 to September 2011. Patient A was seen by respondent for a total of 10 visits. Patient A was also seen by Dr. Keller, Dr. Evans, Dr. Yang, and PA Boone.

44. Respondent saw Patient A on August 8, 2008. Respondent reported Patient A's chief complaints were his back, neck problem and joint pain. Patient A's medications were listed as methadone[17] 20 mg, twice a day, Percocet[18] 10/325 mg, four times a day, Elavil[19] 50 mg, at nighttime, Prilosec 20 mg, once a day, Lyrica, Colace, Senna, Lactulose and prednisone 7 mg, daily. The purpose of these medications is not specified in the treatment note. Patient A reported a Visual Analog Score (VAS) of six to seven, with pain radiating into his legs. Respondent documented that Patient A's condition was steady in all parts, medication was helping to an extent without side effects noted in other tried medications, and his activities of daily living, functioning and quality of life were the same. Respondent performed a physical examination and reported his objective findings. The treatment plan was to continue conservative treatment (exercises, stretching, heat and ice), review home exercise program, and prescribe methadone 20 mg (#180), three times a day, Percocet 10/325 mg (#120), as needed, and Elavil 50 mg, in an amount not listed.

45. The period of treatment at issue in this proceeding is from November 2009 to September 2011. Patient A was seen in the practice every four to eight weeks.

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[17] Methadone hydrochloride is a synthetic opioid analgesic with multiple actions quantitatively similar to morphine. Methadone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Methadone may be administered as an injectable liquid or in the form of a tablet, disc, or oral solution. Methadone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and section 1308.12 of title 21 of the Code of Federal Regulations. It is a dangerous drug as defined by Business and Professions Code section 4022.

[18] Percocet and Endocet are trade names for a combination of oxycodone hydrochloride and acetaminophen. Oxycodone hydrochloride is a semisynthetic opioid analgesic with multiple actions similar to those of morphine. It is a Schedule II controlled substance and narcotic pursuant to Health and Safety Code section 11055, subdivision (b)(1)(N), and section 1308.12 of title 21 of the Code of Federal Regulations. It is a dangerous drug as defined by Business and Professions Code section 4022.

[19] Amitriptyline, which is known by the trade name of Elavil, is a tricyclic antidepressant. It is a dangerous drug as defined by Business and Professions Code section 4022.

46. The last documented visit with respondent was on February 24, 2010. The progress note reflected diagnoses of lumbar and cervical degenerative disc disease, lumbar radiculitis, low back pain, right shoulder arthritis, rheumatoid arthritis and sleep apnea. The patient's chief complaint was lower back pain, but he reported it had improved. His VAS was reported as seven to eight. The progress note reflected that Patient A had undergone a spinal cord stimulator trial at UCSF with at least 50 percent improvement, and a permanent implant was planned. Patient A was being treated for the right shoulder condition by a physician outside of the practice for which surgery may be required. The note reflected that activities of daily living, functioning, and quality of life were significantly down, and that pain interfered with all activities of daily living except family relationships. The treatment plan called for continuing conservative treatment; pursuing the implant and shoulder treatment; prescribing methadone 10 mg (# 180), two tablets three times a day, and Percocet 10 mg (#120), one tablet every six hours, and prednisone.

47. The medication list in the progress note for February 24, 2010, reflected that in addition to methadone, Percocet and prednisone, Patient A was taking Elavil, Motrin, Prilosec and AciPhex. The treatment plan does not prescribe Elavil, Voltaren Gel or Lidoderm patches.

48. On March 26, 2010, a date not associated with an office visit, respondent signed three-month refill approvals for Elavil, Voltaren Gel, and Lidoderm patches.

49. On May 14, 2010, respondent issued three-month refill approvals for Elavil 25 mg (# 30). The treatment records show that Patient A's previous appointment with another physician took place on April 30, 2010. The progress note for the April 30, 2010 visit reflected that Patient A had been prescribed a different strength of Elavil.

50. Patient A continued to be examined in the practice through 2010, but by physicians other than respondent. The progress notes reflect that Patient A was examined by Dr. Yang on September 30 and November 2, 2010, but respondent issued the prescriptions for the appointments. Dr. Yang reported that methadone was prescribed as a baseline pain control for chronic pain; Percocet was prescribed as a breakthrough medication on days when pain is excruciating; Cymbalta[20] was prescribed to treat neuropathic pain; and Skelaxin was used as a muscle relaxant to help with musculoskeletal pain.

51. Patient A continued to be examined in the practice in 2011, with his last visit on September 23, 2011, with Dr. Yang. Patient A reported he had been scheduled for placement of an intrathecal pain pump through another pain management specialist. Patient A did not return to the practice after this visit.

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[20] Cymbalta is the trade name for duloxetine. It is a selective serotonin and norepinephrine reuptake inhibitor (SSNRI) antidepressant.

52. The patient records for 2011 are not in the record.[21] It is unclear whether respondent examined the patient in 2011. Respondent testified that he did, but a treatment summary he provided to the Board (see fn. 21, ante) does not reflect that he examined the patient on any of the seven occasions he was in clinic between March 8 and September 23, 2011. On each occasion Patient A was seen by Dr. Yang, with the exception of August 9, 2011, when he was seen by PA Boone. CURES shows that respondent continued to be involved in the care and treatment of the patient in his issuance of prescriptions to Patient A during the 2011 treatment period.

53. CURES shows that November 2009 to 2011 Patient A filled the following prescriptions that were issued by the practice:

Date	Drug/Strength	Quantity
November 2009	Endocet (325/10 mg)	120
	Methadone HCL (10 mg)	180
January 2010	Endocet (325/10 mg)	120
	Methadone HCL (10 mg)	180
February 2010	Endocet (325/10 mg)	120
	Methadone HCL (10 mg)	180
March 6, 2010	Endocet (325/10 mg)	120
	Methadone HCL (10 mg)	180
March 8, 2010[22]	Methadone HCL (10 mg)	180
	Endocet (325/10 mg)	120

[21] The records for Patient A provided to the Board, and certified as complete by respondent in April 2014, ended in 2010. In an April 29, 2014 letter submitted to the Board by respondent in response to a complaint filed by Patient A, respondent advised the Board that he had treated Patient A into 2011, and he summarized his treatment records for March to September 2011. Respondent also referenced the 2011 patient records during his Board interview on July 7, 2016. The investigator requested the documents but they were not produced until July 2018, after the Board's expert had completed her review, the accusation has been issued, and the hearing scheduled. In an in limine ruling issued prior to hearing, the 2011 records were ruled inadmissible at hearing because they had not been timely disclosed in violation of the Prehearing Conference Order. Respondent was permitted to review the 2011 patient records to refresh his recollection at hearing, and the summary of care he provided to the Board was received in evidence.

[22] CURES reflects the same prescription numbers for the methadone and Endocet filled on March 6, 2010. These entries could be a reporting error as suggested by respondent, or it could be a refill, per Dr. Buntin. The medical records in evidence do not answer the question.

April 2010	Endocet (325/10 mg)	120
	Methadone HCL (10 mg)	300
May 2010	Endocet (325/10 mg)	120
	Methadone HCL (10 mg)	300
June 2010	Endocet (325/10 mg)	90
	Methadone HCL (10 mg)	240
July 4, 2010	Endocet (325/10 mg)	90
July 6, 2010	Methadone HCL (10 mg)	120
July 25, 2010	Endocet (325/10 mg)	90
August 5, 2010	Endocet (325/10 mg)	90
	Methadone HCL (10 mg)	120
August 31, 2010	Endocet (325/10 mg)	90
	Methadone HCL (10 mg)	120
September 2010	APAP/Oxycodone (325/10 mg)	90
	Methadone HCL (10 mg)	120
November 2010	Endocet (325/10 mg)	90
	Methadone HCL (10 mg)	120
December 2010	Endocet (325/10 mg)	120
	Methadone HCL (10 mg)	97
February 2011	Endocet (325/10 mg)	90
	Methadone HCL (10 mg)	100
March 2011	Endocet (325/10 mg)	90
	Methadone HCL (10 mg)	100
April 6, 2011	Endocet (325/10 mg)	90
	Methadone HCL (10 mg)	100
April 9, 2011	Methadone HCL (10 mg)	20
May 2011	Endocet (325/10 mg)	90
	Methadone HCL (10 mg)	120
June 4, 2011	Methadone HCL (10 mg)	120
June 18, 2011	Endocet (325/10 mg)	90
June 24, 2011	Endocet (325/10 mg)	90
	Methadone HCL (10 mg)	120

August 1, 2011	Endocet (325/10 mg)	90
	Methadone HCL (10 mg)	120
August 25, 2011	Endocet (325/10 mg)	90
	Methadone HCL (10 mg)	180
September 2011	Endocet (325/10 mg)	90
	Methadone HCL (10 mg)	180
November 2011	Endocet (325/10 mg)	90
	Methadone HCL (10 mg)	180

54. Respondent issued the prescriptions for methadone and Endocet that Patient A filled in March, June, September, and November 2010. Respondent issued the prescriptions for methadone and Endocet that Patient A filled in February, May, June, August, September and November 2011. These amounted to a total of 940 tablets of methadone, and 630 tablets of Endocet.

55. In April 2010, Dr. Keller documented this concern about Patient A's opioid use:

> All efforts need to be made so the patient can obtain his medications on a timely basis because if there is any interruption, particularly in the opioid medications, there is a risk of severe medication withdrawal and even mortality.

In the treatment plan, Dr. Keller wrote:

> The patient's medications are being renewed as listed above. All these medications need now to be prescribed monthly, particularly methadone which is a potent opioid and without a regular prescription schedule will result in opioid withdrawal and a potentially lethal situation.

56. Dr. Yang documented his concern about the amount of methadone being taken by Patient A in his progress notes of September 30 and November 2, 2010. He wrote in his September 30 note:

> I did speak with the patient that his methadone dosage is a bit high and I would like to try to wean himself off such a high dose. However, the patient states that he actually is taking a much higher dose from the previous prescription and is actually taking 6 tablets a day. I again stressed this is rather high and he should come down. Patient understands and agrees to the above plan.

In his progress note for November 2, Dr. Yang wrote the following plan:

> The above medications are refilled for the methadone and Percocet. However, I did speak with the patient that his methadone usage is high and I would like for him to try to wean himself off such a high dose. However, the patient says he has pains elsewhere and he needs the pain medication for his back as well as other parts of his body. I again stressed that it is rather high and he should come down. Patient understands and agrees to the above plan.

57. The last progress note in evidence is for December 30, 2010. Patient A reported to Dr. Evans that he had been seen by an ophthalmologist for blurred and double vision, and by a gastroenterologist for significant gastrointestinal (GI) discomfort in the form of dyspepsia and reflux, with gallbladder involvement and substantial slowdown of peristalsis caused by the medications he was taking. UCSF had recommended a spinal infusion pump for medication delivery.

The medication list reflected that Patient A was taking the following medications: methadone 10 mg, one tablet every six hours; Percocet 10/325, one tablet every eight hours; Cymbalta 60 mg, for sleep, Skelaxin 800 mg, twice a day, Lyrica 100 mg, every 8 hours, Prilosec 20 mg, every day, Aciphex 20 mg, every day, Voltaren gel and Lidoderm patches for topical control. The medication listing also reflected that Patient A was taking Valium[23] once a day, potassium and Lasix. Patient A reported having some benefit for his leg pain from the stimulator which allowed him to ambulate, but did not provide relief for his back pain. Despite the pain medications, he rated his overall pain as 9 out of 10 and his leg pain as 8 out of 10. Dr. Evans thought Patient A's vision issues might be related to the opioids, and for that reason, his treatment plan was to start reducing methadone, and taper Percocet later.

58. Patient A was seen at the UCSF Pain Management Center on January 18, 2011, as a follow-up visit from the May 2010 implant of the spinal cord stimulator. The report indicated that Patient A was having severe side effects from his opioid intake, in the form of exacerbation of GI difficulties, in the form of bowel peristalsis and worsened constipation, and acid reflux. Patient A reported that the medication was impacting his cognitive and functional abilities.

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[23] Valium is the trade name for diazepam, a psychotropic drug used for the management of anxiety. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057. It is a dangerous drug as defined by Business and Professions Code section 4022.

59. The patient was receiving opioids when he started under the care of the practice. By 2009, his daily dosage was approximately 660 MME's and they remained in that range until the patient left the practice in 2011.

60. The daily MME of the opioids prescribed to Patient A were not calculated or documented in the patient record. The medical records do not completely document the amount of opioids and other medications taken by Patient A during the course of treatment. The medical records do not completely document the amount of medications prescribed to and obtained by Patient A through the in-house pharmacy. For Patient A, these medications included Norco, Elavil, and Flexeril. The practice utilized a pre-printed Prescription Form for such medications. The prescriber could circle the type of medication, the dosage, the directions and quantity. Many of the forms maintained in the patient records are illegible and incomplete.

61. During 2010 and 2011, the medical records do not reflect that medication reconciliation was performed regarding this patient. The medical records do not reflect that a urine screen was obtained. The medical records do not reflect that a Patient Activity Report or a report from outside pharmacies regarding filled prescriptions was obtained.

62. It was not established that respondent issued prescriptions for Schedule II controlled substances that were dispensed outside of a scheduled appointment, as alleged.

63. Patient A signed a one-page Pain Center Prescription Contract (contract) on June 7, 2005. Under the terms of this contract, Patient A agreed to comply with a request by his physician for a random urine screen to determine compliance with the pain control regimen; to not request or receive medications from physicians outside the practice; and to not use illegal drugs or medications. The contract did not restrict where Patient A could fill prescriptions, did not carry any advisements about risks, benefits or alternative to treatment, and did not list any consequences for failing to comply with the contract.

64. Patient A wrote a complaint to the Board in October 2012 about his care and treatment. In particular, he felt he had been overprescribed narcotics, to the point he was "a walking zombie."

Respondent's Testimony

65. According to respondent, Patient A was the most difficult pain patient he has had. Over the course of treatment, Patient A developed rheumatoid arthritis, gained significant weight and developed sleep apnea. During the course of treatment, he had cervical neck fusion, right shoulder surgery and he had overlapping psychiatric diagnoses of depression and pain disorder. He was followed by a neurosurgeon, a rheumatologist, and a pulmonologist, and was evaluated by a two psychiatrists.

66. Respondent cannot pinpoint when in the course of treatment that he diagnosed Patient A as having intractable pain. In his view, Patient A's pain level was excessive, and

for that reason, the foundation of his treatment was opioids so that Patient A could function. Respondent believed that without opioids, Patient A would not be able to function. Respondent testified, however, that toward the end of Patient A's treatment, he told Patient A that he was on a lot of oral pain medication, and that "may not be conducive over time." If this advice was given, it is not reflected in the treatment records in evidence.

67. Respondent was satisfied with Patient A's progress because he did not expect Patient A to make progress unless the pain resolved. In his opinion, Patient A did not have any significant complications from the medications. Ultimately Patient A obtained an intraspinal infusion pump which allowed him reduce his oral medications.

68. Respondent explained that his practice with each patient was to discuss any new medication's risks, benefits, and alternatives, provide the patient with instructional sheets on the medications, and obtain the patient's verbal consent to treatment. He does not document those discussions in the patient's record.

69. Respondent explained that his practice with each new patient is to have the patient sign a pain management agreement at their initial consultation. In his view, this contract supplements verbal consent to treatment.

70. Respondent's practice is to recommend conservative measures to his patients, but he does not document what conservative measures the patient is performing, or what benefit the patient is experiencing from those measures.

71. Respondent explained that in his opinion the calculation of MME's is not a pertinent factor for his clinical practice, and for that reason he does not calculate it.

72. The practice did not conduct urine drug screens during the course of treatment of Patient A. Respondent explained that urine drug screens were ordered at the discretion of the provider if there was an indication of abuse or misuse, or to verify that the patient was taking medications appropriately. Respondent did not see evidence of abuse or misuse by Patient A.

73. In respondent's opinion, his care and treatment of Patient A met the standard of care in all respects. Respondent does not consider the prescribing excessive for the chronic pain of this patient. In his opinion, his records are accurate and sufficient for a pain specialist to review and understand that he is prescribing because of pain associated with the patient's conditions.

Findings Regarding Patient A

PERIODIC REVIEW, ASSESSMENT AND EVOLVING TREATMENT PLAN

74. The experts disagree regarding whether the standard of care for periodic review and assessment of the course of pain treatment, and adjustment to the treatment plan

based on an evaluation of the patient's progress toward treatment objectives, was met for Patient A.

In Dr. Brose's opinion, the standard of care was met. The understood goal of treatment of a long-term patient like Patient A with chronic pain is to help provide a modicum of pain relief so the patient can continue to live his or her life. Dr. Brose did not express concern regarding the documented adverse effects from treatment.

In Dr. Buntin's opinion, the plan for treating Patient A's pain was conservative treatment referrals and follow-up clinic appointments for medication refills. The treatment plan did not have goals. The patient's response to the pain medication treatment was not assessed in a meaningful way. The treatment plan did not evolve based on the patient's response to that treatment which included adverse effects to the medication regimen. In her opinion, the failure to assess and adjust the treatment plan based on the patient's response to treatment constituted an extreme departure from the standard of care.

The 2010 progress notes, which are the only ones in evidence over the relevant time period, support Dr. Buntin's opinion. They do not reflect an evolving treatment plan based on an assessment of the patient's response to treatment.

By 2010, the patient had been on high doses of long-acting methadone and short acting opioids for many years. He was prescribed Valium by an outside provider, a controlled substance which can have a synergistic effect upon opiates and increase the risk of adverse events to the patient caused by high dose opioids. Those risks, which can include death, respiratory suppression, overdose, dependence, addiction, abuse, anxiety, and depression, increase with the long-term use of opioids.

In 2010, Patient A's tolerance to the opioids, adverse medical effects, and his self-increased use of methadone was documented. Clinical concerns regarding the amount of methadone being taken by Patient A were documented. When Patient A's functioning and activities of daily living were assessed, which was not done each visit, they were either the same or worse. The patient did not report improvement in function from the treatment.

The medical evidence supports the opinion of Dr. Buntin and her opinion is found persuasive. The standard of care required assessment of the appropriateness of continuing the treatment plan of prescribing methadone and Percocet in such high doses, and adjusting that treatment as patient harm, not progress, was being demonstrated. This failure constituted an extreme departure from the standard of care.

PRESCRIBING WITHOUT MEDICAL INDICATION

75. The experts disagree as to whether Patient A was prescribed dangerous drugs without medical indication. Dr. Brose opines that he was not. Dr. Buntin opines he was.

The progress notes as a whole do not document the reason for the dangerous drugs prescribed to the patient. Dr. Buntin's opinion is supported by the evidence is found persuasive. There was insufficient medical indication for the prescribing of dangerous drugs to Patient A.

EXCESSIVE PRESCRIBING

76. In Dr. Brose's opinion, the amounts prescribed to Patient A were not excessive, and were within the standard of what a reasonably prudent pain specialist would have prescribed if faced with a similar patient in 2010 and 2011. In Dr. Buntin's opinion, the amounts of controlled substances prescribed to Patient A were excessive, and constituted an extreme departure from the standard of care.

Toward the end of 2010 concerns were documented in Patient A's record about the high doses of methadone and Percocet being prescribed. Concerns were also documented about adverse effects Patient A was experiencing. Notwithstanding this, the patient continued to be prescribed methadone in doses which increased from 97, to 120, and to 180 tablets per month, while also receiving an ongoing monthly dose of 90 tablets of Percocet. In view of the risks to the patient from these medications, and in the absence of documented medical indication for these dosages, they were excessive.

TREATMENT RECORDS

77. The standard of care requires the physician to keep accurate and complete records of all matters associated with the standard of care for prescribing controlled substances. This includes documenting treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient, and periodic reviews of the treatment plan.

Dr. Buntin performed a thorough review of the records, and in her opinion the records are incomplete in the documentation of treatment plan objectives, medications, rationale for changes in medications, and periodic reviews of the treatment plan. In these elements, the record keeping deficiencies were an extreme departure from the standard of care. Dr. Brose does not share Dr. Buntin's criticism. In his opinion, the records are accurate and adequate, and sufficient for him as a pain management specialist to review the records, understand the treatment, and render his expert opinion thereon.

Dr. Buntin's opinion is supported by the evidence and is found persuasive. The progress notes do not consistently identify the controlled substance being prescribed with the relevant diagnosis and treatment goal. The records do not consistently reflect the type, dosage, and quantity of each medication prescribed. The records do not reflect the amount of medications taken by the patient. The records do not document periodic review of the treatment plan. The treatment records are incomplete, and constitute an extreme departure from the standard of care.

INFORMED CONSENT FOR TREATMENT

78. The standard of care requires that informed consent be obtained for treatment, and that a discussion be held with the patient about the risks, benefits, and alternatives to treatment each time a new controlled substance is introduced. The standard of care also requires that informed consent be documented.

Respondent credibly testified that informed consent to treatment was obtained verbally from the Patient A. Informed consent to treatment was not documented, either in the treatment notes or in the pain management agreement that Patient A signed, which did not mention risks, benefits or alternatives to treatment by controlled substances.

In Dr. Buntin's opinion, the failure to document informed consent constituted a simple departure from the standard of care. Dr. Brose does not agree that the standard of care requires informed consent be in writing or documented in the patient chart. He opines that hospitals and insurance providers may require consent to treatment be in a writing signed by the patient, but the standard of care does not. Dr. Brose does not agree that the standard of care required a medication agreement with the patient. But if one exists with a patient, he opines that it documents that there is an ongoing dialog with the patient about the risks, benefits and alternatives to treatment.

Dr. Brose's opinion regarding documentation of informed consent is inconsistent with the Board's standards requiring documentation of obtaining informed consent to treatment, and for that reason it is not persuasive. Also not persuasive is his opinion that informed consent was documented through the contract signed by Patient A. As set forth above, the pain management contract signed by Patient A did not discuss any risks, benefits or alternatives to treatment by controlled substances.

The evidence supports Dr. Buntin's opinion and it is found persuasive. The failure to adequately document obtaining informed consent for treatment is a simple departure from the standard of care.

WORKERS' COMPENSATION RECORDS

79. As provided to the Board, the records regarding the care and treatment of Patient A's workers' compensation injury were intermingled with the records pertaining to the care and treatment of Patient A's non-workers' compensation conditions. Respondent testified that in fact the practice keeps two separate charts for the purpose of billing, but because he wants to have knowledge about all the patient's conditions, he includes some information regarding the non-workers' compensation injuries in the workers' compensation records.

In Dr. Buntin's opinion, the standard of care requires the provider to separate treatment records associated with a workers' compensation injury from the treatment records associated with conditions that are not work related.

In Dr. Brose's opinion, the standard of care does not require that a patient's treatment records for a workers' compensation injury be maintained separately from the treatment records of the care on non-workers' compensation conditions. While that practice may be preferred as a billing or business practice, from a clinical perspective, it is appropriate to merge the records as they pertain to a single patient.

Dr. Buntin did not provide a compelling rationale for her opinion. The explanation provided by Dr. Brose is found persuasive. Complainant has not established that the combining of Patient A's workers' compensation medical records and his non-workers' compensation medical records constituted a violation of the standard of care.

OTHER ALLEGATIONS

80. All factual allegations and allegations of unprofessional conduct in connection to the care and treatment of Patient A not discussed above are found not established by clear and convincing evidence.

Care and Treatment of Patient B

81. Patient B was a 52-year-old[24] heavy machine operator who was referred to respondent for a pain management consultation following surgery related to a work-related lumbar spine injury sustained in July 2007. Patient B had undergone a lumbar laminectomy and discectomy in November 2007, was off work and was on disability. Patient B had previously undergone a laminectomy in 2003 for another work-related back injury.

82. Patient B was assessed by respondent on November 11, 2007. Patient B complained of low back pain with bilateral leg pain, and was taking Celebrex, Valium, and Vicodin for pain. Respondent assessed multilevel degenerative disc disease with spinal stenosis and lumbar facet osteoarthritis throughout. Respondent's treatment plan called for performing an epidural steroid injection, continuing with current medications, prescribing Neurontin for neuropathic pain, and a follow-up visit for treatment recommendations after the injection.

83. Patient B was referred back to respondent in January 2010 for consultation regarding continued back pain and a trial of epidural injections prior to consideration of further back surgery. An initial consultation was conducted on January 4, 2010, by Dr. Keller. Dr. Keller assessed failed back surgery syndrome with bilateral lumbar radiculopathy. The treatment plan called for scheduling Patient B for bilateral transforaminal

[24] The accusation incorrectly reflects the patient's age as 32.

steroid injections to alleviate pain. Patient B's medications were changed. Dr. Keller prescribed methadone, Percocet, Flexeril,[25] Feldene and Prilosec. Respondent performed a lumbar epidural injection under fluoroscopy guidance later that month.

84. The accusation addresses the treatment of Patient B from May 4, 2010, to January 2016. During that time, Patient B had follow up visits approximately every four to eight weeks for treatment for pain. Respondent examined Patient B periodically in 2013, 2014 and 2015. Patient B was examined by other providers, including Dr. Keller in 2010, Dr. Yang in 2011 and Dr. Leung in 2012 and 2013. Patient B was also examined periodically by PA's Boone and Martin, and NP's O'Neill-Conover, Senock, Kladar, Buescher, Dobrov and Semati.

85. Over this time period, Patient B was provided with various treatments including chiropractic, physical therapy, interventional procedures, and medications. Home exercise, and walking, stretching, and use of ice and heat was recommended. Patient B was prescribed monthly a combination of opioid analgesics of the same class including Fentanyl,[26] oxycodone,[27] morphine sulfate,[28] Butrans,[29] hydrocodone,[30] Vicodin/Norco,

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[25] Flexeril, a trade name for cyclobenzaprine, is a muscle relaxant. It is a dangerous drug as defined by Business and Professions Code section 4022.

[26] Fentanyl is an opioid analgesic which can be administered by injection, through a transdermal patch, known as Duragesic, by oral lozenge, or by tablet. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and section 1308.12 of title 21 of the Code of Federal Regulations. It is a dangerous drug as defined in Business and Professions Code section 4022.

[27] Oxycodone hydrochloride is a semisynthetic opioid analgesic with multiple actions similar to morphine. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(N), and section 1308.12 of title 21 of the Code of Federal Regulations. It is a dangerous drug as defined in Business and Professions Code section 4022.

[28] Kadian and MS Contin are trade names for morphine sulfate, an opioid pain medication. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b). It is a dangerous drug as defined by Business and Professions Code section 4022.

[29] Butrans is the trade name for buprenorphine. It is an opioid partial agonist-antagonist that works by binding receptors in the brain and nervous system to help prevent withdrawal symptoms. It is a Schedule III controlled substance pursuant to Health and Safety Code section 11056. It is a dangerous drug as defined by Business and Professions Code section 4022.

[30] Hydrocodone bitartrate is a semi-synthetic opioid analgesic. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b). It is a dangerous drug as defined by Business and Professions Code section 4022.

Percocet, and methadone. Patient B was also prescribed central nervous system acting medications, including Flexeril, Soma,[31] Valium, Gabapentin, Celebrex, Mobic, and Feldene.

86. The exact amount of medications prescribed to Patient B over the course of treatment cannot be determined from reviewing the patient's medical records in evidence.

87. According to CURES, Patient B filled the following prescriptions, issued by the practice, between May 2010 and January 2016:

Date	Drug/Strength	Quantity
May 2010	Vicodin (325/10 mg)	180
June 4, 2010	Kadian (30 mg)	10
	Percocet (325/10 mg)	40
June 11, 2010	Kadian (60 mg)	30
	Percocet (325/10 mg)	150
June 21, 2010	Fentanyl (50 mcg/1hr)	10 TDM[32]
July 2010	Fentanyl (50 mcg/1hr)	10
	Percocet (325/10 mg)	90
August 2010	Fentanyl (75 mcg/1hr)	10
	Percocet (325/10 mg)	90
September 2010	Fentanyl (50 mcg/1hr)	10
	Percocet (325/10 mg)	120
October 2010	Fentanyl (50 mcg/1hr)	10
	Percocet (325/10 mg)	180
November 2010	Fentanyl (50 mcg/1hr)	10
	Percocet (325/10 mg)	120
December 2010	Fentanyl (50 mcg/1hr)	10
	Percocet (325/10 mg)	120

[31] Soma is a trade name for carisoprodol, which is a muscle relaxant and a sedative. It is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug as defined by Business and Professions Code section 4022.

[32] TDM is an abbreviation for transdermal patch. All fentanyl prescribed to Patient B was in this form.

January 2011	Fentanyl (50 mcg/1hr)	15
	Percocet (325/10 mg)	120
February 2, 2011	Percocet (325/10 mg)	120
	Morphine Sulfate (15 mg)	90
February 9, 2011	Morphine Sulfate (30 mg)	90
March 2011	Percocet (325/10 mg)	120
	Morphine Sulfate (30 mg)	120
April 2011	Percocet (325/10 mg)	120
	Morphine Sulfate (30 mg)	120
May 2011	Percocet (325/10 mg)	120
	Morphine Sulfate (30 mg)	120
June 2011	Percocet (325/10 mg)	120
	Morphine Sulfate (30 mg)	120
July 2011	Percocet (325/10 mg)	120
	Morphine Sulfate (30 mg)	120
August 2011	Percocet (325/10 mg)	90
	Morphine Sulfate (30 mg)	150
September 1, 2011	Percocet (325/10 mg)	90
	Morphine Sulfate (30 mg)	150
September 30, 2011	Percocet (325/10 mg)	90
	Morphine Sulfate (30 mg)	150
October 2011	Percocet (325/10 mg)	90
	Morphine Sulfate (30 mg)	150
November 2011	Percocet (325/10 mg)	120
	Morphine Sulfate (30 mg)	150
December 2011	Percocet (325/10 mg)	120
	Morphine Sulfate (30 mg)	150
January 2012	Percocet (325/10 mg)	120
	Morphine Sulfate (30 mg)	150
February 2012	Percocet (325/10 mg)	120
	Morphine Sulfate (30 mg)	150
March 2012	Percocet (325/10 mg)	120
	Morphine Sulfate (30 mg)	150

April 2012	Percocet (325/10 mg)	120
	Morphine Sulfate (30 mg)	150
May 2012	Percocet (325/10 mg)	120
	Morphine Sulfate (30 mg)	180
June 2012	Percocet (325/10 mg)	120
	Morphine Sulfate (30 mg)	180
July 12, 2012	Percocet (325/10 mg)	60
	Morphine Sulfate (30 mg)	90
July 27, 2012	Percocet (325/10 mg)	120
	Morphine Sulfate (30 mg)	180
August 2012	Percocet (325/10 mg)	120
	Morphine Sulfate (30 mg)	180
September 2012	Percocet (325/10 mg)	120
	Morphine Sulfate (30 mg)	150
October 2012	Percocet (325/10 mg)	120
	Morphine Sulfate (30 mg)	180
November 2012	Percocet (325/10 mg)	120
	Morphine Sulfate (30 mg)	180
December 2012	Percocet (325/10 mg)	150
	Morphine Sulfate (30 mg)	150
January 2013	Percocet (325/10 mg)	150
	Morphine Sulfate (30 mg)	150
February 2013	Percocet (325/10 mg)	180
	Morphine Sulfate (30 mg)	90
March 2013	Percocet (325/10 mg)	180
	Morphine Sulfate (30 mg)	90
April 2013	Percocet (325/10 mg)	180
	Morphine Sulfate (30 mg)	90
May 2013	Percocet (325/10 mg)	180
	Morphine Sulfate (30 mg)	90
June 2013	Percocet (325/10 mg)	180
	Morphine Sulfate (30 mg)	90

July 2013	Percocet (325/10 mg)	180
	Morphine Sulfate (30 mg)	120
August 2013	Percocet (325/10 mg)	180
	Morphine Sulfate (30 mg)	120
September 2013	Percocet (325/10 mg)	180
	Morphine Sulfate (30 mg)	120
October 2013	Percocet (325/10 mg)	180
	Morphine Sulfate (30 mg)	120
November 2013	Percocet (325/10 mg)	180
	Morphine Sulfate (30 mg)	120
December 2013	Percocet (325/10 mg)	180
	Morphine Sulfate (30 mg)	120
January 2014	Percocet (325/10 mg)	180
	Morphine Sulfate (30 mg)	120
February 2014	Oxycodone HCL (10 mg)	210
	Morphine Sulfate (30 mg)	120
March 2014	Oxycodone HCL (10 mg)	210
	Morphine Sulfate (30 mg)	120
April 2014	Oxycodone HCL (10 mg)	210
	Morphine Sulfate (30 mg)	120
May 2014	Oxycodone HCL (10 mg)	210
	Morphine Sulfate (30 mg)	120
June 2014	Oxycodone HCL (10 mg)	210
	Morphine Sulfate (30 mg)	120
July 2014	Oxycodone HCL (10 mg)	210
	Morphine Sulfate (30 mg)	120
August 4, 2014	Oxycodone HCL (10 mg)	120
	Morphine Sulfate (30 mg)	120
August 21, 2014	Oxycodone HCL (10 mg)	90
September 2014	Oxycodone HCL (10 mg)	210
	Morphine Sulfate (30 mg)	120

October 2, 2014	Oxycodone HCL (10 mg)	210
	Morphine Sulfate (30 mg)	120
October 31, 2014	Oxycodone HCL (10 mg)	105
	Morphine Sulfate (30 mg)	120
November 2014	Oxycodone HCL (10 mg)	105
	Morphine Sulfate (30 mg)	120
December 2, 2014	Oxycodone HCL (10 mg)	105
	Morphine Sulfate (30 mg)	120
December 31, 2014	Oxycodone HCL (10 mg)	105
	Morphine Sulfate (30 mg)	120
January 2015	Oxycodone HCL (10 mg)	90
	Morphine Sulfate (30 mg)	120
March 2015	Oxycodone HCL (10 mg)	94
	Morphine Sulfate (30 mg)	120
April 2015	Oxycodone HCL (10 mg)	60
	Morphine Sulfate (30 mg)	110
May 1, 2015	Oxycodone HCL (10 mg)	50
	Morphine Sulfate (30 mg)	110
May 29, 2015	Oxycodone HCL (10 mg)	50
	Morphine Sulfate (30 mg)	110
June 2015	Oxycodone HCL (10 mg)	50
	Morphine Sulfate (30 mg)	100
July 2015	Oxycodone HCL (10 mg)	60
	Morphine Sulfate (30 mg)	110
	Butrans (20 MCG/1hr)	4 TDM
August 2015	Oxycodone HCL (10 mg)	60
	Morphine Sulfate (30 mg)	110
	Butrans (20 MCG/1hr)	4 TDM
September 2015	Oxycodone HCL (10 mg)	60
	Morphine Sulfate (30 mg)	110
	Butrans (20 MCG/1hr)	4 TDM
October 2015	Oxycodone HCL (10 mg)	60
	Morphine Sulfate (30 mg)	110
	Butrans (20 MCG/1hr)	4 TDM

November 2015	Oxycodone HCL (10 mg)	60
	Morphine Sulfate (30 mg)	110
	Butrans (20 MCG/1hr)	4 TDM
December 2015	Oxycodone HCL (10 mg)	60
	Morphine Sulfate (30 mg)	110
	Butrans (20 MCG/1hr)	4 TDM
January 2016	Oxycodone HCL (10 mg)	60
	Morphine Sulfate (30 mg)	110

88. Of the prescriptions listed in CURES, respondent issued 77 of them covering the following months: June, August, September, October, November and December 2010; January, February, June, July, August, September, October, November and December 2011; September, October, November and December 2012; November and December 2013; and, January, February, March, and April 2014. Respondent directly supervised NP Semati who wrote all the opioid prescriptions for Patient B from May 2015 through January 1, 2016.

89. In addition to prescribing opioids for pain management, respondent performed a series of bilateral L4-5, L5-S1 transforaminal epidural steroid injections with lumbar epidurograms on Patient B. These were performed in January 2010, April 2010, August 2012, November 2013, and April 2014. Dr. Leung also performed this procedure on Patient B in January 2013. Informed consent for the procedures was obtained and documented.

90. Respondent's last documented examination of Patient B was June 5, 2014. At this time, Patient B's opioid medications were MS Contin 30 mg (one in the morning, one midday, and two at bedtime), and oxycodone 10 mg, up to seven tablets per day for breakthrough pain. Patient B reported having 70 percent relief from the April 2014 epidural. Respondent did not change the amount of opioids prescribed to Patient B after this examination.

91. Because Patient B was a workers' compensation patient, requests for authorization of coverage of his chronic pain medications could be subject to review, and modified or denied.

In February 2015, a request for MS Contin 30 mg (#120) and oxycodone 20 mg (#90) was found to be unsupported by the documentation presented. With respect to the MS Contin, the reviewer noted that Patient B had been taking it since September 2011. The clinical notes were found to lack documentation of quantified pain relief, side effects, physical and psychosocial functioning, or aberrant behavior. There was no current urine screen to assess aberrant behavior. The request did not include medical frequency. With respect to the oxycodone, the reviewer found that Patient B had been taking it since at least February 2014. The documentation was found lacking in the same respects.

In May 2015, a request for MS Contin 30 mg (#110) and oxycodone 20 mg (#60) were found to be similarly unsupported by medical documentation. The reviewer recommended a weaning schedule.

In June 2015, a request to continue the authorization for Flexeril 30 mg (#30), which had been prescribed since February 2011, was denied. The reviewer found the request lacking documentation of either an acute exacerbation of the chronic low back condition or any therapeutic benefit which would support the continued use of the muscle relaxant. The reviewer recommended that Patient B's use of the muscle relaxant be tapered and discontinued.

92. Patient B was prescribed high-dose chronic opioid therapy over the course of his treatment. According to Dr. Buntin's calculations, which were based on CURES, in June 2010, the MME's were approximately 166 per day. In October 2014, the MME's were approximately 225 per day. According to Dr. Brose, in 2010 the MME's were 80, they escalated to 390 in 2012, and had dropped to 170 as of June 2016.

93. The progress notes did not document consideration of the risk factors associated with the high doses of opiates prescribed. The clinical notes do not document clinical consideration of the risk factors associated with the high doses of opiates prescribed to Patient B in conjunction with other medications prescribed for him. The progress notes do not contain calculations of the MME's of the opiates prescribed for Patient B. The progress notes do not document discussions held with Patient B regarding the risks associated with opioids and/or the concurrent effects with other medications.

94. At the time of Patient B's treatment, the practice utilized a different one-page pain management agreement than used with Patient A. This agreement, called a Pain Center Prescription Agreement, was to be signed by both the patient and the physician. The patient agreed, among other things, to fill all pain prescriptions at one pharmacy, comply with random urine tests on request, to not request or receive pain medications or controlled substances from any physician who is not with the practice, and to not use illegal drugs or medication obtained through illegal channels. The agreement carried the provision that a violation of the agreement could result in a dismissal from the practice.

Patient B signed this agreement twice, in November 2007 and in January 2010. By signing this medication agreement, the patient "acknowledged" the following:

> I am aware that the risks of opiates/benzodiazepines/muscle relaxants may include addiction, sedation, physical dependence, nausea/vomiting, drowsiness, slowed reflexes and response time, and constipation.

95. The records reflect urine drug screens were run three times over the course of treatment. Unexpected findings were made on two of the screens. In 2010, fentanyl was not detected although it was prescribed. In 2012, tetrahydrocannabinol, the active ingredient in

cannabis, and Soma were detected although not prescribed. Patient B had not reported using cannabis. Patient B's use cannabis was in violated the medication agreement. The progress notes do not reflect assessment of the unexpected findings in the urine drug screen, or discussion with the patient regarding the contract violation.

96. In an August 2010 QME evaluation, Patient B reported having side effects of constipation.

97. In March 2011, Patient B's primary care physician diagnosed Patient B with secondary hypogonadism due to long-term use of opioids, and prescribed testosterone for him. The clinical notes do not reflect that this adverse effect was considered during the course of Patient B's treatment.

98. In a March 7, 2014 progress note, the NP recommended obtaining a urine drug screen and a CURES report at the patient's next appointment. The reason for the recommendation is not indicated in the progress note. The next appointment was with respondent on March 26, 2014. Respondent did not order a CURES report or a urine drug screen. The progress note does not reflect the basis for that decision.

99. The records reflect two CURES reports were obtained in 2015.

100. Patient B used three different pharmacies to fill prescriptions, which was a violation of the pain management agreement. The patient records do not reflect discussion with the patient regarding this violation.

Respondent's Testimony

101. Respondent explained that Patient B was a patient with failed back surgery who was treated with intermittent procedures, coupled with medications of different classes, in order to keep his pain from getting worse. Patient B is still a patient in the clinic. Respondent reports he has been able to titrate Patient B's Schedule II medications down to Suboxone, a Schedule III medication with less risk of side effects and complications.

102. Respondent explained that MME's is not a pertinent factor for his clinical practice, and for that reason, they are not calculated. In 2015, respondent began calculating MME's for this patient because of workers' compensation requirements not for clinical purposes.

103. Respondent was not concerned about the absence of Fentanyl in the 2010 urine drug screen because the patient had reported that the patch kept falling off. Respondent was also not concerned about the 2012 urine drug screen detecting cannabis. Respondent believed, but was not sure, that someone had spoken with the patient about using cannabis after its use had been detected. Notwithstanding the language of his medication agreement, respondent testified that he did not have a problem with patients using medical marijuana as

it does not have an adverse effect in connection with opioids, and it could reduce the amount of opioids taken by the patient.

104. Respondent was asked why he did not reassess the amount of opioids he prescribed following the patient's report that he had 70 percent decrease in pain following the epidural. Respondent explained that it was his practice to leave it to the patient to decide if he or she is able to cut back on as needed opiates.

105. Respondent's practice is to not document whether the patient is experiencing breakthrough pain, or what is causing the breakthrough pain, because there are so many potential causes for breakthrough pain, and the pain can happen throughout the day. It is the purpose of short acting opioids to address breakthrough pain when it arises. He prescribes an adequate daily dose to address breakthrough pain should it happen.

106. It is not respondent's practice to document the details of the patient's daily functioning or what activities of daily living the patient can perform. It is discussed with the patient during the examination, but it is not documented.

107. Respondent's practice is to document obtaining informed consent at the beginning of treatment only, and that is done through the execution of the medication agreement.

108. In respondent's opinion, his care and treatment of Patient B met the standard of care in all respects. Respondent does not consider the prescribing excessive for the chronic pain of this patient. In his opinion, his records are accurate and sufficient for a pain specialist to review and understand that he is prescribing medications based on the pain associated with the patient's conditions.

Findings Regarding Patient B

PERIODIC REVIEW, ASSESSMENT, AND EVOLVING TREATMENT PLAN

109. The experts disagree as to whether the standard of care for periodic review and assessment of the course of pain treatment, and adjustment to the treatment plan based on an evaluation of the patient's progress toward treatment objectives, was met for Patient B.

In Dr. Brose's opinion, the records met the standard of care. The understood goal of treatment of a long-term patient like Patient B with chronic pain is to help provide a modicum of pain relief so the patient can continue to live his or her life.

In Dr. Buntin's opinion, the plan for treating Patient B's pain was conservative treatment, referrals and follow-up clinic appointments for medication refills. The treatment plan did not have stated goals. The patient's response to the pain medication treatment was not assessed in a meaningful way. The treatment plan did not evolve based on the patient's response to that treatment which included adverse effects to the medication regimen. In her

opinion, the failure to assess and adjust the treatment plan based on the patient's response to treatment constituted an extreme departure from the standard of care.

The experts agree that Patient B was on high doses of opioids for a long period of time, coupled with other medications that could potentiate their risks. The medical records do not reflect any meaningful benefit from treatment in the way of improvement in function, quality of life, or returning to work. The medical records do not reflect adjustments to the treatment plan in light of the lack of progress or benefit. The medical records do not reflect assessment being made when red flags arose during the course of treatment, such as inconsistent results in urine screens, violation of the pain management agreement, or adverse effects to the patient from opioids.

Dr. Buntin's testimony is supported by the evidence and is found persuasive. Continuing to prescribe high doses of opioids without adequate periodic review, and assessment of, and adjustment to the treatment plan in light of the risks of harm posed to the patient from such high doses, in combination with other controlled substances, constituted an extreme departure from the standard of care.

PRESCRIBING WITHOUT MEDICAL INDICATION

110. The experts disagree whether Patient B was prescribed dangerous drugs without medical indication.

In Dr. Brose's opinion, the patient's pain and its impact on her functioning, quality of life and ability to perform activities of daily living was sufficient medical indication for the dangerous drugs prescribed to Patient B.

In Dr. Buntin's opinion, the prescribing of high doses of dangerous drugs to Patient B is not medically indicated. The patient's status, functioning, quality of life, or ability to perform activities of daily living did not progress or improve over the many years of opioid treatment. While Dr. Buntin's opinion does not rely upon the findings of the 2014 and 2015 Workers' Compensation Review, it is noted that the findings of the independent workers' compensation review are in line with her assessment that Patient B was prescribed controlled substances without documented medical indication. And the medical records show that it was these findings which led to the decrease in opioid prescribing, rather than clinical judgment by respondent.

Dr. Buntin's opinion is supported by the evidence is found persuasive. There was insufficient medical indication for the prescribing of dangerous drugs to Patient B.

EXCESSIVE PRESCRIBING

111. The experts agree that Patient B was prescribed high doses of opiates over five years of treatment.

In Dr. Brose's opinion, the amounts prescribed to Patient B were in keeping with the standard of care practiced in the community at the time.

In Dr. Buntin's opinion, the doses were excessive in that the patient was prescribed high doses of multiple opioids, coupled with central acting medications that potentiate the effects and side effects of opiates. The records do not reflect consideration of the risks associated with opioids, which include constipation, gastroenteritis, and urinary retention, anxiety and depression, tolerance, respiratory suppression, addiction, substance abuse disorders, overdose and death, risks which raise with an increase in dosage. The risks are further raised when they are prescribed long term, and when used in combination with other controlled substances that potentiate their effect.

Dr. Buntin's opinion is supported by the evidence and is found persuasive. The progress notes do not document the medical basis for the ongoing opiate treatment at such high levels. The records do not reflect consideration of weaning the patient off the medications until the workers' compensation review in 2015. In view of the risks to the patient from the long-term high doses of opioids, and the absence of documented medical indication for prescribing them, the prescribing is found to be excessive.

TREATMENT RECORDS

112. The experts disagree as to whether the records maintained on Patient B met the standard of care for treatment records.

Dr. Brose finds the medical records maintained on Patient B to be accurate and to meet the standard of care as it allowed him to offer his expert opinion on the care and treatment provided to the patient.

Dr. Buntin conducted a thorough review of the records maintained on Patient B, and in her opinion, they were incomplete in their documentation of treatment plan objectives, the patient's controlled substance history and usage, the medical indication for prescribing, the conducting of periodic review of the treatment plan, and documenting the patient's progress toward objectives. In her opinion the treatment records are an extreme departure from the standard of care.

The evidence establishes that the medical records are deficient in their documentation in the manner identified by Dr. Buntin. For this reason, Dr. Buntin's opinion is found persuasive. The treatment records are incomplete, and they constitute an extreme departure from the standard of care.

INFORMED CONSENT FOR TREATMENT

113. Respondent credibly testified that informed consent was verbally obtained from Patient B. However, the standard of care also requires that informed consent be documented in the patient's records.

In Dr. Buntin's opinion, the patient records do not adequately document that informed consent was obtained. Dr. Brose finds that the medication contract signed by Patient B in 2007 and 2010 was sufficient documentation on informed consent. This version of the contract is broader than the contract utilized with Patient A as it lists some of the risks of treatment from opioids. In Dr. Buntin's opinion it still does not satisfy the documentation required for informed consent to treatment, as it does not fully educate the patient of the risks, or discuss the benefits or alternatives to treatment.

The medication agreement was signed in 2010. The medications prescribed to the patient changed over five years of treatment. The 2010 contract cannot be found to evidence an ongoing discussion with the patient about the risks, benefits and alternatives to the many other controlled substances prescribed over the course of treatment.

The failure to adequately document obtaining informed consent for treatment is a simple departure from the standard of care and renders the patient's records incomplete.

OTHER ALLEGATIONS

114. All factual allegations and allegations of unprofessional conduct in connection the care and treatment of Patient B not discussed above are found not established by clear and convincing evidence.

Care and Treatment of Patient C

115. Patient C was a 57-year-old pharmacy technician who was referred to respondent in August 2011 for an initial pain consultation and treatment for pain associated with non-work related onset of pain in the lower back and down both legs.

116. Respondent performed an initial pain consultation on August 27, 2011. Imaging studies performed earlier that month showed a broad based disc bulge at L3-L4 and L4-L5, spinal stenosis at L3-4 and facet arthropathy at L4 through S1. Respondent reported that Patient B's current medications were Cymbalta, nortriptyline, Lasix, potassium and Cozaar.

Respondent diagnosed Patient C with spinal stenosis at L3-L4, facet osteoarthritis, and degenerative disc disease. The treatment plan was to perform lumbar epidural injections to treat the spinal stenosis, and bilateral medial branch facet injections for diagnosing low back pain, and if helpful, to be followed by radiofrequency rhizotomy for prolonged pain relief. No medications were prescribed at this visit.

117. Between September 11, 2011 and January 19, 2015, respondent performed 10 interventional procedures on Patient C, including bilateral transforaminal epidural steroid injections, bilateral sacral ala and dorsal ramus medial branch nerve facet injections, bilateral sacral ala and dorsal ramus medial branch nerve radiofrequency rhizotomy, and associated

diagnostic injection procedures. The evidence established that respondent obtained and documented informed consent for performing these procedures on Patient C.

118. Patient C was seen in the practice every one to two months. She was prescribed controlled substances by respondent, Dr. Leung, Dr. Evans, PA Williams, and NP's Buescher, Kladar, Semati and Dobrov.

119. The last documented visit with respondent was on September 2, 2015. On that date, Patient C's chief complaint remained the same as over the course of treatment, low back pain radiating down both legs. She reported a pain level of 10 without pain medications, and five to six with pain medications. The patient had just undergone shoulder surgery.

The progress note reflects that Patient C was taking the following medications prescribed by the practice: MS Contin 30 mg, every 8 hours, Norco 10/325 mg, every 6 to hours as needed, Oxycodone 10 mg as needed for severe pain, Gabapentin, Flexeril 10 mg, Trazadone, and Cymbalta. The amounts of these medications that Patient C was taking daily was not listed. The reasons each of these medications was prescribed was not documented. Other medications listed as being prescribed to the patient by her primary care physician were Cozaar, Lasix, potassium and Plavix. The note does not reflect if Patient C was continuing to take these medications.

The progress note reflects that Patient C was using MS Contin, Norco, and "very occasionally oxycodone which helps her from going to the ER." Patient C reported benefit from the surgery, and that the stabbing pain from her shoulder had resolved. Patient C reported that she "may not need the oxycodone anymore." The note does not reflect whether the patient was also receiving pain medication from her surgeon.

The treatment plan called for: conservative treatment measures as tolerated by the patient; prescribe MS Contin, Norco and Flexeril; and discontinue oxycodone. Respondent ordered a preliminary drug screen, which he reported to be appropriate and without aberrancy. With respect to the opioids, respondent wrote that he hoped to be able to begin to wean them down with a reduction in shoulder pain and a reduction in back pain following another scheduled interventional procedure.

120. There are no further treatment records for Patient C in the record. CURES reflects that between December 2011 and February 2016, Patient C filled the following prescriptions that had been issued by the practice:

Date	Drug/Strength	Quantity
December 2011	Vicodin (325/10 mg)	90
January 2012	Vicodin (325/10 mg)	90

February 2012	Vicodin (325/10 mg)	90
March 2012	Vicodin (325/10 mg)	90
April 5, 2012	Vicodin (325/10 mg)	90
April 20, 2012	Vicodin (325/10 mg)	180
May 2012	Vicodin (325/10 mg)	180
June 2012	Norco (325/10 mg)	180
July 13, 2012	Norco (325/10 mg)	180
July 25, 2012	Percocet (325/10 mg)	180
August 8, 2012	Morphine Sulfate (15 mg)	90[33]
August 24, 2012	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
September 2012	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
October 2012	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
November 2012	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
December 2012	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
January 2013	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
February 2013	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
March 8, 2013	Norco (325/10 mg)	30
March 10, 2013	Norco (325/10 mg)	90
March 15, 2013	Morphine Sulfate (30 mg)	120
April 4, 2013	Norco (325/10 mg)	30
April 9, 2013	Norco (325/10 mg)	180
May 2013	Norco (325/10 mg)	180

[33] All morphine sulfate was in the form of extended release tablets.

June 2013	Norco (325/10 mg)	180
July 2013	Norco (325/10 mg)	180
August 2013	Norco (325/10 mg)	240
September 2013	Norco (325/10 mg)	240
October 9, 2013	Morphine Sulfate (30 mg)	90
October 25, 2013	Norco (325/10 mg)	90
November 7, 2013	Morphine Sulfate (30 mg)	90
November 20, 2013	Norco (325/10 mg)	90
December 2013	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	90
January 2014	Morphine Sulfate (30 mg)	90
February 4, 2014	Norco (325/10 mg)	90
February 13, 2014	Morphine Sulfate (30 mg)	90
March 3, 2014	Norco (325/10 mg)	90
March 17, 2014	Morphine Sulfate (30 mg)	90
March 20, 2014	Norco (325/10 mg)	120
April 11, 2014	Morphine Sulfate (30 mg)	90
April 14, 2014	Norco (325/10 mg)	120
May 2014	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
June 2014	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
July 2014	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
August 2014	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
	Lorazepam (0.5 mg)	10
	Oxycodone HCL (10 mg)	20

September 2014	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
	Oxycodone HCL (10 mg)	20
October 2014	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
	Oxycodone HCL (10 mg)	20
November 2014	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
	Oxycodone HCL (10 mg)	20
December 2014	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
	Oxycodone HCL (10 mg)	20
January 2015	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	90
	Oxycontin (10 mg)	30
February 2015	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	90
	Oxycodone HCL (10 mg)	30
March 2015	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	90
	Oxycodone HCL (10 mg)	30
April 2015	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	90
	Oxycodone HCL (10 mg)	30
May 2015	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
	Oxycodone HCL (10 mg)	30
June 2015	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
	Oxycodone HCL (10 mg)	30
July 2015	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
	Oxycodone HCL (10 mg)	30

August 2015	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
	Oxycodone HCL (10 mg)	30
September 2015	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
October 2015	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
	Oxycodone HCL (10 mg)	30
November 2015	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
	Oxycodone HCL (10 mg)	30
December 2015	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
	Oxycodone HCL (10 mg)	30
January 2016	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120
February 2016	Morphine Sulfate (30 mg)	90
	Norco (325/10 mg)	120

121. Of these 112 prescriptions, respondent issued 56 of them. Respondent signed prescriptions filled in December 2011; January, February, September, October, November and December 2012; January, February March April, November and December 2013; January, February, March, April, June, July, September, October, November and December 2014; February, July, and September 2015; and, January 2016. In addition to issuing these prescriptions, from April 2015 to February 2016, respondent, as the only physician in the practice, supervised the PA and NP's who issued 23 opioid prescriptions to Patient C.

122. Patient C was prescribed a combination of opioids over the course of her treatment, which concluded MS Contin, Norco and oxycodone. In addition, Patient C was prescribed central nervous system-acting medications, including Flexeril, Trazodone, Cymbalta, Nortriptyline, Celexa, Chantix, Ativan, and Ultram.

123. During the course of treatment, Patient C received high doses of long term opiates and controlled substances through respondent's practice. Patient C started in the practice in December 2011 with an average MME of 30 mg per day. By December 2012 the MME escalated to 130 mg per day. In March 2013 the daily MME was 150 mg. In 2014 the daily MME was 160 mg. In August 2015, the daily MME slightly dropped to 145 mg. In September 2015, respondent calculated the MME's to be 120 mg per day.

124. Over the course of her treatment, Patient C filled prescriptions issued by the practice at four different pharmacies.

125. On occasion during her course of treatment, Patient C was prescribed opiates by her primary physicians in addition to those prescribed through the pain clinic.

126. A progress note for August 9, 2013 visit reflects that Patient C reported having psychosocial stresses from a family situation. She reported that she was averaging a daily intake of eight tablets of Norco, which was more than she had been prescribed. She also reported, and it was diagnosed, that she was beginning to experience physical withdrawal symptoms because she completed all her Norco "several days" earlier. Because she was on chronic opioid therapy, had run out of Norco, and was experiencing physical withdrawal symptoms, the provider recommended a random urine drug screen be conducted. At the patient's request, the provider increased the amount of Norco from 180 to 240 tablets (one to two tablets every four to six hours as needed for pain). The patient reported having low back pain of seven out of 10, and lower extremity pain of four out of 10. She reported that her pain moderately interfered with her activities of daily living and overall functioning, and that prolonged standing aggravated her pain. How the pain impacted her activities of daily living and her functioning was not further specified.

127. A progress note for February 13, 2014, reflected that the patient had had an unspecified "cerebrovascular accident" in January. Subsequent progress notes do not consistently reflect this event in the assessment section.

128. The records are incomplete with respect to the amount of Schedule III medications prescribed to Patient C and that were filled through the in-house pharmacy.

129. The medical records for Patient C are incomplete and do not consistently reflect the medications prescribed to Patient C at each patient visit. For example, in the November 2013 progress note, the medications listed were MS Contin, Norco, and Neurontin. The patient's progress note for December 2013, contains a medication listing that also included Cyclobenzaprine, Cymbalta, Trazadone, Cozaar, Lasix, and potassium. The listing of medications did not include the dosage.

130. The medical records for Patient C do not reflect the patient's daily medication use. The medical records do not reflect calculation of the MME's of the opioids prescribed to Patient C with the exception of respondent's very last progress note.

131. The medical records do not identify and connect the patient's diagnosis with the relevant controlled substance.

132. The patient records do not contain an executed pain management agreement with Patient C. The patient records do not reflect written documentation that informed consent was obtained prior to treatment by pain medication.

133. During the course of treatment, one CURES report was obtained in September 2015.

134. During the course of treatment, urine drug screens were obtained in November 2013 and September 2015.

135. The November 2013 urine drug screen showed the presence of opiates, oxycodone and benzodiazepines. The patient's progress note for November 2013 does not reflect that she was taking a benzodiazepine. This urine drug screen is reflected across the patient's progress notes as having expected results. A follow-up urine screen was not conducted.

136. Over the course of treatment, Patient C did not did not demonstrate any meaningful gains or benefits from opiate treatment. Over the course of treatment, the medical records do not reflect consideration of non-opioid medications for treating her pain.

137. The medical records for this patient often repeat this language:

> Patient reports the benefit of chronic pain medication maintenance regime, activity restriction, and rest continue to keep pain at management level to allow [patient] to complete necessary activities of daily living.

The records are not specific to this patient as to her benefit from treatment. The specific activities of daily living that the patient could perform as a result of treatment were not identified.

Respondent's Testimony

138. Respondent believes that the pain clinic had a pain management agreement with Patient C, but he did not provide it to the Board in his certified records.

139. With respect to the presence of a benzodiazepine in Patient C's urine drug screen in November 2013, respondent does not view this is as an inconsistent finding. Respondent explained:

> Knowing this patient, she has some . . . psychological issue, anxiety and insomnia, so now and then if we see a benzodiazepine and we know that it could come from the primary care [physician], that's not an abnormal finding.

Respondent testified that because the benzodiazepine was not a medication that he prescribed, it was not a medication that is listed in the patient chart. All medications that a patient is taking are listed at the initial evaluation, but medications provided by the primary care physician subsequent to that are not documented. If there are contraindications to the

pain regime he prescribes from medications prescribed by the primary care physician, respondent expects that the primary care physician will notify him.

140. With respect to the documentation associated with the "cerebrovascular accident," respondent explained that from the examination one could tell she had a transient ischemic attack (TIA) not a stroke. A TIA, and any medications associated with that incident, would not change the clinical treatment of Patient C's pain.

141. With respect to documenting MME's in the September 2015 progress note, respondent explained that he did not do that for clinical reasons, but because of workers' compensation requirements.

142. Respondent does not agree that Patient C's progress was stagnant. In his view, she will never progress to where she is completely recovered and off pain medication, similar to the life of a diabetic. He testified that his goal was to minimize her pain and thereby improve her quality of life. For that reason, in his view it is not necessary to document how specifically how her life is impacted, or what tasks she is or is not able to do; it is sufficient to document that her activities of daily living are impacted by the pain. In his opinion, without medications, Patient C's activities of daily living would be reduced. In his view, she had good and positive gains from the treatment. In his view, she tolerated the medication well, and although she developed tolerance, he found no indication of adverse side effects, risky behavior, over medication or respiratory suppression.

143. In respondent's opinion, his care and treatment of Patient C met the standard of care in all respects, and the prescribing was not excessive for the chronic pain of this patient. In his opinion, his records are accurate and sufficient for a pain specialist to review and understand that he is prescribing medications based on the pain associated with the patient's conditions.

Findings Regarding Patient C

PERIODIC REVIEW, ASSESSMENT, AND EVOLVING TREATMENT PLAN

144. Dr. Buntin and Dr. Brose disagree regarding whether the standard of care for periodic review and assessment of the course of pain treatment, and adjustment to the treatment plan based on an evaluation of the patient's progress toward treatment objectives, was met for Patient C.

In Dr. Brose's opinion, the treatment met the standard of care because the understood goal of treatment of a long-term patient like Patient C with chronic pain is to help provide a modicum of pain relief so the patient can continue to live his or her life.

In Dr. Buntin's opinion, the plan for treating Patient C's pain was conservative treatment referrals and follow-up clinic appointments for medication refills. The treatment plan did not have stated goals. The patient's response to the pain medication treatment was

not assessed in a meaningful way. The treatment plan did not evolve based on the patient's response to that treatment which included adverse effects to the medication regimen and use of benzodiazepines which would potentiate their effect. In her opinion, the failure to assess and adjust the treatment plan based on the patient's response to treatment constituted an extreme departure from the standard of care.

Over the course of treatment, Patient C's pain regimen progressed from a single opiate with a low MME, to a combination of three opiates with a much higher MME. Patient C remained at this level for a prolonged period of time. The risks of adverse effects and harm to a patient increase with an increase in dosage, with combination of opiates, and with prolonged use. In addition to the combination of three different opioids, Patient C was prescribed other central nervous system acting medications that could potentiate their effects and risks to the patient. The medical records do not reflect any meaningful benefit from treatment in the way of improvement in function, quality of life, or returning to work. The medical records do not reflect adjustments to the treatment plan in light of the lack of progress or benefit. The records do not reflect consideration of weaning the patient from opiates until the l ast reported visit in September 2015. Although oxycodone was discontinued, CURES reflects that it was prescribed again. The medical records do not reflect adequate assessment or adjustment being made when "red flags" arose during the course of treatment, such as the use of multiple pharmacies, obtaining opioids from multiple physicians, the unexpected finding of benzodiazepine in the urine drug screen, a significant psychosocial event leading to the patient's self-increased use of Norco and experiencing physical withdrawal symptoms from running out of the opioid.

Dr. Buntin's testimony is supported by the evidence and is found persuasive. Continuing to prescribe a combination of opioids in combination with other controlled substances, over a prolonged period of time, without adequate periodic review, and assessment of, and adjustment to the treatment plan constituted an extreme departure from the standard of care.

PRESCRIBING WITHOUT MEDICAL INDICATION

145. The experts disagree as to whether Patient C was prescribed dangerous drugs without medical indication.

In Dr. Brose's opinion, the patient's pain and its impact on functioning, quality of life and ability to perform activities of daily living is sufficient medical indication, is sufficient medical indication for the prescribing.

In Dr. Buntin's opinion, Patient C was prescribed dangerous drugs without demonstrated benefit or medical indication. The patient's status, functioning, quality of life, or ability to perform activities of daily living did not progress or improve over the many years of opioid treatment, and at times worsened.

The evidence supports Dr. Buntin's opinion and it is found persuasive. Patient C was prescribed dangerous drugs without medical indication.

EXCESSIVE PRESCRIBING

146. The experts disagree as to whether Patient C was excessively prescribed controlled substances.

In Dr. Brose's opinion, the amounts prescribed to Patient C were in keeping with the standard of care practiced in the community at the time. Dr. Buntin finds them excessive for this patient.

Dr. Buntin's opinion is supported by the evidence and found persuasive. The progress notes do not document the medical basis for the ongoing opiate treatment at such high levels. The records do not reflect consideration of weaning the patient off any opiate until the very end of prolonged treatment at high doses. In view of the risks to this patient from the high doses of opioids, in combination with other controlled substances, and over a prolonged period of time, and the absence of documented medical indication, the prescribing is found to be excessive.

TREATMENT RECORDS

147. The experts disagree whether the records maintained on Patient C met the standard of care for treatment records.

Dr. Brose finds the medical records maintained on Patient C to be accurate and to meet the standard of care as it allowed him to offer his expert opinion on the care and treatment provided to the patient.

Dr. Buntin conducted a thorough review of the records maintained on Patient C, and in her opinion, they were incomplete in their documentation of treatment plan objectives, the patient's controlled substance history and usage, the medical indication for prescribing, the conducting of periodic review of the treatment plan, and documentation of patient progress toward objectives. In her opinion this constitutes an extreme departure from the standard of care.

The evidence establishes that the medical records are deficient in their documentation in the manner identified by Dr. Buntin, and for this reason her opinion is found persuasive. The treatment records maintained on Patient C are incomplete and constitute an extreme departure from the standard of care.

INFORMED CONSENT

148. Respondent may well have obtained verbal consent to treatment from Patient C, but the record does not contain documentation of obtaining informed consent. An

executed opioid agreement is not in evidence and for that reason, it cannot be reviewed. The failure to document informed consent to treatment constitutes a simple departure from the standard of care.

OTHER ALLEGATIONS

149. All factual allegations and allegations of unprofessional conduct in connection to the care and treatment of Patient C not discussed above are found not established by clear and convincing evidence.

Care and Treatment of Patient D

150. Patient D was a 47-year-old woman who was referred to the practice from her primary care physician for acute onset of neck pain associated with a whiplash injury. She was evaluated by Dr. Keller on March 8, 2010. Imaging studies showed a disc bulge at level two of her spine. Dr. Keller diagnosed cervical degenerative disc disease, recurrent with bilateral arm pain. The patient's medications on referral were Percocet as needed, Valium, Restoril,[34] and Marinol[35] for sleep. She had a history of epidural injections by another provider. The treatment plan called for repeat cervical epidural steroid injections, and for patient D to use prescribed medications of Percocet and Valium, use Restoril as a sleep aid, and to discontinue using Marinol. Patient D signed a Pain Center Prescription Agreement.

151. Respondent performed the steroid injections on March 22, 2010. Patient D's condition improved with this treatment.

152. On June 6, 2010, Patient D suffered a work-related injury while working with a client at a care home. Patient D was referred through the workers' compensation system to respondent for an initial pain evaluation.

The initial pain evaluation took place on September 22, 2010. Imaging studies showed a right sided T7-8 disc protrusion pushing on the spinal cord, as well as a disc bulge at T6-7 and a mild disc protrusion at T8-9. Respondent diagnosed a work-related thoracic spine injury due to degenerative disc disease, with significant thoracic back pain and mild myofascial problems.

Respondent listed Patient D's current medications, as prescribed by her primary care physician, as Percocet, Valium, Restoril, Marinol, Aleve and Voltaren Gel. The reasons for these medications were not listed. Respondent's treatment plan included taking Patient D off work for two months, ordering thoracic epidural steroid injections at T7-8, continuing

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[34] Restoril is the trade name for temazepam.

[35] Marinol is the trade name for dronabinol, a cannabis-derivative that is manufactured pharmaceutically.

Restoril, Percocet, and Voltaren Gel, and adding Celebrex and Lidoderm patches. The reasons for these medications was not listed.

Respondent discussed the risks and benefits of each medication he prescribed that visit. Patient D and respondent signed the one-page pain management agreement. Under the terms of this agreement, Patient D agreed to fill her medications at a single pharmacy.

153. On the pain management assessment Patient D completed prior to the consultation, she reported that she had ADHD and depression. Respondent understood from Patient D that she had been prescribed Valium for anxiety and panic attacks. In his pain consultation report, respondent listed under Patient D's psychosocial history: "No history of substance abuse or psychiatry problems. The patient does have reactive depression."

154. Patient D was referred by her primary care physician for a psychological evaluation in connection with her workers' compensation claim. The psychological evaluation, dated October 10, 2010, is contained in Patient D's records.

The evaluator diagnosed Patient D with preexisting conditions of ADHD, generalized anxiety disorder, and borderline personality features. The evaluation reports a history of amphetamine abuse as a teenager, completion of alcohol rehabilitation program approximately 20 years earlier, admitted daily use of marijuana to address pain, ADHD, an anxiety disorder, and using Marinol as an appetite stimulant. Patient D reported having pain-related depression. The evaluator recommended that respondent prescribe Patient D an anti-depressant (Cymbalta) as a possible trial for her symptoms of anxiety and depressed mood. He also recommended cognitive behavior therapy to improve her chronic pain management coping skills.

155. Respondent became Patient D's PTP, and remained her PTP over the course of treatment. Patient D was seen in the practice approximately every one to three months from September 2010 through August 2015[36] for a total of 40 visits. She was seen by respondent as well as Dr. Leung, PA's Redick and Williams, and NP's Kladar, Buescher, Semati, and Dobrov. Each of these providers prescribed controlled substances to Patient D. During this time, Patient D was also prescribed controlled substances by providers outside of the practice.

156. On October 24, 2010, respondent performed the first of 11 interventional procedures he performed on Patient D during her course of treatment. These procedures included thoracic epidural steroid injections at T7-8, bilateral T5-T7 facet medial branch blocks, and right side T5-T7 radiofrequency rhizotomies. The evidence established that respondent obtained and documented informed consent for the each of these procedures.

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[36] The last progress note in evidence appears to be that for August 2015. CURES reflects that prescriptions from the practice were filled into January 2016.

157. CURES reflects that between September 2010 and January 2016 Patient D filled the following prescriptions issued by the practice:

Date	Drug/Strength	Quantity
September 2010	Oxycodone HCL (325/10 mg)	30
October 2010	Oxycodone HCL (325/10 mg)	30
November 2010	Oxycodone HCL (325/10 mg)	30
December 2010	Oxycodone HCL (325/10 mg)	30
April 2011	Oxycodone HCL (325/10 mg)	30
May 9, 2011	Hydrocodone Bitartrate (325/10 mg)	30
May 27, 2011	Hydrocodone Bitartrate (325/10 mg)	30
September 2011	Temazepam 30 mg	30
	Hydrocodone Bitartrate (325/10 mg)	60
October 2011	Hydrocodone Bitartrate (325/10 mg)	60
November 2011	Temazepam 30 mg	30
December 2011	Temazepam 30 mg	30
	Diazepam 5 mg	90
January 2, 2012	Temazepam 30 mg	30
January 27, 2012	Diazepam 5 mg	60
January 31, 2012	Diazepam 5 mg	90
February 2012	Hydrocodone Bitartrate (325/10 mg)	30
	Temazepam 30 mg	30
March 2012	Temazepam 30 mg	30
April 2012	Diazepam 5 mg	60
	Temazepam 30 mg	30
May 2012	Temazepam 30 mg	30
June 2012	Temazepam 30 mg	30
July 2012	Diazepam 5 mg	60
	Temazepam 30 mg	30

August 2012	Temazepam 30 mg	30
September 2012	Diazepam 10 mg	60
	Temazepam 30 mg	30
October 2012	Temazepam 30 mg	30
November 2012	Hydrocodone Bitartrate (325/10 mg)	30
	Temazepam 30 mg	30
December 12, 2012	Hydrocodone Bitartrate (325/10 mg)	30
December 21, 2012	Diazepam 10 mg	60
December 26, 2012	Temazepam 30 mg	30
December 26, 2012	Temazepam 30 mg	30
January 2013	Diazepam 10 mg	60
	Hydrocodone Bitartrate (325/10 mg)	30
February 2013	Hydrocodone Bitartrate (325/10 mg)	30
March 2013	Diazepam 10 mg	60
April 2013	Hydrocodone Bitartrate (325/10 mg)	30
	Temazepam 30 mg	30
	Diazepam 10 mg	60
May 2013	Temazepam 30 mg	30
	Diazepam 10 mg	60
June 2013	Temazepam 30 mg	30
July 2013	Temazepam 30 mg	30
	Diazepam 10 mg	60
August 2013	Hydrocodone Bitartrate (325/10 mg)	30
	Temazepam 30 mg	30
October 1, 2013	Diazepam 10 mg	60
October 11, 2013	Temazepam 30 mg	30
	Hydrocodone Bitartrate (325/10 mg)	30
October 30, 2013	Diazepam 10 mg	60
November 2013	Hydrocodone Bitartrate (325/10 mg)	60
	Diazepam 10 mg	60
	Temazepam 30 mg	30

December 2013	Hydrocodone Bitartrate (325/10 mg)	90
	Diazepam 10 mg	60
	Temazepam 30 mg	30
January 2014	Hydrocodone Bitartrate (325/10 mg)	90
	Diazepam 10 mg	60
February 2014	Diazepam 10 mg	60
	Hydrocodone Bitartrate (325/10 mg)	90
	Temazepam 30 mg	30
March 2014	Diazepam 10 mg	60
April 2014	Hydrocodone Bitartrate (325/10 mg)	90
May 2014	Diazepam 10 mg	60
	Temazepam 30 mg	30
June 2014	Hydrocodone Bitartrate (325/10 mg)	90
	Diazepam 10 mg	60
	Temazepam 30 mg	30
July 2014	Hydrocodone Bitartrate (325/10 mg)	90
	Diazepam 10 mg	60
August 2014	Oxycodone HCL (325/10 mg)	110
	Diazepam 10 mg	60
	Temazepam 30 mg	30
September 2014	Oxycodone HCL (325/10 mg)	110
	Diazepam 10 mg	60
	Temazepam 30 mg	30
October 2014	Oxycodone HCL (325/10 mg)	110
November 2014	Hydrocodone Bitartrate (325/10 mg)	100
	Diazepam 10 mg	60
	Temazepam 30 mg	30
December 2014	Hydrocodone Bitartrate (325/10 mg)	90
	Diazepam 10 mg	60
	Temazepam 30 mg	30

January 2015	Hydrocodone Bitartrate (325/10 mg)	90
	Diazepam 10 mg	60
	Temazepam 30 mg	30
February 2015	Hydrocodone Bitartrate (325/10 mg)	90
	Diazepam 10 mg	60
March 2015	Hydrocodone Bitartrate (325/10 mg)	90
	Diazepam 10 mg	60
April 2015	Hydrocodone Bitartrate (325/10 mg)	90
	Carisoprodol 350 mg	60
	Temazepam 30 mg	30
May 2015	Hydrocodone Bitartrate (325/10 mg)	90
	Carisoprodol 350 mg	60
June 2015	Hydrocodone Bitartrate (325/10 mg)	90
	Carisoprodol 350 mg	60
	Temazepam 30 mg	30
August 2015	Hydrocodone Bitartrate (325/10 mg)	90
	Temazepam 30 mg	30
	Diazepam 10 mg	60
September 2015	Hydrocodone Bitartrate (325/10 mg)	60
	Diazepam 10 mg	30
November 2015	Hydrocodone Bitartrate (325/10 mg)	90
	Diazepam 10 mg	60
	Temazepam 30 mg	30
December 2015	Tramadol HCL 50 mg	90
	Temazepam 30 mg	30
	Diazepam 10 mg	60
	Belsomra 20 mg	30
January 2016	Hydrocodone Bitartrate (325/10 mg)	80
	Temazepam 30 mg	30
	Diazepam 10 mg	30

158. Respondent issued 63 prescriptions that were filled by Patient D in the following months: September, October, November and December 2010; April, September, October, November and December 2011, every month in 2012, January, April, July, August, November and December 2013; January, February, March, June, July, September, October,

and December 2014; and, January, March, April, May, and December 2015. Respondent supervised the practitioners who issued the prescriptions filled in the months of June, August, September, and November 2015, and January 2016.

159. Over the course of treatment, Patient D was prescribed on a regular basis a combination of opioids, benzodiazepines, and central-nervous system acting medications. Patient D was prescribed hydrocodone, oxycodone, Valium, and Restoril, as well as anti-depressants, anti-seizure medications, muscle relaxants, hypnotics, Marinol and NSAID's. She was prescribed antacids for opioid-related gastroesophageal reflux.

160. On referral, Patient D's MME's were 15 mg per day based on the medications prescribed by her primary care physician. During the course of treatment, they rose to approximately 60 mg per day. The MME's were 30 mg per day in January 2016 when Patient B transitioned care.

161. Over the course of treatment, Patient D was regularly prescribed diazepam and temazepam by providers outside of the practice in addition to that prescribed by the practice.

162. Over the course of her treatment, Patient D was prescribed medications by respondent and other providers in the practice on a preprinted prescription form that was filled through an in-house pharmacy, as well as controlled substances filled in commercial pharmacies. Some of the preprinted prescription forms are unintelligible. Some are not complete in that they do not list all required information. The medical records maintained on Patient D do not completely document the medications filled through the in-house pharmacy. The medical records do not completely document medications refilled at commercial pharmacies. The medical records maintained do not completely document the medications prescribed by outside providers. The medical records do not completely document the medications taken by Patient D.

163. In 2015, Patient D utilized three pharmacies to fill prescriptions for controlled substances, which was a violation of the opioid agreement she signed. The medical records do not reflect that this violation was acted upon by the practice.

164. During the course of five years of treatment, CURES reports were not obtained. Urine drug screens were obtained in June 2012 and in March 2013.

The June 2012 urine drug screen reported two unexpected results. It did not detect hydrocodone, but it did detect THC, which is a violation of the pain management agreement. Subsequent progress notes do not reflect an assessment of these urine drug screen results.

The March 2013 screen was negative for opioids. The progress note for April 2013 progress note reflects the results of this urine drug screen, but does not reflect an assessment regarding them, or a change in the treatment plan.

165. Respondent examined Patient D on February 27, 2014. This visit followed a thoracic radiofrequency rhizotomy procedure that had been performed by respondent in January. Patient D reported that the previous thoracic radiofrequency rhizotomy procedure she had resulted in six months of reduced pain and increased functioning. From this thoracic radiofrequency rhizotomy and ongoing aqua therapy, Patient D reported she had "continued improvement in her pain and functioning." With respect to activities of daily living, the report reflects: "She reports pain after RFR has significantly decreased and she slowly is increasing activities of daily living." The history section contains the following language which is repeated in many of the progress notes:

> Patient reports the benefit of chronic pain medication maintenance regime, activity restriction, and rest to continue to keep pain at management level to allow [patient] to complete necessary activities of daily living.

The progress note does not provide any detail regarding her improved function and ability to increase activities of daily living.

The treatment plan was to continue conservative treatment measures, prescribe Norco, Valium, temazepam (Restoril), and Gabapentin 30 mg (#30), as needed. The progress note specified that Valium was for spasm, and Restoril was for insomnia due to back pain. It did not specify the medical indication for Gabapentin, which was a new medication for Patient D. The treatment plan contained the following language frequently repeated in progress notes:

> Chronic pain medication regime benefit includes reduction in pain, increased activity tolerance, and restoration of partial overall functioning. Chronic pain medication regime is and result continue to keep pain within management level allowing [patient] to complete the necessary activities of daily living.

166. Patient D continued on the same medication regime following the February 2014 visit.

167. On August 11, 2014, Patient D reported having diffuse body pain, including chronic thoracic back pain. The patient reported that her overall pain generally interfered with her activities of daily living, but the note did not provide specifics. The treatment plan was to continue the same conservative treatment measures, continue all medications previously prescribed; discontinue Norco, and start Percocet 10/325 mg, three to four per day, as needed. The medical indication for Percocet was not listed.[37]

[37] Percocet was discontinued and replaced with Norco in November 2014 because Patient D reported side effects of feeling "too wired."

168. A Drug Utilization Assessment was conducted in connection with Patient D's workers' compensation claim. The report, issued January 8, 2015, reviewed Patient D's medications which included Norco, temazepam, diazepam, and topical NSAID's. The reviewer found it "unclear" from the medical records submitted if Patient D had a current diagnosis requiring routine opioid therapy. The recommendation was to initiate a gradual taper and if possible to discontinue. With respect to temazepam and diazepam, the recommendation was to discontinue the long-term use of the benzodiazepines because of their adverse effects of sedation, tolerance and dependence, and to substitute an alternative for treating insomnia and for acting as a muscle relaxant.

169. Respondent examined Patient D on April 22, 2015. This visit followed a thoracic radiofrequency rhizotomy procedure that had been performed by respondent in February. Patient D reported she was continuing to have 70 percent relief in pain from the procedure. She reported with medication, her pain was five out of 10, and without medication, it was 8 out of 10. At this visit respondent added Soma 350 mg (# 60) to the medication regime. The reason for prescribing this controlled substance was not documented in the progress note.

170. Respondent examined Patient D on May 21, 2015. The progress note states that Patient D reported having no pain that day, and that when she had pain, it was intermittent. The note does not specify what activity triggered the intermittent pain. The note does not reflect how much Norco the patient was taking for pain, or how much Restoril the patient was taking for insomnia. Under activities of daily living, the progress note reflects the patient having overall pain that generally interferes with daily activities and overall function. The specifics of the interference are not documented. The treatment plan was to continue conservative treatment measures, continue with all previously prescribed medications, and prescribe Norco (#90) and Soma (#60).

Respondent's Testimony

171. Respondent discussed with Patient D any new medication's risks, benefits, and alternatives, provided her with instructional sheets on the medications, and obtained her verbal consent to treatment.

172. Respondent testified that he reviewed the psychological report, discussed its findings with Patient D, and that they came to a "mutual understanding." The progress notes do not reflect this conversation. In respondent's view, Patient D did not have a history of psychiatric problems. He took into consideration that with her history she would be more prone to problems with long-term opioid use, but he did not believe that she required closer monitoring than any other patient.

173. Respondent explained that he was not concerned by Patient D's urine drug screens results. With respect to THC, he believed the patient has been prescribed Marinol in the past. With respect to the absence of opioids, she was on hydrocodone as needed, and it

would appear that she either did not need to take it at that time, or was using less than one pill per day which would not necessarily show in a drug screen.

174. Respondent explained that he does not change the amount of pain medications after an interventional procedure where the patient reports a reduction in pain because he never knows how long the patient will benefit from an interventional treatment. He expected the patient to cut back usage by herself. With respect to temazepam, he continued to prescribe it as needed for a sleep aid even though he had not assessed ongoing problems with sleep. Gabapentin was prescribed as a neuropathic for nerve pain. Although it was not documented that she had such pain, he knew that she had it because of her complaint of pain radiating down her back.

175. Respondent explained he prescribed Soma in April 2015, because he believed the patient was having muscle spasms. His progress note listed Valium as being prescribed for muscle spasms. Respondent testified that Valium was given for anxiety and panic disorder, but that is not documented as the medical indication for Valium in the progress note.

176. In respondent's opinion, his care and treatment of Patient D met the standard of care in all respects, and his prescribing was not excessive for the chronic pain of this patient. In his opinion, his medical records are accurate and sufficient for a pain specialist to review and understand that he is prescribing medications based on the pain associated with the patient's conditions.

Findings Regarding Patient D

PERIODIC REVIEW, ASSESSMENT, AND EVOLVING TREATMENT PLAN

177. Dr. Buntin and Dr. Brose disagree regarding whether the standard of care for periodic review and assessment of the course of pain treatment, and adjustment to the treatment plan based on an evaluation of the patient's progress toward treatment objectives, was met for Patient D. In Dr. Brose's opinion, the standard of care was met.

Dr. Buntin does not agree. In her opinion, a treatment plan with specific goals was not established for this patient who had psychological conditions that warranted consideration in establishing them. She finds the progress notes to be repetitive in the treatment plan of conservative treatment, referrals, medication refills, and follow-up appointments. The treatment plan did not have stated goals. The effectiveness of the treatment by prescribing a combination of opioids, benzodiazepines, hypnotics, and muscle relaxants over a prolonged period of time was not periodically reviewed and assessed. The treatment plan did not change when the patient reported benefit from interventional treatment. There was no meaningful assessment of how her functioning and activities were impacted by pain and treatment. Notwithstanding her many years of usage of opiates for her ongoing condition, and without documented benefit, consideration of weaning Patient D from opiates was not made. The records do not reflect adequate consideration of the red flags

for abuse, including her use of multiple pharmacies, infrequent appointments, multiple providers of benzodiazepines, and most importantly the risks from treatment associated with Patient D's psychological history.

The evidence supports Dr. Buntin's opinion and it is found persuasive. The absence of stated treatment goals, ongoing periodic review and assessment of progress toward goals, and an evolving treatment plan constituted an extreme departure from the standard of care for prescribing controlled substances.

PRESCRIBING WITHOUT MEDICAL INDICATION

178. The experts disagree as to whether Patient D was prescribed dangerous drugs without medical indication.

In Dr. Brose's opinion, the patient's pain and its impact on functioning, quality of life and ability to perform activities of daily living is sufficient medical indication, is sufficient medical indication for the prescribing.

Dr. Buntin opined that respondent prescribed dangerous drugs to Patient D without medical indication. The reason for ongoing opiate and benzodiazepine use over so many years was not indicated. And although Dr. Buntin did not rely on it, the conclusion of the drug utilization reviewer supports her opinion. The evidence supports Dr. Buntin's opinion and it is found persuasive. Patient D was prescribed dangerous drugs without medical indication.

EXCESSIVE PRESCRIBING

179. The experts disagree whether Patient D was excessively prescribed controlled substances. In Dr. Brose's opinion, the amounts prescribed to Patient D were in keeping with the standard practiced in the community at the time. Dr. Buntin finds them excessive for this patient.

Dr. Buntin's opinion is supported by the evidence and is found persuasive. In light of the risk of harm posed to the patient from long-term opioid use in combination with benzodiazepines, and in the absence of medical indication for it, the prescribing is found to be excessive.

TREATMENT RECORDS

180. The experts disagree as to whether the records maintained on Patient D were accurate and met the standard of care. Dr. Brose finds the medical records maintained on Patient D to be accurate, and to meet the standard of care at the time of treatment as it allowed him to offer his expert opinion on the care and treatment provided to the patient.

Dr. Buntin conducted a thorough review of the records maintained on Patient D, and in her opinion, they were incomplete in the documentation of treatment plan objectives, the patient's controlled substance history and usage, the medical indication for prescribing, periodic review of the treatment plan, and documentation of patient progress toward objectives. In her opinion this constitutes an extreme departure from the standard of care.

The evidence establishes that the medical records are deficient in their documentation, and for this reason, the opinion of Dr. Buntin is found persuasive. The treatment records maintained on Patient D are incomplete, and constitute an extreme departure from the standard of care.

INFORMED CONSENT

181. Respondent credibly testified that informed consent was verbally obtained from Patient D, but the standard of care requires documentation of obtaining informed consent. This documentation is not contained in the medical records. The pain management agreement signed in 2010 is not sufficient to evidence an ongoing discussion with the patient about the risks, benefits and alternatives to the many controlled substances prescribed over the course of treatment. The failure to adequately document obtaining informed consent for treatment is a simple departure from the standard of care.

OTHER ALLEGATIONS

182. All factual allegations and allegations of unprofessional conduct in connection to the care and treatment of Patient D not discussed above are found not established by clear and convincing evidence.

Care and Treatment of Patient E

183. Patient E was a 50-year-old man who incurred a work-related lumbar spine injury in September 2006. He was taken off work in November 2006 due to pain.

184. Patient E was referred to respondent for a pain consultation that was conducted on January 28, 2008. Patient E complained of low back pain and bilateral leg pain, for which he was taking Aleve. Respondent assessed degenerative disc disease at multiple levels, with the L4-5 and L5-S1 being the most severe, and indications of sacroiliac dysfunction. Respondent's treatment plan was to continue conservative measures; arrange for a series of epidural steroid injections; reassess in the future for sacroiliac joint injections; and prescribe medications of Ultracet, Neurontin, Mobic, and Pepcid for GI irritation. Patient E signed a Patient Center Prescribing Agreement written in Spanish at that visit.

185. Patient E continued in care with the practice in 2008. There was a gap in care from 2009 to April 2010. In November 2009, Patient E underwent L4 to S1 laminectomies and posterior interbody and lateral fusion by Eldan Eichbaum, M.D.

186. Dr. Eichbaum referred Patient E to respondent for a pain consultation that was conducted on April 28, 2010. Imaging studies showed stable post-operative L4-5 and L5-S fusion with hardware. Patient E reported having significant residual low back pain and bilateral leg pain since the lumbar fusion surgery. He was taking oxycodone up to 7 pills per day and Neurontin 300 mg, two tablets, three times per day, and reported his pain improved with pain medications. Patient E had undergone physical therapy and was using a TENS unit with some benefit. Respondent assessed failed low back "syndrome" with multifactorial pain. The treatment plan was to continue with conservative treatment (physical rehabilitation); and prescribe Percocet, Neurontin, and Prilosec for gastric protection. Patient E signed a new medication agreement at that visit.

187. Patient E had appointments in the practice approximately every 30 to 90 days. He was treated by nine providers: respondent, Dr. Evans, Dr. Leung, Dr. Yang, PA's Chavez and Boone, and NP's Kladar, Buescher, and Dobrov.

188. CURES reflects that from May 2010 to January 2013, respondent issued 21 of the prescriptions of controlled substances issued by the practice. These include prescriptions for Percocet, Vicodin, and tramadol.[38] Respondent issued prescriptions that were filled by Patient E in; October 2010; October, November and December 2012; October and November 2013; January, February, March, April, June, and October 2014; February, March, April July, and September 2015; and January 2016. Respondent was the only supervisor of NP's who issued 14 prescriptions for controlled substances filled in May, June, July, September, October, November and December 2015, and January 2016.

189. In addition to Vicodin, Percocet and tramadol, over the course of his treatment Patient E was also prescribed Flexeril, Neurontin and Mobic, as well as medications for GI issues and constipation associated with his pain medications.[39]

190. During the course of treatment, the MME's of the opioids prescribed to Patient E ranged from 60 to 90 mg per day. The patient records do not contain MME calculations.

191. Over the course of treatment, one urine drug screen was obtained in February 2011, and one CURES report was obtained on December 30, 2013. The urine drug screen reported inconsistent results. The declared medication was Percocet, but oxycodone was not detected. THC was not declared, but detected. The patient records do not reflect consultation with the patient regarding the inconsistent findings, or that a follow-up urine drug screen was performed.

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[38] Tramadol has a trade name of Ultram. It is an opioid agonist of the morphine type that is indicated for the management of moderate to severe pain. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057. It is a dangerous drug as defined by Business and Professions Code section 4022.

[39] The record does not reflect that Patient E was prescribed either Valium or Restoril as alleged.

192. Respondent performed numerous interventional procedures on Patient E including a spinal cord stimulator trial, which failed. Informed consent for the procedures was obtained and documented in the patient records maintained where the procedures were performed. It was not established that respondent failed to disclose his financial interests in North Coast Surgery Center as alleged.

193. Respondent examined Patient E on October 12, 2012. Patient E's chief complaints were reported as lower back pain and pain in the back of both legs. His VAS was reported as two to three, with pain worse in cold temperature. Patient E reported he was unable to work because of pain. The progress note reflects that Patient E's pain interfered "a lot" with work, concentration, mood, sleep patterns, and overall functions. The details of the interference were not further specified. The treatment plan called for: continuing with conservative therapy; reviewing home exercise program; scheduling a therapeutic injection (a spinal cord stimulator trial); continuing with medications of Flexeril, Neurontin, and tramadol; and adding Vicodin (#60). The reason for Vicodin was not documented. The home exercise program was not documented.

194. Respondent saw Patient E on October 29, 2012. The spinal cord stimulator trial had been unsuccessful, and the stimulator had been removed. The patient reported a VAS of six to seven. The progress note does not reflect the reason for Patient E's increased pain. The progress note reflects that the patient's functioning, quality of life, and daily activities were down, but the specifics were not documented. Current medications were listed as Flexeril, Ultram, Neurontin, Vicodin and Prilosec. Dosages and instructions were not listed. The treatment plan called for: continuing with conservative therapy; reviewing home exercise program; and, "same meds."

195. Respondent saw the patient with other providers, or collaborated with other providers regarding the care and treatment of Patient E through 2014. Respondent personally examined the patient on November 29, 2014. At that visit, the chief complaint of back pain and recurring leg pain remained the same, and there were no new complaints. In the interval history, Patient E reported his pain as seven to eight without medication, and one to two with medication. The note reflected the following language, which is frequently utilized in the progress notes:

> Patient reports the benefit of chronic pain medication maintenance regime, activity restriction, and rest continue to keep pain within a manageable level to allow [patient] to complete necessary activities of daily living, such as walking, standing, shopping, and light household chores.

The progress note reflects Patient E's medications were: Norco, four per day for pain; tramadol 50 mg, one every four hours for pain; Gabapentin, one tablet, three times a day, Senna for constipation, and omeprazole for stomach upset secondary to medications. The patient reported three medication side effects: constipation, GI discomfort, and nausea. The treatment plan was: continue conservative measures; request an interventional

procedure; and, prescribing Vicodin 300/10 mg (#90), one tablet, three times per day, and Ultram 50 mg (#180). The progress note does not document how often Patient E was taking Ultram or Vicodin. The listing of Norco as a medication was an error.

196. Respondent saw Patient E on July 23, 2015. At this visit, the patient's chief complaint was the same. In the interval section of the progress note, it is written that Patient E reported his pain as zero with medication, and seven to eight without medication. The progress note documented that Patient E was able to perform necessary activities of daily living, including walking, shopping and light household chores. Patient E reported that he was volunteering in his community since his home burned down, and that he found that work rewarding, although the activity can flare his pain. Under activities of daily living, the progress note reflected this language, which is frequently recited in the progress notes:

> Patient reports that pain mildly to moderately interferes with relationships, mood, sleeping patterns, work/concentration, and his overall functioning with his current treatment regime.

The details of this mild to moderate interference is not specified. The treatment plan was to continue conservative treatment, and to prescribe Norco 10/325 mg (#120), 1 tablet four times per day as needed for "severe pain."

197. The patient was seen by NP Buescher on August 20, 2015. Respondent signed the progress note and wrote the prescriptions for this visit, meaning that he was also present during the examination. Patient E reported his pain was zero to three with medication, and six to eight without medication. The note indicated he was able to perform necessary activities of daily living, including walking, shopping and light household chores. The treatment plan was to continue conservative treatment; and prescribe Norco (#120), 1 tablet, four times per day as needed for pain, Ultram (#120), 1 tablet four times per day as needed for pain, and Gabapentin (#90).

198. The medical records maintained on Patient E do not adequately document the medications prescribed to Patient E. The medical records do not adequately document the amounts of medications dispensed to Patient E, either from the in-house pharmacy or from outside pharmacies. The medical records do not document Patient E's daily use of controlled substances.

199. The medical records maintained on Patient E do not document a treatment plan with specific goals. The medical records do not reflect assessment of treatment goals.

200. The medical records do not document that informed consent was obtained from Patient E with respect to the controlled substances that were prescribed.

201. From 2013 to 2015 there was ongoing utilization review by Workers' Compensation medical reviewers about Patient E's medication treatment. The medical reviewer determined in December 2013 that continued use of hydrocodone was not

supported by the medical documentation, and that weaning should be initiated. CURES reflect that Vicodin continued to be prescribed in the same amount to Patient E.

Respondent's Testimony

202. Patient E remains respondent's patient.

203. Respondent explained that home exercises for his patients are recommended at the first patient visit in order to maintain baseline function. The specifics are not documented because they are not relevant to the treatment plan.

204. Respondent does not inquire about the amount of "as needed" pain medications taken by his patients, or whether the patient has medication remaining before refilling pain medication. Respondent does not reduce or reassess the amount of pain medication he prescribes when the patient reports having no pain while on medications. In his opinion, pain is dynamic and his goal is to keep the patient stabilized.

205. In respondent's opinion, his care and treatment of Patient E met the standard of care in all respects, and his prescribing was not excessive for the chronic pain of this patient. He believes that his records are accurate and sufficient for a pain specialist to review and understand that he is prescribing medications based on the pain associated with the patient's conditions.

Findings Regarding Patient E

PERIODIC REVIEW, ASSESSMENT, AND EVOLVING TREATMENT PLAN

206. Dr. Buntin's undisputed opinion is that the standard of care for periodic review and assessment of the course of pain treatment, and adjustment to the treatment plan based on an evaluation of the patient's progress toward treatment objectives, was not met for Patient E. Dr. Buntin finds no stated treatment goals, no ongoing assessment of treatment in relation to the goals, and no adjustment to the treatment plan in response to assessment. There are some red flags in the record, such as the unexpected findings in the urine drug screen. Those findings were not explored. Dr. Buntin does not see any meaningful progress to Patient E from the ongoing opioid treatment.

Dr. Buntin's opinion is supported by the evidence and is found persuasive. Continuing to prescribe controlled substances without adequate periodic review, and assessment of, and adjustment to the treatment plan constituted an extreme departure from the standard of care.

PRESCRIBING WITHOUT MEDICAL INDICATION

207. Dr. Buntin's undisputed opinion is that there is insufficient medical indication for the continued prescribing of dangerous drugs to Patient E. The evidence established that

treatment records failed to specify the treatment rationale for the long-term use of opioids for this patient. And although it was not relied on by Dr. Buntin, as of 2013 the workers' compensation reviewers were critical of the lack of medical documentation for the continued use of hydrocodone. Dr. Buntin's opinion is supported by the evidence and is persuasive. The evidence establishes that Patient E was prescribed dangerous drugs without medical indication.

EXCESSIVE PRESCRIBING

208. Dr. Buntin's undisputed opinion is that controlled substances were excessively prescribed to Patient E. Dr. Buntin's opinion is supported by the evidence and is found persuasive. In light of the risk of harm posed to the patient from long-term opioid use and in the absence of medical indication for it, the prescribing is found to be excessive.

TREATMENT RECORDS

209. Dr. Buntin's undisputed opinion is that the records maintained on Patient E were incomplete and are an extreme departure from the standard of care. In her opinion, they were incomplete in their documentation of treatment plan objectives, the patient's controlled substance history and usage, the medical indication for prescribing, periodic review of the treatment plan, and documentation of the patient's progress toward objectives.

The evidence supports Dr. Buntin's opinion that the medical records are deficient in their documentation, and for this reason, the opinion of Dr. Buntin is found persuasive. The treatment records maintained on Patient E are incomplete, and constitute an extreme departure from the standard of care.

INFORMED CONSENT

210. Respondent may have obtained verbal consent to treatment, but the standard of care also requires that informed consent be documented in the patient's records. Informed consent was not sufficiently documented across the course of treatment. The failure to document informed consent to treatment is a simple departure from the standard of care.

OTHER ALLEGATIONS

211. All factual allegations and allegations of unprofessional conduct in connection to the care and treatment of Patient E not discussed above are found not established by clear and convincing evidence.

Care and Treatment of Patient F

212. Patient F was a 26-year-old man who received a work-related injury on May 22, 2007. In September 2009, Patient F underwent back surgery, an L4-5 and L5-S1

discectomy. Patient F had persistent back pain and left sciatica post surgery and was not able to return to work.

213. Patient F was referred to respondent by his surgeon for evaluation of back and leg pain post surgery. Dr. Keller performed the initial consultation on June 14, 2010. Patient F reported that the surgery greatly relieved his sciatica pain but he continued to have back discomfort and had not been able to return to work. He described the pain as aching, excruciating, sharp, and present 24 hours a day. The patient reported he was taking oxycodone hydrochloride 30 mg for pain, and Valium 10 mg.

Dr. Keller's impression was failed back surgery with persistent left sciatica. The treatment plan was to schedule lumbar facet blocks, and lumbar epidural steroid injections. Patient F was provided with ibuprofen, Prilosec, Robaxin and Zanaflex. Schedule II medications were requested by the patient, but were not provided as a transfer of care to respondent had not been arranged. Patient F signed the one-page Pain Center Prescribing Agreement on June 14, 2010.

214. Respondent became Patient F's PTP, and first evaluated Patient F on July 21, 2010. The treatment note is difficult to read. The patient's chief complaint was left lower back pain. The patient reported no interference with family relationships, some interference with mood and sleep, and a lot of interference with work/concentration and overall functioning. Objective findings were normal. The treatment plan was continued conservative treatment with exercise, stretching, ice and heat; diagnostic medial branch facet injections; and prescribing oxycodone 30 mg (#120), Klonopin 0.5 mg (#10), Robaxin, Motrin, Lidoderm patches, and Prilosec. The progress note does not contain treatment goals or the medical indication for the medications prescribed, including Klonopin.

215. Patient F was followed in the practice every 30 to 90 days from July 2010 to March 2015. He was seen in the practice 59 times. Medical reports reflect he was examined by respondent, Dr. Leung, Dr. Evans, Dr. Yang, Dr. Keller, PA Redick, and NP's Kladar, Williams and Semati.

216. Respondent performed numerous procedures on Patient F, including left L4-L5 sacra ala and S1 medial branch facet injections (2010 and 2013), left L5-S1 transforaminal steroid injections (2012 and 2013) and bilateral sacroiliac joint injections (2014). Informed consent for these procedures was obtained and documented. It was not established that respondent failed to disclose his financial interests in North Coast Surgery Center as alleged.

217. Over the course of treatment with the practice, Patient F was prescribed a combination of opioids in high doses in combination with a benzodiazepine. Patient F was also prescribed muscle relaxants, hypnotics and NSAID's, as well as antacids for opioid related GERD. The medical records do not provide for a determination of the amounts of all medications prescribed to Patient F, the amounts of medications obtained by Patient F, or the amounts of medications taken by Patient F over the course of treatment.

218. CURES reflects that Patient F filled the following prescriptions, issued from the practice, from July 2010 to March 2015:

Date	Drug/Strength	Quantity
July 2010	Oxycodone HCL 30 mg	120
	Clonazepam .5 mg	10
August 2010	Oxycodone HCL 30 mg	120
	Clonazepam .5 mg	15
September 2010	Oxycodone HCL 30 mg	120
	Clonazepam .5 mg	15
October 2010	Oxycodone HCL 30 mg	120
	Clonazepam .5 mg	30
November 2010	Oxycodone HCL 30 mg	90
	Methadone HCL 5 mg	90
December 2010	Oxycodone HCL 30 mg	60
	Methadone HCL 5 mg	120
January 2011	Oxycodone HCL 15 mg	120
	Methadone HCL 10 mg	90
February 2011	Oxycodone HCL 30 mg	60
	Methadone HCL 10 mg	120
March 2011	Oxycodone HCL 15 mg	120
	Methadone HCL 10 mg	120
April 2011	Oxycodone HCL 30 mg	60
	Methadone HCL 10 mg	120
August 2011	Oxycodone HCL 30 mg	60
	Methadone HCL 10 mg	120
September 2011	Oxycodone HCL 30 mg	60
	Methadone HCL 10 mg	120
October 2011	Oxycodone HCL 30 mg	60
	Methadone HCL 10 mg	120

December 2011	Oxycodone HCL 30 mg	60
	Methadone HCL 10 mg	120
January 2012	Oxycodone HCL 30 mg	60
	Methadone HCL 10 mg	120
February 2012	Oxycodone HCL 30 mg	60
	Methadone HCL 10 mg	120
March 2012	Oxycodone HCL 30 mg	90
	Methadone HCL 10 mg	120
April 2012	Oxycodone HCL 30 mg	90
	Methadone HCL 10 mg	120
May 2012	Oxycodone HCL 30 mg	90
	Methadone HCL 10 mg	120
June 2012	Oxycodone HCL 30 mg	90
	Methadone HCL 10 mg	120
July 2012	Oxycodone HCL 30 mg	90
	Methadone HCL 10 mg	120
August 1, 2012	Oxycodone HCL 30 mg	90
	Methadone HCL 10 mg	120
August 31, 2012	Oxycodone HCL 30 mg	90
	Methadone HCL 10 mg	120
September 2012	Oxycodone HCL 30 mg	30
October 4, 2012	Oxycodone HCL 30 mg	90
	Methadone HCL 10 mg	120
October 30, 2012	Oxycodone HCL 30 mg	90
	Methadone HCL 10 mg	120
November 2012	Oxycodone HCL 30 mg	90
	Methadone HCL 10 mg	120
December 2012	Oxycodone HCL 30 mg	90
	Methadone HCL 10 mg	120
January 2013	Oxycodone HCL 30 mg	90
	Methadone HCL 10 mg	120

February 2013	Oxycodone HCL 30 mg	120
	Methadone HCL 10 mg	120
March 2013	Oxycodone HCL 30 mg	120
	Methadone HCL 10 mg	120
April 2013	Oxycodone HCL 30 mg	120
	Methadone HCL 10 mg	120
May 2013	Oxycodone HCL 30 mg	120
	Methadone HCL 10 mg	120
June 2013	Oxycodone HCL 30 mg	120
	Methadone HCL 10 mg	120
	Clonazepam 0.5 mg	60
July 2013	Oxycodone HCL 30 mg	120
	Methadone HCL 10 mg	120
	Clonazepam 0.5 mg	60
August 2013	Oxycodone HCL 30 mg	120
	Methadone HCL 10 mg	120
	Clonazepam 0.5 mg	60
September 2013	Oxycodone HCL 30 mg	120
	Methadone HCL 10 mg	120
	Clonazepam 0.5 mg	60
October 2013	Oxycodone HCL 30 mg	120
	Methadone HCL 10 mg	120
	Clonazepam 0.5 mg	20
November 2013	Oxycodone HCL 30 mg	120
	Methadone HCL 10 mg	120
	Clonazepam 0.5 mg	90
December 2013	Oxycodone HCL 30 mg	30
	Methadone HCL 10 mg	120
	Clonazepam 0.5 mg	90
January 6, 2014	Oxycodone HCL 30 mg	120
	Methadone HCL 10 mg	120
	Clonazepam 0.5 mg	90
January 21, 2014	Oxycodone HCL 30 mg	30

February 4, 2014	Oxycodone HCL 30 mg	120
	Methadone HCL 10 mg	120
	Clonazepam 0.5 mg	90
February 19, 2014	Oxycodone HCL 30 mg	56
March 2014	Oxycodone HCL 30 mg	120
	Methadone HCL 10 mg	120
	Clonazepam 0.5 mg	90
April 2014	Oxycodone HCL 30 mg	120
	Methadone HCL 10 mg	120
	Clonazepam 0.5 mg	90
May 2014	Oxycodone HCL 30 mg	120
	Methadone HCL 10 mg	120
	Clonazepam 0.5 mg	90
June 2014	Oxycodone HCL 30 mg	120
	Methadone HCL 10 mg	120
	Clonazepam 0.5 mg	90
July 2014	Oxycodone HCL 30 mg	120
	Methadone HCL 10 mg	120
	Clonazepam 0.5 mg	90
August 2014	Oxycodone HCL 30 mg	120
	Methadone HCL 10 mg	120
	Clonazepam 0.5 mg	90
	Lorazepam 1 mg	10
September 2014	Oxycodone HCL 30 mg	120
	Methadone HCL 10 mg	120
	Lorazepam 1 mg	60
October 2014	Oxycodone HCL 30 mg	120
	Methadone HCL 10 mg	120
	Lorazepam 1 mg	30
November 2014	Oxycodone HCL 30 mg	120
	Methadone HCL 10 mg	120
	Clonazepam 0.5 mg	90
December 2014	Oxycodone HCL 30 mg	120
	Methadone HCL 10 mg	120
	Clonazepam 0.5 mg	90

January 2015	Oxycodone HCL 30 mg	90
	Methadone HCL 10 mg	90
	Clonazepam 0.5 mg	60
February 2015	Oxycodone HCL 30 mg	90
	Methadone HCL 10 mg	90
	Clonazepam 0.5 mg	75
March 2015	Oxycodone HCL 30 mg	120
	Methadone HCL 10 mg	90

219. Of the prescriptions for controlled substances issued by the practice, respondent issued 79 of them. Respondent issued prescriptions which were filled by Patient F from July 2010 through November 2011, September 2012 through April 2013, and September 2013 through July 2014. Prescriptions issued to Patient F from August 2014 to March 2015 were issued by NP's Williams and Semati, supervised by respondent. Most, but not all, of these prescriptions were initialed by respondent.

220. The MME's were very high, and ranged from 180 mg per day in July 2010 to 584 mg per day in February 2014. The patient records do not contain MME calculations.

221. During the course of treatment, Patient F obtained controlled substances from three different pharmacies. This was a violation of the opioid agreement. The medical records do not reflect that this violation was identified or assessed.

222. Over the course of treatment, one preliminary urine drug screen was obtained in February 2012. The results were as expected. Treatment plans in March, April, and July 2012 recommended random urine drug screens for Patient F. The same was recommended in treatment plans for March, April, May, June, July and August 2013, and January and February 2014. Not one was performed.

223. Over the course of treatment, one CURES report was obtained in September 2014.

224. On October 14, 2010, Patient F was examined by PA Reddick. Respondent signed the prescriptions for the day, indicating his involvement with the patient at the visit, but that involvement is not indicated on the patient record. Patient F had missed a scheduled appointment for a lumbar steroid injection. He reported that he had self-increased his use of oxycodone to more than four tablets per day, and that he had fully used his prescription three days early. Patient F reported that his pain was worse, at a level of five to seven. He reported that his pain interfered somewhat with his activities of daily living. The treatment plan was to continue conservative treatment; reschedule the injection; refer Patient F to cognitive behavior therapy (CBT) for depression; refill medications, and prescribe oxycodone (#120) and diazepam (#60). The reason for the CBT referral was not documented in the patient's progress note.

Patient F had a transforaminal epidural steroid injection procedure on October 25, 2010. On November 1, 2010, he called the office requesting to consult with respondent and increase his oxycodone to five tablets a day. The patient reported it was urgent to speak with respondent before his scheduled appointment on November 10. Respondent wrote a note to staff with his instructions, not all of which are legible. Respondent indicated he would not increase the dosage of oxycodone because of physical tolerance, but would consider other medications to address pain.

225. At the November 10, 2010 appointment with Dr. Yang, Patient F reported no relief from the injection, and that his pain was seven on the VAS. He described his lower back pain as significant, and he had dull, aching, throbbing, radicular pain into his left calf. Patient F reported he could not do his daily exercises, and his mood, functioning and activities of daily living were all affected by the pain. His family relationships, work, concentration, and sleep patterns were somewhat affected. The only relief for him was oral medications. The treatment plan was: no further interventions; and adjust medications to address pain. Oxycodone 30 mg, was decreased to three times a day. Medications of methadone 5 mg, three times a day, and Flexeril 10 mg, two times per day, were added. Zanaflex was discontinued. Patient F was advised he should not self-increase his oral pain medications without clinic authorization, and upon violation of the pain contract again, he would be subject to discharge from the clinic. Patient F agreed to the plan. The progress note does not reflect follow-up regarding the CBT referral. The progress note does not reflect the medical indication for Flexeril. Respondent issued the prescriptions from this visit, indicating he coordinated Patient F's care with Dr. Yang.

226. At the December 8, 2010 appointment, Patient F reported his pain level was still seven, but had found methadone was more helpful with his pain. The progress note reflected the same language regarding impact on activities of daily living and functioning from the previous appointment. The treatment plan was to decrease oxycodone 30 mg to two times per day and increase methadone 5 mg to four times per day. Neurontin 300 mg, three times a day, was added to the medication regime for "severe" radicular symptoms. Respondent issued the prescriptions for this visit, indicating he coordinated the patient's care with Dr. Yang.

227. The progress note for January 10, 2011, used very similar language to that reflected for the prior two months. The VAS was the same, as was the patient's report on how the pain impacted his activities and functioning. Patient F reported again that the only alleviating factor for his pain was the medications, of which methadone the most effective. The treatment plan was: increase methadone from 5 mg to 10 mg, three times a day; reduce oxycodone from 30 mg to 15 mg, four times a day; and, continue with Motrin, Flexeril, Neurontin and Prilosec.

228. At the next appointment on February 9, 2011, the VAS score was the same, as was the report on how the pain impacted the patient's activities and functioning. The patient reported again that methadone was more effective than oxycodone, which was not that helpful. The treatment plan was: increase methadone 10 mg, from three to four times a day,

and increase oxycodone to 30 mg (#60), twice a day. The "rest of the medications" were continued, but Neurontin was no longer listed as a medication.

229. Over 2012, Patient F's monthly methadone 10 mg prescription remained at four tablets per day. In February and March, he requested an increase in oxycodone, saying that it was more effective and had a quicker onset to reduce his pain than methadone. After conducting a random urine drug screen in February, which had expected results and no evidence of illegal substances, oxycodone 30 mg was increased from two to three tablets per day.

In April 2012, the patient reported his VAS as six. He reported he felt less pain with the higher quantity of oxycodone, and that he felt a sense of security that he would not run out early. Patient F reported that his pain moderately interfered with his relationships and sleep, but significantly interfered with concentration, mood and overall functioning. The treatment plan was to request authorization for Prolotherapy as requested by Patient F for relief from muscle tightness; prescribe methadone and oxycodone at the same levels; and refill Flexeril, Motrin and Prilosec.

In July 2012, Patient F reported his pain as an eight, with most of the pain in his lower back. He reported increased activity in preparing for the birth of his child, including laying floor. He requested an increase in pain medication at the visit, and to repeat L4-S1 transforaminal injections, from which he had relief when last performed in September 2011. The treatment plan was to request authorization for the injections, and to keep medications at the same levels.

Many of the 2012 treatment notes are handwritten and difficult to read. Respondent performed the epidural injections on September 25, 2012, for which he prescribed Patient F oxycodone 30 mg (#60) for pain associated with the treatment. Patient F reported only short-term benefit from the procedure.

In the October 4, 2012 progress note, which was written by another provider but initialed by respondent, the treatment plan noted that Patient F was not due for a refill of oxycodone until October 24, 2012. The patient was told the prescription would be refilled, but that he would not be given another until November 23, 2012. A discussion was held regarding the patient's health, and the patient agreed to "come off meds" within six to seven months, or "at least minimal dose." Respondent issued the prescriptions for methadone and oxycodone from that visit.

230. Respondent examined Patient F on February 27, 2013. Patient F reported that his back pain had been significantly aggravated by taking care of his six-month-old child. A pain score was not documented. The progress note reflects that all of Patient F's activities of daily living, including work, concentration, mood, and sleeping pattern as well as his overall functioning were significantly impacted by his pain. The patient's opioid medications at this time were methadone 10 mg, four tablets a day, and oxycodone 30 mg, three tablets a day. Patient F reported using "at least" one additional oxycodone tablet to cover exacerbations

during the day. The treatment plan for this visit was: bilateral medial branch facet diagnostic injections, and if positive benefit, to be followed with radiofrequency rhizotomy; increase oxycodone to 30 mg, four times a day, and continue with all other medications as prescribed. Patient F was advised that these were "the maximum opiates . . . for his condition and will not be increased over time."

231. The medication regime remained the same in March, April and May 2013. The progress notes do not reflect how Patient F was taking his pain medications. He underwent bilateral L4-S1 medial branch injections on April 23, 2013, which he reported "definitively helped" with his pain.

In May 2013, Patient F reported that his low back pain was at five or six, and that his pain only moderately interfered with his daily activities and functioning. He requested bilateral L4-S1 medial branch radiofrequency rhizotomy for longer term pain relief.

In June 2013, a trial of Klonopin .5 mg (#60) was added to the medication regime at Patient F's request following his report of a "rough month of pain and anxiety." Patient F reported that Klonopin had helped him in the past to sleep and to reduce his anxiety.

In the July 2013 progress note, Patient F's anxiety is not mentioned. Activities of daily living were not reviewed. Patient F reported a pain level of six, with increased lower left lower extremity pain. He requested a lumbar epidural injection. The medication regime, including Klonopin, was continued.

232. Patient F was examined on October 15, 2013. Patient F reported that in addition to pain, he felt his heart was racing like he was having a panic attack. He reported that he had taken Klonopin days earlier and was not finding it helpful with his anxiety. He expressed a willingness to reduce his usage of Klonopin with the goal of eliminating it over the next two months. He reported tingling pain radiating from his lower back, and requested Lyrica. The patient's functioning and activity associated with his pain was not evaluated. The note does not reflect how the patient was using his medications. The treatment plan included prescribing Atenolol for elevated blood pressure, giving a trial sample of Lyrica, continuing with opioids of methadone and oxycodone, reducing Klonopin to one-half to one tablet as needed, and refilling Flexeril, Motrin and Prilosec. Patient F was prescribed pain medications of the same amounts for the remainder of the year.

233. In January 2014, Patient F reported no change in severity or frequency of his pain, and reported that it interfered moderately in his activities of daily living and his overall functioning. He reported that he would be completely incapacitated without pain medications, and because of them he was able to perform "necessary" activities and care for his toddler. The progress note does not reflect how the patient was using his medications. In addition to prescribing medications at the same levels, and requesting further injections, the treatment plan called for six visits with, and an evaluation by, Keith Bridges, Ph.D., for treatment recommendations for pain-induced anxiety, and recommendation for a safe anxiety medication regimen or psychiatric treatment plan.

234. Patient F underwent bilateral sacroiliac injections on January 16, 2014. In his February 4, 2014 visit, Patient F reported having a 40 percent reduction in pain for 10 days, but recent flares. He reported moderate interference with activities of daily living and functioning, and requested an increase in pain medication. The note does not reflect how the Patient F was using his medications. Medications were prescribed at the same level, including methadone 10 mg (#120) and oxycodone 30 mg (#120). The treatment plan called for 20 tablets of Klonopin 0.5 mg, one-half to one tablet, three times per day. The prescription was issued for the visit was for 90 tablets of Klonopin.

235. In a February 19, 2014 visit, Patient F reported again that his medication regimen was not sufficient for his pain. He reported that taking one oxycodone tablet in between taking methadone was not enough, so he was taking two to three tablets at a time for a total of seven to eight tablets a day. He further reported that taking three tablets at a time provided him with four to five hours of pain relief. Patient F also reported that he was taking one tablet of Klonopin per day.

Dr. Evans, in consultation with respondent, counseled Patient F on his overuse of oxycodone, and about the risks of taking methadone with a benzodiazepine. Patient F was advised that if he overused again, he would be taken off opioids. The decision was made not to increase the oxycodone, but to prescribe enough oxycodone to get Patient F to his next appointment (56 tablets). The treatment plan reflected that a urine screen would be performed that day, but the record does not reflect that was one was performed. The treatment plan called for a referral to a surgeon for a back consultation. Consideration of addiction was made. It was determined that Patient F was not addicted, but was overusing because of pain. The note added:

> We will see if we can get it better under control without increasing the opioids.

236. Respondent examined Patient F on March 6, 2014. At this visit, Patient F reported he was taking 3 Klonopin tablets a day, and two to three oxycodone tablets at a time. The patient's pain level was five or six with medications, and 10 without medications. With medication, Patient F reported he was able to take care of his child and perform home chores at times. The record does not reflect any discussion with the patient about the amount of his opioid use, the manner in which he was taking it, or his increased use of the benzodiazepine. The record does not reflect that a urine screen was performed or reviewed. The treatment plan included continuing with all medications.

237. Patient F reported using oxycodone two to three tablets at a time throughout 2014. The progress notes do not mention the previous referral for a psychological evaluation and treatment.

In August, a trial of Lorazepam 1 mg, at night, was started. The indication for Lorazepam was not reported. In September, Patient F reported that Lorazepam was "very

beneficial" and that he would like to discontinue Klonopin. The treatment plan discontinued Klonopin, and started Lorazepam 1 mg (#60), one to two tablets at night.

In October, Lorazepam was reduced to one tablet at night. The progress note does not reflect how Patient F was taking the Lorazepam, or why the amount was reduced.

In November, Lorazepam was discontinued, and Restoril 22.5 mg (#30), one tablet at night, was prescribed. The reason for discontinuing Lorazepam of for starting Restoril was not documented.

In December, Patient F reported that he had increased problems with sleeping and with anxiety. Restoril was discontinued for "bad dreams," and Klonopin (#90) was prescribed for anxiety.

238. Utilization Review Decisions were issued in December 2014 in connection with respondent's request for authorization of methadone 10 mg (#120), oxycodone 30 mg (#120), and Restoril 22.5 (#30). Patient F's MED level was calculated by the reviewer to be 340 mg per day. The reviewer noted that Patient F had been on methadone and oxycodone at least since 2013, without documented functional improvement or improvement in pain as a result of this regime. The reviewer noted that Patient F had been on current long-term benzodiazepine therapy since at least 2013. Long-term use of benzodiazepine put Patient F at risk of dependence without proven efficacy. Long-term benzodiazepine use current with opioids put Patient F at increased risk of morbidity and mortality. For Patient F, the reviewer did not find documented improvement with, or objective evidence of the need for, the ongoing long-term benzodiazepine treatment. The more appropriate treatment for anxiety disorder was an antidepressant. A peer-to-peer consultation was held with respondent, who agreed to start weaning by reducing oxycodone to three tablets a day. Restoril was approved for one refill, in order for respondent to begin weaning Patient F.

239. The practice started to titrate oxycodone and methadone in January 2015, and to titrate Klonopin in February 2015. Patient F indicated his willingness to work with the practice on the titration plan.

240. Patient F's final progress note was dated March 18, 2015. At that appointment, Patient F reported his pain was four to five with medications, and seven to eight without medications. Patient F continued to stay home with his child. He reported his pain somewhat interfered with his activities of daily living. He requested to stop using methadone completely. The treatment plan was to discontinue methadone, but continue with oxycodone, Klonopin, Flexeril and Motrin.

Respondent's Testimony

241. In respondent's opinion, Patient F was a chronic pain patient who could not do anything without pain medication.

242. Respondent was not concerned about Patient F misusing his oxycodone when he ran out of it early in the month, as that is typical of patients in chronic pain, and for that reason he gives the patient leeway to report two or three days early for their as needed medications.

243. Respondent explained that he wrote Patient F one-time prescriptions for oxycodone following interventional treatments because Patient F's pain did not improve from the intervention right away, and the patient usually had pain associated with the procedure. Respondent did not view this as increasing the patient's opiate dose.

244. Respondent was not concerned when Patient F used his oxycodone 30 mg by taking two or three tablets at a time for sleep, rather than taking them over the course of the day as prescribed. Because it was an "as needed" medication, Patient F was allowed to use the medication in that manner.

245. In respondent's opinion, his care and treatment of Patient F met the standard of care in all respects, and his prescribing was not excessive for the chronic pain of this patient. In his opinion, his records are accurate and sufficient for a pain specialist to review and understand that he is prescribing medications based on the pain associated with the patient's conditions.

Findings Regarding Patient F

PERIODIC REVIEW, ASSESSMENT, AND EVOLVING TREATMENT PLAN

246. Dr. Buntin and Dr. Brose disagree as to whether the standard of care for periodic review and assessment of the course of pain treatment, and adjustment to the treatment plan based on an evaluation of the patient's progress toward treatment objectives, was met for Patient F. Dr. Brose opines that the standard of care was met. Dr. Buntin does not agree.

In Dr. Buntin's opinion, a treatment plan with specific goals was not established for this patient who had anxiety as well as pain. She finds the progress notes to be repetitive in the treatment plan of conservative treatment, referrals, medication refills, and follow-up appointments. The effectiveness of the treatment by prescribing a combination of opioids, benzodiazepines, and muscle relaxants over a prolonged period of time was not sufficiently periodically reviewed and assessed. When an assessment and referral was made for a psychological assessment or treatment, there was no follow-up, or coordination of care with such a provider. The documented need for urine screens over three years was not implemented. The treatment plan did not change when the patient reported benefit from interventional treatment. There was no meaningful assessment of how his functioning and activities of daily living were impacted by pain and treatment. The records do not reflect adequate ongoing consideration of the "red flags" for drug abuse, including his self-reported overuse, multiple violations of the opioid contract, requests for early refills, and ongoing requests for increased amounts of short acting opiates. Finally, steps to reduce this patient's

medication regime in light of his prolonged use without demonstrated benefit were not taken until the Utilization Decision was issued, a decision which respondent reportedly agreed with.

The evidence supports Dr. Buntin's opinion and it is found persuasive. The absence of stated treatment goals, ongoing periodic review and assessment of progress toward goals, and an evolving treatment plan was an extreme departure from the standard of care for prescribing controlled substances.

PRESCRIBING WITHOUT MEDICAL INDICATION

247. The experts disagree as to whether Patient F was prescribed dangerous drugs without medical indication. Based on his review of the record, Dr. Brose opines that the medical indication is sufficiently stated in the records. Dr. Buntin however believes that there is insufficient medical indication for the prescribing of opiates in such high doses, over so many years, and for prescribing benzodiazepine in combination with the high doses of opioids for so many years. She does not see patient benefit from the treatment, and sees significant instances of patient tolerance, misuse and abuse. And although Dr. Buntin did not rely on it in forming her opinion, the conclusion of the drug utilization reviewer supports her opinion, as do the medical records. Dr. Buntin's opinion is found persuasive, and is adopted. Patient F was prescribed dangerous drugs without medical indication.

EXCESSIVE PRESCRIBING

248. The experts disagree as to whether Patient F was excessively prescribed controlled substances. In Dr. Brose's opinion, the amounts prescribed to Patient B were in keeping with the standard practiced in the community at the time. Dr. Buntin finds them excessive for the patient.

Dr. Buntin's opinion is supported by the evidence and is found persuasive. In light of the risk of harm posed to the patient from the high doses of opioids prescribed to Patient F over so many years, in combination with benzodiazepine therapy, and in the absence of medical indication for them, the prescribing is found to be excessive.

TREATMENT RECORDS

249. The experts disagree as to whether the records maintained on Patient F were accurate and met the standard of care. Dr. Brose finds the medical records maintained on Patient F to be accurate, and to meet the standard of care as it allowed him to offer his expert opinion on the care and treatment provided to the patient.

In Dr. Buntin's opinion, the records are incomplete in their documentation of treatment plan objectives, the patient's controlled substance history and usage, the medical

indication for prescribing, periodic review of the treatment plan, and documentation of the patient's progress toward objectives.

The evidence establishes that the medical records are deficient in their documentation. For this reason, the opinion of Dr. Buntin is found persuasive. The treatment records maintained on Patient F are incomplete, and constitute an extreme departure from the standard of care.

INFORMED CONSENT

250. Respondent may have obtained verbal consent to treatment, but the standard of care also requires that obtaining informed consent be documented in the patient's records. The failure to document obtaining informed consent across the course of treatment constitutes a simple departure from the standard of care.

OTHER ALLEGATIONS

251. All factual allegations and allegations of unprofessional conduct in connection the care and treatment of Patient F not discussed above are found not established by clear and convincing evidence.

Additional Testimony and Letters of Support

252. Lisa Tran testified at hearing. Since 2004 her duties have involved assisting in the examination room and administrative tasks. She serves as a liaison for the patients with their insurance companies, outside referrals, and imaging centers. She frequently served as the point of contact in the office for the adjustor in the workers' compensation system assigned to the claim. She also served as a "scriber" for medical providers during the office transition to the electronic medical records. As a "scriber" she would type in the dictation provided to her by the practitioner.

253. Minh Tran testified at hearing. He has been the business administrator for the practice since in 2000. His duties have varied over time, but they include recruiting, hiring, training, and supervising staff; implementing policies and procedures from the medical providers; facilitating staff meetings; acquiring and maintaining office equipment and medical equipment, and implementation of office systems. He is responsible for maintaining patient records, and for the transition to an electronic medical record, which was completed in 2012.

254. Matthew Manalac worked as an administrative assistant in the back office of the practice from approximately 2010/2011 to 2015/2016 under the supervision of Minh Tran. Manalac testified at hearing, describing respondent as a warm and good man who cares about his patients. A lot of patients in the practice liked respondent as a physician and said "good things" about him.

255. Alannah Tobias Baechtel has worked for the practice as an administrative assistant since she graduated from high school in 2009. Baechtel testified at hearing, describing respondent as the greatest physician she has ever known, and wishing that all physicians could be like him. Respondent cares about his patients, and takes the time necessary to help each of them.

256. Julia Rodriguez is a certified medical interpreter who has performed translation services in respondent's practice over many years. Rodriguez testified at hearing regarding her observations of respondent with hundreds of patients in the examination room. Rodriquez confirmed that all new patients begin with an evaluation by respondent. Respondent took his time with each patient, often taking longer than the time allotted for the visit. He was compassionate and listened. She observed him discussing risks and benefits with any change in treatment. She observed him to provide thorough instructions, and to confirm with each patient that they understood respondent's instructions. In her opinion, respondent's patients appreciate him.

257. Catherine Louise Flynn is a retired psychiatric technician. Flynn has been respondent's patient since 2004. Flynn testified at hearing and wrote a letter of support at his request. Flynn is very satisfied with respondent's treatment of her pain condition. He has been conservative in his treatment, and she feels safe and comfortable with him. He fully explains the risks, benefits, and alternatives in treatment to her. He has always answered all of her questions.

Following her initial consultation with respondent in 2004, she has had office visits about once a month. She saw other providers in the practice over the years, but always considered respondent to be her physician, and she has been seen by him at least once every six months for some form of treatment. Sometimes respondent has been present in the treatment room when she was being seen by another provider. Respondent was always accessible to her should she need to see him. The other providers knew of respondent's treatment plan, and would consult with respondent about care and treatment.

258. Tammy Mollai Kazemini was a patient of respondent's and wrote a letter of support. She reports that respondent treated her pain condition successfully and to her satisfaction. She has found respondent to be an extraordinary physician and human being.

259. John J. Gallagher is a retired superior court judge who was referred to respondent for treatment in approximately 2004. He has remained social friends with respondent and wrote a letter of support. In his opinion, respondent is an honorable and religious man who holds himself to a high moral and ethical code in his profession and in his community.

260. John P. Williams, D.O., has known respondent in a professional capacity for 15 years and has referred most of his patients needing pain management to respondent. Dr. Williams wrote a letter of support. Dr. Williams respects respondent, has found respondent to provide excellent and compassionate care to his patients, and to be an "irreplaceable asset

to our respective communities, to my patients and to my practice." Dr. Williams is aware of the basic allegations of the accusation, and believes that respondent can "adapt and grow from here."

261. Eric J. Grigsby, M.D., is a pain management specialist who has been a professional colleague of respondent for more than 20 years. Dr. Grigsby wrote a letter of support. Respondent has the professional reputation of being an excellent surgeon. Dr. Grigsby and respondent have shared patients over the years. Dr. Grigsby has found respondent to be kind and good natured in all of his interactions with patients, families, and staff. He believes respondent's knowledge and decision making to be consistent with "the teaching and training of the time." In his view, respondent is "really one of the good guys in medicine in our area, with an old school and personal approach to his patients and colleagues."

262. William Kivett, M.D., is board certified in plastic surgery, facial plastic and reconstructive surgery and dermatology. Dr. Kivett has known respondent professionally for approximately 20 years, referred patients to him, and wrote a letter of support. Dr. Kivett has found respondent to be a genuinely caring and selfless physician, who is dedicated to alleviating pain, suffering and debility over his own self-aggrandizement.

263. Gregory Rosa, M.D., is a board certified family practice physician who has been a colleague of respondent since 1998. Dr. Rosa wrote a letter of support. Dr. Rosa has great confidence in respondent's skill, based on his observations of him as an anesthesiologist, and in the care he has provided to patients Dr. Rosa has referred to him for pain management. He has found respondent to be very conscientious and devoted to his patients. He is not aware of any complaints by his patients regarding care they have received from respondent.

264. Frank Epperson, Jr., is a Roman Catholic priest of the Santa Rosa parish that respondent has attended for approximately seven years. Epperson testified at hearing and wrote a letter of support. Respondent attends mass weekly, is active in the parish, and participates as a medical team member on retreats. Respondent also volunteers his time on medical mission trips to the Philippines. In Epperson's opinion, respondent is an honest, ethical, and moral man.

LEGAL CONCLUSIONS

1. The burden of proof is on complainant to prove the charging allegations by clear and convincing evidence to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856; Evid. Code, § 500.) Clear and convincing evidence requires an evidentiary showing that is more exacting than preponderance of evidence; it requires a finding of high probability. (*In re Angelia P.* (1981) 28 Cal.3d 908, 204; *In re Marriage of Weaver* (1990) 224 Cal.App.3d 478, 486.)

2. Business and Professions Code section 2234 authorizes the Board to impose discipline against a licensee for unprofessional conduct.

Unprofessional conduct is defined to include acts of gross negligence (subd. (b)) and repeated negligent acts (subd. (c)).

Business and Professions Code section 2242, subdivision (a), defines unprofessional conduct to include prescribing dangerous drugs, as defined by Business and Professions Code section 4022, without an appropriate prior examination and a medical indication. "Medical indication" has been defined to mean the existence of symptoms or presence of satisfying evidence suggesting the need to prescribe the use of a dangerous drug. (*Whitlow* v. *Board of Medical Examiners* (1967) 248 Cal.App.2d 478.)

Business and Professions Code section 725, subdivision (a), defines unprofessional conduct to include repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment.

Business and Professions Code section 2266 defines unprofessional conduct to include the failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patient.

Business and Professions Code section 2234 defines unprofessional conduct to include the failure of a physician and surgeon to properly or adequately supervise the prescribing of drugs by a physician assistant or nurse practitioner in violation of Business and Professions Code section 4170.

First Cause for Discipline: Unprofessional Conduct in the Treatment of Patient A

3. Complainant established by clear and convincing evidence that respondent committed acts of gross negligence in connection with the care and treatment of Patient A. (Findings 74 & 77.) Complainant established by clear and convincing evidence that respondent prescribed medications without medical indication. (Finding 75.) Complainant established by clear and convincing evidence that respondent excessively prescribed drugs to Patient A. (Finding 76.) Cause for discipline exists pursuant to Business and Professions Code sections 2234, subdivision (b), 2242, subdivision (a), and 725, for unprofessional conduct in the treatment of Patient A.

Second Cause for Discipline: Unprofessional Conduct in the Treatment of Patient B

4. Complainant established by clear and convincing evidence that respondent committed acts of gross negligence in connection with the care and treatment of Patient B. (Findings 109 and 112.) Complainant established by clear and convincing evidence that respondent prescribed medications without medical indication. (Finding 110.) Complainant established by clear and convincing evidence that respondent excessively prescribed controlled substances and dangerous drugs to Patient B. (Finding 111.) Cause for discipline

exists pursuant to Business and Professions Code sections 2234, subdivision (b), 2242, subdivision (a), and 725, for unprofessional conduct in the treatment of Patient B.

Third Cause for Discipline: Unprofessional Conduct in the Treatment of Patient C

5. Complainant established by clear and convincing evidence that respondent committed acts of gross negligence in connection with the care and treatment of Patient C. (Findings 144 & 147.) Complainant established by clear and convincing evidence that respondent prescribed medications without medical indication. (Finding 145.) Complainant established by clear and convincing evidence that respondent excessively prescribed drugs to Patient C. (Finding 146.) Cause for discipline exists pursuant to Business and Professions Code sections 2234, subdivision (b), 2242, subdivision (a), and 725, for unprofessional conduct in the treatment of Patient C.

Fourth Cause for Discipline: Unprofessional Conduct in the Treatment of Patient D

6. Complainant established by clear and convincing evidence that respondent committed acts of gross negligence in connection with the care and treatment of Patient D. (Findings 177 & 180.) Complainant established by clear and convincing evidence that respondent prescribed medications without medical indication. (Finding 178.) Complainant established by clear and convincing evidence that respondent excessively prescribed drugs to Patient D. (Finding 179.) Cause for discipline exists pursuant to Business and Professions Code sections 2234, subdivision (b), 2242, subdivision (a), and 725, for unprofessional conduct in the treatment of Patient D.

Fifth Cause for Discipline: Unprofessional Conduct in the Treatment of Patient E

7. Complainant established by clear and convincing evidence that respondent committed acts of gross negligence in connection with the care and treatment of Patient E. (Findings 206 & 209.) Complainant established by clear and convincing evidence that respondent prescribed dangerous drugs without medical indication. (Finding 207.) Complainant established by clear and convincing evidence that respondent excessively prescribed to Patient E. (Finding 208.) Cause for discipline exists pursuant to Business and Professions Code sections 2234, subdivision (b), 2242, subdivision (a), and 725, for unprofessional conduct in the treatment of Patient E.

Sixth Cause for Discipline: Unprofessional Conduct in the Treatment of Patient F

8. Complainant established by clear and convincing evidence that respondent committed acts of gross negligence in connection with the care and treatment of Patient F. (Findings 246 & 249.) Complainant established by clear and convincing evidence that respondent prescribed dangerous drugs without medical indication. (Finding 247.) Complainant established by clear and convincing evidence that respondent excessively prescribed drugs to Patient F. (Finding 248.) Cause for discipline exists pursuant to

Business and Professions Code sections 2234, subdivision (b), 2242, subdivision (a), and 725, for unprofessional conduct in the treatment of Patient F.

Seventh Cause for Discipline: Unprofessional Conduct: Repeated Negligent Acts

9. Complainant established by clear and convincing evidence that respondent committed repeated negligent acts in connection with the care and treatment of Patients A, B, C, D, E, and F. (Findings 78, 113, 148, 181, 209, & 250.) Cause for discipline exists pursuant to Business and Professions Code section 2234, subdivision (c).

Eighth Cause for Discipline: Unprofessional Conduct: Inadequate Records

10. Complainant established by clear and convincing evidence that respondent failed to maintain adequate and accurate records pertaining to the provision of services to Patients A, B, C, D, E and F. (Findings 77, 111, 147, 180, 209 & 249.) Cause for discipline exists pursuant to Business and Professions Code section 2266, for unprofessional conduct in the maintaining of inadequate and inaccurate records.

Ninth Cause for Discipline: Unprofessional Conduct: Improper Supervision

11. A physician assistant may only provide those medical services within his or her competence, consistent with his or her education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared by the physician assistant. (Cal. Code Regs., tit. 16, § 1399.540, subd. (a).) The delegation must be made in writing in a delegation of services agreement. (*Id.*, subd. (b).) A physician may delegate the authority for a physician assistant to issue a drug order in a delegated services agreement, but the agreement must be in compliance with the requirements of Business and Professions Code section 3502.1. A physician assistant may not prescribe drugs unless he or she is functioning pursuant to a section 3502.1. (Bus. & Prof. Code, §§ 4170, subd. (a)(8), & 4174.) Complainant established by clear and convincing evidence that respondent failed to maintain delegated services agreements for the physician assistants he supervised. (Findings 13-16.)

A nurse practitioner may only issue a drug order if in compliance with Business and Professions Code section 2836.1, which requires that they are furnished in accordance with standardized procedures or protocols developed by the nurse practitioner and supervising physician. A nurse practitioner may not prescribe drugs unless he or she is functioning pursuant to section 2836.1. (Bus. & Prof. Code, §§ 4170, subd. (a)(8), & 4174.) Complainant established by clear and convicting evidence that respondent failed to maintain standardized procedures with the nurse practitioners he supervised. (Findings 17-20.)

Cause for discipline of respondent pursuant to Business and Professions Code section 2234 for improper supervision of physician assistants and nurse practitioners was established.

Disciplinary Considerations

12. As cause for discipline has been established, the appropriate level of discipline must be determined. The Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th ed., 2016) recommends, at a minimum, stayed revocation and five years' probation for respondent's misconduct under sections 2234, 2242, and 2266. The maximum discipline for each of these violations is license revocation. In exercising its disciplinary functions, protection of the public is the highest priority of the Board. (Bus. & Prof. Code, § 2229, subd. (a).) To the extent it is not inconsistent with public protection, disciplinary action taken against a physician should be calculated to aid in his or her rehabilitation. (Bus. & Prof. Code, § 2229, subd. (b).)

In the instant case, respondent's deficient prescribing practices, medical record keeping and supervision of PA's and NP's constituted unprofessional conduct. Respondent's misconduct involved multiple patients whom he treated over many years. Respondent's testimony at hearing reflected a lack of insight into his obligations as a pain management specialist.

At the same time, respondent is a hard-working and dedicated physician who has practiced medicine for 20 years, and this is his first disciplinary matter before the Board. Additionally, he appears to have sincerely believed that his practices complied with the standard of care. Complainant suggests, and it is found, that the public will be adequately protected by the imposition of probation, with additional terms designed to aid in respondent's rehabilitation. Accordingly, respondent's license will be placed on probation for five years, subject to terms and conditions set forth below.

ORDER

Certificate No. G85353 issued to respondent Michael Long Tran. M.D., is revoked pursuant to Legal Conclusions 3 through 11, separately and for all of them. However, the revocation is stayed and respondent is placed on probation for five years upon the following terms and conditions:

1. Controlled Substances-Maintain Records and Access to Records and Inventories

   Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the

indications and diagnosis for which the controlled substances were furnished.

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

2. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

3. Prescribing Practices Course

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

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

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

4. Medical Record Keeping Course

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

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

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

5. Monitoring – Practice

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

serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s) and Accusation(s), and a proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

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

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine and whether respondent is practicing medicine safely. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine

until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

6. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

7. Notification

Within seven (7) days of the effective date of this Decision, respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or

membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

8. Supervision of Physician Assistants

During probation, respondent is prohibited from supervising physician assistants.

9. Obey All Laws

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

10. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

11. General Probation Requirements

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

12. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

13. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

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

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

Periods of non-practice will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

14. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

15. Violation of Probation

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

16. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his or her license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to great the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's

wallet and wall certificate to the Board or its designee and respondent shall not longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

17. Probation Monitoring Costs

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

DATED: August 12, 2019

DocuSigned by:
Melissa G. Crowell
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MELISSA G. CROWELL
Administrative Law Judge
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against: **Michael Long Tran, M.D.** 4704 Hoen Avenue Santa Rosa, CA 95405 Physician's and Surgeon's Certificate No. G85353 Respondent.	Case No. 800-2013-001365 OAH No. 2018051293 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Second Amended Accusation (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 23, 1999, the Medical Board issued Physician's and Surgeon's Certificate Number G85353 to Michael Long Tran, 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 February 28, 2021, unless renewed.

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3. From about July 2009, Respondent was the owner of Acadia Pain Management Group, Inc. (APMG) in Santa Rosa, California.

JURISDICTION

4. 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.

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

6. 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."

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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 of the Code states:

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

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

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

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

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

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

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

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

9. Section 2264 of the Code states:

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

10. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

11. Section 3502.1 of the Code provides, in pertinent part, that a physician assistant is authorized to issue a drug prescription provided that the physician assistant is under the supervision of a licensed physician and is acting on behalf of, and as an agent for, the supervising physician.

12. Section 4170 of the Code sets forth the requirements for the dispensing of drugs or dangerous devices.

13. Section 4174 of the Code provides for the dispensing of drugs or devices upon an order of a nurse practitioner or of a physician assistant.

14. Section 11157 of the Health and Safety Code provides that no person shall issue a prescription that is false or fictitious in any respect.

15. Section 11164 of the Health and Safety Code provides that no person shall prescribe a controlled substance, nor shall any person fill, compound, or dispense a prescription for controlled substances, unless it complies with the specific requirements listed therein.

16. Section 11190 of the Health and Safety Code sets forth the information that is required to be documented in a record by every practitioner, other than a pharmacist, who prescribes or administers a controlled substance classified in Schedule II.

PERTINENT CONTROLLED SUBSTANCES/DANGEROUS DRUGS

17. Amitriptyline, known by the trade name of Elavil, is a tricyclic antidepressant that is used to treat symptoms of depression. It is a dangerous drug as defined in Business and Professions Code section 4022.

18. Ativan, a trade name for lorazepam, is a benzodiazepine and central nervous system (CNS) depressant used in the management of anxiety disorder for short-term relief from the symptoms of anxiety or anxiety associated with depressive symptoms. It is a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code and by 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. Long-term or excessive use of Ativan can cause dependency. Concomitant use of alcohol or other CNS depressants may have an additive effect.

19. Butrans, a trade name for buprenorphine, is an opioid (narcotic) partial agonist-antagonist that works by binding receptors in the brain and nervous system to help prevent withdrawal symptoms in someone who has stopped taking narcotics (e.g., heroin, oxycodone). Buprenorphine is used as part of an office-based opiate maintenance treatment. It is a Schedule III controlled substance as defined by section 11056 of the Health and Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022.

20. Celexa, a trade name for citalopram, is an antidepressant in a group of drugs called a selective serotonin reuptake inhibitor ("SSRI") and it is used in the treatment of depression. It has primary CNS depressant effects and should be used with caution in combination with other centrally acting drugs. Celexa is a dangerous drug as defined in Business and Professions Code section 4022 of the Code.

21. Cymbalta, a trade name for duloxetine, is a selective serotonin and norepinephrine reuptake inhibitor (SSNRI) antidepressant that is used in the treatment of major depressive disorder, general anxiety disorder, and also may be used to treat fibromyalgia and diabetic neuropathy.

22. Endocet and Percocet are trade names for a combination of oxycodone hydrochloride and acetaminophen which is a semisynthetic opioid analgesic with multiple actions qualitatively similar to those of morphine. Oxycodone is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1)(N), of the Health and Safety Code, and a Schedule II controlled substance as defined 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.

23. Fentanyl is an opioid analgesic which can be administered by an injection, through a transdermal patch (known as Duragesic), as an oral lozenge (known as Actiq), or in tablet form (known as Fentora). 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. When patients are receiving fentanyl, the dosage of central nervous system depressant drugs should be reduced. Use of fentanyl together with other central nervous system depressants, including alcohol, can result in increased risk to the patient.

24. Flexeril, a trade name for cyclobenzaprine, is a muscle relaxant and is a dangerous drug as defined in Business and Professions Code section 4022.

25. Hydrocodone bitartrate with acetaminophen, which is known by the trade names Norco or Vicodin, is a semi-synthetic opioid analgesic. It is a Schedule II controlled substance as defined by section 11055, subdivision (b) of the Health and Safety Code, and is a Schedule II controlled substance as defined 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.

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

27. 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.

[1] Effective 10/06/2014, 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.

28. Kadian and Ms Contin are trade names for morphine sulfate which is an opioid pain medication indicated for the management of moderate to severe acute and chronic pain. Morphine is a 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.

29. Neurontin is a trade name for gabapentin which is an anti-convulsant, anti-epileptic. It is a dangerous drug as defined in Business and Professions Code section 4022.

30. Restoril, a trade name for temazepam, is in the benzodiazepine class of drugs and is used to treat insomnia. It is a Schedule IV controlled substance under Health and Safety Code section 11057 and is a dangerous drug as defined in Business and Professions Code section 4022.

31. 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.

32. Trazodone is an antidepressant and is a dangerous drug as defined in Business and Professions Code section 4022.

33. Ultram, a trade name for tramadol, is an opioid agonist of the morphine-type that is indicated for the management of moderate to severe pain. It is a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code and is a dangerous drug as defined in Business and Professions Code section 4022. Tramadol may be expected to have additive effects when used in conjunction with alcohol, other opioids, or illicit drugs that cause central nervous system depression.

34. 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 by 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 pre-disposition of such patients to habituation and dependence.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient A[2]: Gross Negligence/Excessive Prescribing/ Prescribing Without Exam/Medical Indication)

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

36. On March 12, 2004, Respondent first saw and examined Patient A, a 45-year-old male, who was referred for evaluation and pain management of chronic low back pain. Patient A had suffered an employment-related injury in February 2003 while working as a surgical technician at UCSF Hospital and had a pending workers compensation claim. The patient presented with low back pain and with a tingling numbing sensation radiating down to the left thigh and calf. An MRI revealed bulging discs in the spine at L4-L5 and at L5–S1. At the time, the patient was taking Vicodin four to six times a day, 200 mg. of Celebrex daily, and 300 mg of Neurontin at bedtime. It was determined that the patient had plateaued for physical treatment and was a candidate for diagnostic epidural steroid injections. Respondent's treatment plan included lumbar epidural steroid injections and a change in the patient's medications to replace Vicodin with Vicoprofen every four to six hours. Also, Neurontin 100 mg. was to be taken three times a day and Pamelor 10 mg., a tricyclic antidepressant, was to be taken daily at bedtime in place of the Neurontin. The patient was advised to continue with physical therapy.

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

37. On or about March 13, 2004, Respondent assumed the patient's care and management of the chronic back pain, which was a workers compensation related injury.

38. Patient A was seen at Respondent's Acadia Pain Management Group clinic ("APMG") on approximately a monthly basis for a period of more than seven years, from March 2004 until at least September 23, 2011. During that time, Respondent personally saw and evaluated Patient A for a total of about ten visits. Patient A's remaining visits at APMG were with other physicians and clinic staff. The medical records do not always indicate who saw the patient during each visit.

39. During the course of his treatment from Respondent's APMG, Patient A developed other chronic pain issues that were not related to his workers compensation claim and that correlated with multiple diagnoses which included: multi-levels of cervical degenerative disc disease, right shoulder injury, lumbar degenerative disc disease, rheumatoid arthritis, and complex regional pain syndrome of the right arm.

40. In or about June 2005, Patient A was also referred to Respondent for pain complaints regarding his neck, shoulder, and right arm that were related to an auto accident in October 2004.

41. Between the initial visit in March 2004 and October 15, 2007, Respondent did not see Patient A for an office visit. Patient A was seen on approximately a monthly basis by others at APMG.

42. The last documented visit at which Respondent personally saw and examined Patient A was on February 24, 2010. Respondent's progress note indicates that the plan was that the patient have a permanent spinal cord stimulator implanted. The patient reported that he was seeing another physician for his right shoulder pain problems. Respondent noted that he refilled the prescriptions for #180 Methadone 10 mg. and #120 Percocet 10 mg.

43. After February 24, 2010, Patient A was seen at APMG on approximately a monthly basis by others, not by Respondent. Yet, Respondent continued to issue refill prescriptions for the patient.

44. Respondent, or his staff, issued refill prescriptions that were outside of scheduled visits and which were not always accurately documented in the patient's chart. For example, on

or about March 25, 2010, Respondent issued refills to Patient A for #30 Lidoderm patches and for Voltaren Gel without seeing the patient and without documenting medical indications to support the prescribing. None of these medications were listed as prescriptions in the chart notes for Patient A's most recent visit on February 24, 2010.

45. On or about May 14, 2010, Respondent issued three months of refills for #30 Elavil 25 mg. to Patient A. The patient's most recent documented visit prior to May 14, 2010 was with another physician at APMG on April 30, 2010. The progress note stated that the patient was prescribed 50 mg. of Elavil at bedtime, which is inconsistent with the amount that was prescribed by Respondent.

46. A prescription dated September 30, 2010 purportedly issued by Respondent was actually written by another physician using Respondent's prescription pad. The prescription for Patient A was for #120 Methadone 10 mg., #90 Percocet 10/325 mg., and #30 Cymbalta 60 mg. Respondent had not seen and examined the patient before the issuing of these prescriptions.

47. A prescription dated November 2, 2010 purportedly issued by Respondent was actually written by another physician using Respondent's prescription pad. The prescription for Patient A was for #120 Methadone 10 mg. and #90 Percocet 10/325 mg. Respondent had not seen and examined the patient before the issuing of these prescriptions.

48. On December 30, 2010, Patient A saw another physician at APMG with a primary complaint of G.I. discomfort and blurred and double vision. The physician noted that the vision problems may be caused by the opiate medication and the plan was to titrate and decrease the Methadone.

49. In 2011, Respondent did not see Patient A at APMG, yet Respondent issued prescriptions for Schedule II controlled substances (Methadone and Endocet/Percocet) without having seen the patient. In 2011, Respondent issued to Patient A at least seven prescriptions for Endocet 10/325 mg. for a total of #630 pills and at least seven prescriptions for Methadone 10 mg. for a total of #940 pills.

50. Respondent's overall conduct, acts and/or omissions, with regard to Patient A, as set forth in paragraphs 35 through 49 herein, constitutes unprofessional conduct through gross

negligence and/or prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, pursuant to Business and Professions Code Sections 2234 subdivisions (b) and/or section 2242 and/or section 725, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient A as follows:

a. Respondent's records were missing or lacking complete and comprehensive documentation of the patient's complaints, assessments, progress, diagnoses, status, response to treatment, and evolving treatment plan.

b. Respondent failed to document that informed consent was obtained and that the patient was informed of the risks and benefits of each controlled substance prescribed.

c. Respondent failed to conduct periodic review and assessment. Respondent failed to intervene and continued to prescribed controlled substances when evidence of abuse, misuse, and tolerance emerged.

d. Respondent failed to conduct proper monitoring of the patient and failed to conduct random drug screens.

e. Respondent excessively prescribed high doses of long-term opioids and other controlled substances to the patient.

f. Respondent prescribed controlled substances and/or dangerous drugs without documented prior medical examinations and/or medical indications.

g. Respondent issued prescriptions for Schedule II controlled substances that were dispensed outside a scheduled appointment.

h. Respondent's records are incomplete and inadequate and fail to document a comprehensive and complete controlled substance medication history and the patient's daily medication use. The records do not provide sufficient information to identify and connect the diagnosis with the relevant controlled substance prescriptions.

i. Respondent's records for Patient A's workers compensation injury and treatments/prescriptions were not kept separate from the patient's non-workers compensation complaints and treatments/prescriptions.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient B: Gross Negligence/Excessive Prescribing/ Prescribing Without Exam/Medical Indication)

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

52. On or about November 21, 2007, Patient B, a 32-year-old male, saw Respondent for evaluation and medical care for a work–related lumbar spine injury. The patient complained of low back pain and bilateral leg pain. The patient was on workers' compensation disability. The injury purportedly occurred on or about July 11, 2007. The patient reported currently using Celebrex, Valium, and Vicodin/Norco for pain. Respondent's plan was to continue with the medications, prescribe Neurontin, and recommend an epidural injection.

53. Patient B signed a Pain Center Prescription Agreement on November 21, 2007 and another on January 3, 2010.

54. Between November 28, 2007 and April 12, 2010, Respondent performed four epidural steroid injections on Patient B.

55. From as early as May/June 2010, Patient B visited Respondent's clinic (APMG) approximately every four to eight weeks, with some longer lapses between visits. Patient B visited Respondent's clinic for medical evaluations, treatments, procedures and medications. He received injections and/or procedures at Respondent's North Coast Medical Center (North Coast) or at APMG. Patient B was provided acupuncture, PT/chiropractor treatment.

56. From May 25, 2010 through April 7, 2014, Respondent performed four epidural steroid injections on Patient B at North Coast Surgery Center while another physician employed by Respondent also performed two epidural steroid injections on the patient during that same time period.

57. There was no documentation in Respondent's records for Patient B to establish that informed consent was obtained and that the patient was informed of the risks and benefits of the treatment, and/or about alternatives.

58. Respondent also owned and operated an in-house pharmacy from which medications were dispensed to Patient B. Medication logs were not maintained. Detailed information about Respondent's in-house pharmacy and the medications dispensed, including the identity of individuals doing the dispensing and the quantities dispensed, was not recorded in Patient B's chart.

59. During the course of Patient B's treatment, prescriptions for controlled substances were written and authorized by unsupervised personnel employed by Respondent who were not always identified in the progress notes and/or the prescriptions.

60. Respondent did not adequately and accurately document in Patient B's records the complete information about the medications that were dispensed to the patient from the in-house pharmacy and those medications for which prescriptions were issued. Respondent also did not maintain a prescribing log or in-house pharmacy log for the prescriptions issued to Patient B.

61. During the course of Respondent's treatment of Patient B, the patient received prescriptions from approximately seven different providers at Respondent's clinic. Patient B obtained controlled substances from three different pharmacies. Patient B also obtained prescriptions for controlled substances from at least three other providers that were outside of Respondent's clinic.

62. According to a CURES report, between January 8, 2010 and January 16, 2016, Respondent issued 74 prescriptions for controlled substances to Patient B. Respondent's records for Patient B, however, do not establish that Respondent evaluated the patient prior to issuing each prescription.

63. Patient B was prescribed and/or dispensed a combination of opioid medications, e.g. Fentanyl, Oxycodone, Morphine sulfate, Butrans, Hydrocodone, Norco, Percocet, Methadone, and Kadian.

64. Patient B also was prescribed and/or dispensed central nervous system-acting medications such as Flexeril, Soma, Valium, Gabapentin, Celebrex, Mobic, Feldene, and Lexapro.

65. In 2010, prescriptions were issued to Patient B by Respondent for Fentanyl transdermal patches and for Percocet.

66. In 2011, prescriptions were issued to Patient B by Respondent for Percocet and for MS Contin.

67. In 2013, prescriptions were issued to Patient B by Respondent for Percocet and for MS Contin.

68. In 2014 and 2015, prescriptions were issued to Patient B by Respondent for MS Contin and for Oxycodone IR.

69. During the course of treatment, Patient B's status and progress remained stagnate. There was no improvement in pain, function, or a return to work. The VAS and ADL function grossly remained unchanged or worsened. Many of the chart notes appear to repeat the same text for each visit.

70. The opioid Morphine Milligram Equivalent (MME) levels were high for the opiates prescribed to Patient B. The approximate average MME in June 2010 was 238 mg./d; in September 2011 it was 390 mg./d; in July 2012 it was 360 mg./d; and, in October 2014 it was 450 mg./d.

71. In or about 2014 the Worker's Compensation Utilization Review medical reviewers determined that Patient B was receiving medications that were not beneficial to his recovery, quality of life, and the promotion of patient wellness. It was recommended that the prescribed opioids be decreased.

72. On or about June 28, 2015, the Workers' Compensation Utilization Reviewer denied Respondent's request to continue the long-term prescribing of Flexeril (cyclobenzaprine) to Patient B.

73. During the course of treatment, Patient B was prescribed and/or dispensed, in addition to the high doses of opioids, high doses of other controlled substances, muscle relaxants, antidepressants, hypnotics, and benzodiazepines.

74. During the course of treatment, Patient B was prescribed high doses of controlled substances even after the patient displayed negative or stagnate gains, evidence of tolerance, and poor outcome.

75. Because of Respondent's poor medical record keeping for patient B, the exact amounts of medications prescribed, administered, and/or dispensed directly to the patient are unknown.

76. During the course of about five years of treatment, from August 2010 through June 2015, Respondent obtained only three urine tests. Although the August 2010 test results were inconsistent, there is nothing in Respondent's records to indicate that any action was taken.

77. During an interview with the Medical Board's investigator on July 7, 2016, Respondent provided the following information:

a. APMG, an in-house pharmacy, and the Pain and Wellness Center are all owned by Respondent and are all located at 4704 Hoen Ave, in Santa Rosa. Interventional procedures occur at this location and at another site owned by Respondent, North Coast Surgery Center.

b. Respondent did not personally complete and sign all of his triplicate prescriptions for Schedule II controlled substances and did not authorize or monitor all of the controlled substances prescribed and dispensed to all patients.

c. Respondent did not maintain detailed dispensary logs for his in-house medication dispensary at APMG or at this pharmacy Pain and Wellness.

d. Respondent allowed "scribers" to use his Electronics Medical Record login and to insert his e-signature. He cannot identify these individuals by name and he did not require them to identify themselves in the patients' records or on the prescriptions.

e. In 2013, Respondent's clinic began to transition from paper charting to an Electronic Medical Records system (EMR). The transition took more than two years.

78. Respondent's overall conduct, acts and/or omissions, with regard to Patient B, as set forth in paragraphs 51 through 77 herein, constitutes unprofessional conduct through gross negligence and/or prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, pursuant to Business and Professions Code Sections 2234 subdivisions (b) and/or section 2242 and/or section 725, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient B as follows:

a. Respondent's records were incomplete and missing comprehensive documentation of the patient's complaints, assessments, progress, diagnoses, status, response to treatment.

b. Respondent failed to document that informed consent was obtained and that Patient B was informed of the risks and benefits of each controlled substance prescribed, and the alternatives to the treatment.

c. Respondent failed to document a treatment plan with specific treatment goals.

d. Respondent prescribed and dispensed controlled substances and/or dangerous drugs without documented prior medical examinations and/or medical indications.

e. Respondent improperly delegated his physician responsibilities to treat, prescribe, evaluate and provide patient care to Patient B. Respondent allowed others to prescribe controlled substances, without written physician and health care extender supervision protocols.

f. Respondent failed to conduct an adequate periodic review and assessment of the effectiveness of the treatment of prescribing controlled substances on a chronic basis and/or in combinations of opiates and other central nervous system acting drugs and/or in dosages that exceed 90 morphine milligram equivalents (MME) daily.

g. Respondent failed to intervene and continued to prescribe controlled substances to Patient B after there was evidence of abuse and misuse.

h. Respondent did not monitor and/or enforce compliance with the patient prescribing agreement.

i. Respondent failed to conduct proper monitoring of the patient, such as random drug screens and CURES reports or pharmacy prescribing profiles.

j. Respondent excessively prescribed high doses of long-term opioids, in combination with other controlled substances to Patient B.

k. Respondent's records are incomplete and inadequate and fail to document a comprehensive and complete controlled substance medication history and the patient's daily medication use. The records do not provide sufficient information to identify and connect the diagnosis with the relevant controlled substance prescriptions.

l. Respondent failed to consult with and/or obtain records from other healthcare providers for Patient B.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient C: Gross Negligence/ Excessive Prescribing/ Prescribing Without Exam/Medical Indication)

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

80. Paragraph 77 is incorporated herein by reference, as if fully set forth.

81. On or about August 27, 2011, Patient C began to see Respondent for evaluation and medical care for low back pain and bilateral leg pain, non-work-related. There are no medications documented as being prescribed during the initial visit.

82. Patient C visited Respondent's APMG clinic for medical evaluations, treatments and medications, and received injections and/or procedures at North Coast Medical Center or at Palm Drive Hospital.

83. Between September 9, 2011 through January 19, 2015, Respondent performed at least ten procedures on Patient C, which included epidural steroid injections, radiofrequency rhizotomy, and other diagnostic injection procedures.

84. Patient C continued to visit Respondent's APMG clinic approximately every one to two months. The patient, however, would receive prescriptions from Respondent or from Respondent's staff, up to three times per month, and would pick up prescriptions at the office without having an appointment or office visit.

85. Patient C was prescribed and dispensed simultaneously many controlled substances from the same class (opioids), e.g. fentanyl, hydrocodone, and morphine sulfate.

86. Although all of Patient C's prescriptions were issued by Respondent, Respondent was not present in the office for all of the patient's appointments.

87. During the course of about four years of treatment, Respondent obtained only one CURES report and two urine tests, which produced inconsistent results.

88. There was no documentation in Respondent's records for Patient C that informed consent was obtained and that the patient was informed of the risks and benefits of the treatment, and/or about alternatives to the treatment.

89. During the course of treatment, no opiate agreement was signed by Patient C and Respondent.

90. During the course of Patient C's treatment, prescriptions for controlled substances were written and medications were authorized by unsupervised personnel employed by Respondent who were not always identified in the progress notes and/or the prescriptions.

91. Respondent did not adequately and accurately document in Patient C's records the complete information about medications that were dispensed to the patient from the in-house pharmacy and those medications for which prescriptions were issued. Respondent also did not maintain a prescribing log or in-house pharmacy log for the prescriptions issued to Patient C.

92. During the course of Respondent's treatment of Patient C, the patient received prescriptions from approximately eight different providers at Respondent's clinic. Patient C obtained controlled substances from six different pharmacies. Patient C also obtained prescriptions for controlled substances from approximately nine other health providers that were outside of Respondent's clinic.

93. According to a CURES report, between December 9, 2011 and February 1, 2016, Respondent issued 56 of the 112 prescriptions for controlled substances that were issued to Patient C from Respondent's clinic. Respondent's records for Patient C, however, do not establish that Respondent evaluated the patient prior to issuing each prescription.

94. Patient C was prescribed/dispensed a combination of opioid medications, e.g. fentanyl, hydrocodone, oxycodone, and morphine sulfate, in excessive amounts without documented medical indication.

95. Patient C was also prescribed, without documented medical indications, a combination of controlled substances and central nervous system-acting medications, such as MS Contin, Oxycodone, Norco, Trazodone, Flexeril, Cymbalta, Neurontin, Nortriptyline, Celexa, Chantix, Naproxen, Ativan, and Ultram.

96. In 2012 and in 2013, prescriptions were issued to Patient C by Respondent for MS Contin, Norco, and Neurontin.

97. In 2014, prescriptions were issued to Patient C by Respondent for MS Contin, Norco, and Oxycodone.

98. In 2015, prescriptions were issued to Patient C by Respondent for MS Contin, Norco, Flexeril, Neurontin, and Oxycodone.

99. During the course of approximately four years of treatment, Patient C's status and progress remained stagnate. There was no improvement in pain, function, or a return to work. The VAS and ADL function grossly remained unchanged or worsened. Many of the chart notes appear to repeat the same text for each visit.

100. Patient C started in December 2011 with an average opioid Morphine Milligram Equivalent (MME) daily dose of 30 mg. Without documenting a medical indication or justification, Respondent escalated the patient's MME daily dose to a high level. For example, the approximate MME level for Patient C in December 2012 was 90 mg./d to 116 mg./d; in March 2013 it was 160 mg./d; in March 2014 it was 150 mg./d; and, in August 2015 it was 145 mg./d.

101. During the course of treatment, Patient C was dispensed high doses of long-term opioids and controlled substances, along with muscle relaxants, that were detrimental to patient C's safety and the patient's physical and psychological health.

102. During the course of treatment, Respondent continued to prescribe high doses of controlled substances to Patient C even after the patient displayed negative or stagnate gains, evidence of tolerance, and poor outcome.

103. Because of Respondent's poor medical record keeping for Patient C, the exact amounts of medications prescribed, administered, and/or dispensed directly to the patient are unknown. It is also impossible to determine from the records who actually was present and provided care and medications to Patient C, on behalf of Respondent.

104. Respondent's overall conduct, acts and/or omissions, with regard to Patient C, as set forth in paragraphs 79 through 103 herein, constitutes unprofessional conduct through gross negligence and/or prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, pursuant to Business and Professions Code Sections 2234 subdivisions (b) and/or section 2242 and/or section 725, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient C as follows:

a. Respondent's records were incomplete and missing comprehensive documentation of the patient's complaints, assessments, progress, diagnoses, status, response to treatment

b. Respondent failed to document that informed consent was obtained and that Patient C was informed of the risks and benefits of each controlled substance prescribed, and the alternatives to the treatment.

c. Respondent failed to document a treatment plan with specific treatment goals.

d. Respondent prescribed and dispensed controlled substances and/or dangerous drugs without documented prior medical examinations and/or medical indications.

e. Respondent improperly delegated his physician responsibilities to treat, prescribe, evaluate and provide patient care to Patient C. Respondent allowed others to prescribe controlled substances, without written physician and health care extender supervision protocols.

f. Respondent failed to conduct an adequate periodic review and assessment of the effectiveness of the treatment of prescribing controlled substances on a chronic basis and/or in combinations of opiates and other central nervous system acting drugs and/or in dosages that exceed 90 morphine milligram equivalents (MME) daily.

g. Respondent failed to intervene and continued to prescribe controlled substances to Patient C after there was evidence of abuse and misuse.

h. Respondent did not have an opiate agreement with the patient, did not require that the patient obtain opioids from one provider and one pharmacy, and did not have an established refill policy for the chronic prescribing of controlled substances.

i. Respondent failed to conduct proper monitoring of the patient, such as random drug screens and CURES reports or pharmacy prescribing profiles.

j. Respondent excessively prescribed high doses of long-term opioids, in combination with other controlled substances to Patient C.

k. Respondent's records are incomplete and inadequate and fail to document a comprehensive and complete controlled substance medication history and the patient's daily medication use. The records do not provide sufficient information to identify and connect the diagnosis with the relevant controlled substance prescriptions.

l. Respondent failed to consult with and/or obtain records from other healthcare providers for Patient C.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient D: Gross Negligence/Excessive Prescribing/ Prescribing Without Exam/Medical Indication)

105. Respondent Michael Long Tran, M.D.is subject to disciplinary action for unprofessional conduct under sections 2234(b) and/or 2242 and/or 725 in that Respondent's overall conduct, acts and omissions, with regard to Patient D constitutes gross negligence and/or

prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, as more fully described herein below.

106. Paragraph 77 is incorporated herein by reference, as if fully set forth.

107. On or about March 8, 2010, Patient D, a 47-year-old female, first saw a physician at Respondent's clinic for evaluation and treatment of chronic neck pain. The physician diagnosed cervical degenerative disc disease and ordered a steroid injection. The patient signed a Pain Center Prescription Agreement.

108. On or about March 22, 2010, Respondent performed a cervical epidural steroid injection on Patient D. The procedure was performed at Respondent's North Coast Medical Center.

109. On or about September 22, 2010, Respondent evaluated Patient D for work-related thoracic spine injury and a lumbosacral injury, with back pain and myofascial pain. A Pain Center Prescription Agreement was signed by both the patient and Respondent. Respondent recommended a thoracic epidural steroid injection. Respondent prescribed Restoril, Percocet, Celebrex, Voltaren Gel, and Lidoderm patches.

110. On or about September 22, 2010, Respondent also assumed care as Patient D's primary treating physician for her workers' compensation injury. Respondent declared Patient D to be totally temporarily disabled for up to two months and possibly permanently and stationary for up to one year.

111. Respondent's records for Patient D include a Psychological Evaluation for Injured Worker dated October 10, 2010 in which is reported that Patient D had a history of ADHD and amphetamine abuse as a teenager. The patient had been in an alcohol rehab program about twenty years ago. She admitted to regular marijuana use.

112. Patient D continued to visit Respondent's APMG clinic approximately every one to three months. The patient was seen by other physicians at Respondent's clinic, although Respondent remained the primary treating physician.

113. Patient D visited Respondent's APMG for medical evaluations, treatments and medications, and received injections and/or procedures at North Coast Medical Center. The

patient was provided acupuncture, physical therapy/chiropractic treatment, and was dispensed medications from the in-house pharmacy.

114. Between October 14, 2010 through February 9, 2015, Respondent performed at least eleven procedures on Patient D, which included epidural steroid injections, lumbar facet injections, and radiofrequency rhizotomies.

115. Patient D was prescribed and dispensed simultaneously many controlled substances from the same class, e.g. benzodiazepines and/or opioids.

116. During the course of Patient D's treatment, Respondent prescribed controlled substances, including opioids, benzodiazepines, hypnotics, and muscle relaxants to the patient who had displayed negative or stagnate gains, evidence of tolerance, and poor outcome.

117. During the course of Respondent's treatment of Patient D, the patient received prescriptions from at least seven different providers at Respondent's clinic. Patient D obtained controlled substances from at least three different pharmacies. The patient also obtained prescriptions for controlled substances from other providers that were outside of Respondent's clinic.

118. Patient D also picked up prescriptions for controlled substances from Respondent's office, without having an appointment or office visit.

119. Respondent did not adequately and accurately document in Patient D's records the complete information about the medications that were dispensed to the patient from the clinic and/or the in-house pharmacy. Respondent also did not maintain a prescribing log or in-house pharmacy log for the prescriptions issued to Patient D.

120. In or about March, 2011, Respondent referred Patient D for physical therapy/ chiropractic treatment to be performed at his facility. There is no documentation that Respondent disclosed his financial interest to the Patient D and/or that the patient was given the option to receive treatment from another provider.

121. During the course of about five years of treatment, Respondent obtained only one CURES report and two urine tests, which produced inconsistent results.

122. During the course of about five years of treatment, Patient D's status and progress remained stagnate and/or continued to deteriorate. There was no overall improvement in pain, in function, or a return to work. The VAS and ADL function grossly remained unchanged or worsened. Many of the chart notes appear to repeat the same text for each visit.

123. According to a CURES report, between March 11, 2010 and January 16, 2016, Respondent issued 62 of the 168 controlled substances prescriptions to Patient D that were issued from his clinic. Respondent's records for Patient D, however, do not establish that Respondent evaluated the patient prior to issuing each prescription.

124. During the course of treatment by Respondent, the opioids prescribed to Patient D were an average MME of about 60 mg./d, in combination with high doses of benzodiazepines.

125. Patient D was prescribed, without documented medical indications, a combination of controlled substances and central nervous system-acting medications. Patient D was prescribed on a regular basis: Valium, Hydrocodone/APAP, and Temazepam, in addition to anti-depressants, anti-seizure medications, muscle relaxants, hypnotics, THC, and NSAIDs.

126. In 2010 and 2011, prescriptions were issued to Patient D by Respondent for Percocet, Restoril, Skelaxin, and Norco.

127. In 2012, prescriptions were issued to Patient D by Respondent for Norco.

128. In 2013 through at least March 2015, prescriptions were issued to Patient D by Respondent for Norco, Percocet, Valium, Restoril, Neurontin, and Soma.

129. In or about January 2015, the Worker's Compensation UR/medical reviewer started non-certification and modification of medications because the patient was not showing improvement while on long-term controlled substances. Patient D's medications were not beneficial to the patient's recovery, quality of life, and the promotion of patient wellness.

130. Because of Respondent's poor medical record keeping for Patient D, the exact amounts of medications prescribed, administered, and/or dispensed directly to the patient are unknown. It is also impossible to determine from the records who actually was present and provided care and medications to Patient D, on behalf of Respondent.

131. Respondent's overall conduct, acts and/or omissions, with regard to Patient D, as set forth in paragraphs 105 through 130 herein, constitutes unprofessional conduct through gross negligence and/or prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, pursuant to Business and Professions Code Sections 2234 subdivisions (b) and/or section 2242 and/or section 725, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient D as follows:

a. Respondent's records were incomplete and missing comprehensive documentation of the patient's complaints, assessments, progress, diagnoses, status, and response to treatment.

b. Respondent failed to document that informed consent was obtained and that Patient D was informed of the risks and benefits of each controlled substance prescribed, and the alternatives to the treatment.

c. Respondent failed to document a treatment plan with specific treatment goals.

d. Respondent prescribed and dispensed controlled substances and/or dangerous drugs without documented prior medical examinations and/or medical indications.

e. Respondent improperly delegated his physician responsibilities to treat, prescribe, evaluate and provide patient care to Patient D. Respondent allowed others to prescribe controlled substances, without written physician and health care extender supervision protocols.

f. Respondent failed to conduct an adequate periodic review and assessment of the effectiveness of the treatment of prescribing controlled substances on a chronic basis and/or in combinations of opiates and other central nervous system acting drugs and/or in dosages that exceed 90 morphine milligram equivalents (MME) daily.

g. Respondent failed to intervene and continued to prescribe controlled substances to Patient D after there was evidence of abuse and misuse.

h. Respondent did not monitor and/or enforce compliance with the patient prescribing agreement.

i. Respondent failed to conduct proper monitoring of the patient, such as random drug screens and CURES reports or pharmacy prescribing profiles.

j. Respondent excessively prescribed high doses of long-term opioids, in combination with other controlled substances to Patient D.

k. Respondent's records are incomplete and inadequate and fail to document a comprehensive and complete controlled substance medication history and the patient's daily medication use. The records do not provide sufficient information to identify and connect the diagnosis with the relevant controlled substance prescriptions.

l. Respondent failed to consult with and/or obtain records from other healthcare providers for Patient D.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient E: Gross Negligence/Excessive Prescribing/Prescribing Without Exam/Medical Indication)

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

133. Paragraph 77 is incorporated herein by reference, as if fully set forth.

134. On or about January 28, 2008, Patient E, a 50-year-old Spanish-speaking male, began to see Respondent for medical care for a worker's compensation injury that was incurred on September 15, 2006. The patient complained of low back pain and bilateral leg pain and was not working. Respondent recommended a series of lumbar epidural steroid injections and prescribed Mobic, Gabapentin, Pepcid, and Ultracet. A patient prescribing agreement, written in Spanish, was signed by the patient.

135. Patient E visited Respondent's APMG for medical evaluations, treatments and medications, and received prescriptions, medications, injections, procedures and other non-interventional treatments. The patient was dispensed medications from the in-house pharmacy.

136. Patient E continued to visit Respondent's APMG clinic approximately every one to three months. There was a gap in care, however, in 2009 to early 2010.

137. On April 28, 2010, Patient E's visit was treated as an initial new patient visit. Patient E signed another patient prescribing agreement that was written in Spanish. The patient's complaints were related to the same worker's compensation injury. Although Patient E had a lumbar fusion in November 2009, he continued to have low back pain and bilateral leg pain.

138. During the course of Patient E's treatment, Respondent prescribed controlled substances, including opioids, benzodiazepines, anti-depressants, NSAIDs, and muscle relaxants to the patient who had displayed negative or stagnate gains, evidence of tolerance, and poor outcome.

139. During the course of Respondent's treatment of Patient E, the patient received prescriptions from approximately nine different providers at Respondent's clinic.

140. Patient E also would pick up prescriptions for controlled substances from Respondent's office, without having an appointment or office visit.

141. Respondent did not adequately and accurately document in Patient E's records the complete information about the medications that were dispensed to the patient from the clinic and/or the in-house pharmacy. Respondent also did not maintain a prescribing log or in-house pharmacy log for the prescriptions issued to Patient E.

142. In or about October 2013, Respondent wrote a prescription and referred Patient E for chiropractic treatment to be performed at his facility. There is no documentation that Respondent disclosed his financial interest to the Patient E and/or that the patient was given the option to receive treatment from another provider.

143. In or about July 2015, Respondent wrote a prescription and referred Patient E for acupuncture treatment to be performed at his facility. There is no documentation that Respondent disclosed his financial interest to the Patient E and/or that the patient was given the option to receive treatment from another provider.

144. During the course of treatment, Respondent/APMG obtained only two CURES reports and only two urine drug screening tests for Patient E. A urine toxicology screens collected in February 2011 provided inconsistent results.

145. During the course of treatment, Patient E's status and progress remained stagnate. There was no overall improvement in pain, in function, or a return to work. The VAS and ADL function grossly remained unchanged or worsened. Many of the chart notes appear to repeat the same text for each visit.

146. According to a CURES report, between January 1, 2010 and February 1, 2016, Respondent issued at least 22 of the 57 prescriptions for controlled substances that were issued to Patient E from Respondent's clinic. Respondent's records for Patient E, however, do not establish that Respondent evaluated the patient prior to issuing each prescription.

147. In 2010, prescriptions were issued to Patient E by Respondent for Percocet.

148. In 2012 and 2013, prescriptions were issued to Patient E by Respondent for Vicodin/Norco.

149. In 2014 and 2015, prescriptions were issued to Patient E by Respondent for Norco, Percocet, Valium, Restoril, Neurontin, and Ultram.

150. During the course of treatment, Patient E's average opioid Morphine Milligram Equivalent (MME) was in the daily range of between 60 mg. to 90 mg., in combination with muscle relaxants, and anti-depressants.

151. During the course of treatment of Patient E, there was an on-going utilization review (UR) by a Worker's Compensation medical reviewer about Patient E's treatment. The medical reviewer determined that the hydrocodone medications prescribed on a long-term basis were not beneficial to the patient's recovery, quality of life, and the promotion of patient wellness. Yet, Respondent and his agents continued to request these medications for Patient E.

152. Respondent did not properly supervise the issuance of prescription refills, particularly for controlled substances.

153. Because of Respondent's poor medical record keeping for Patient E, the exact amounts of medications prescribed, administered, and/or dispensed directly to the patient are

unknown. It is also impossible to determine from the records who actually was present and provided care and medications to Patient E, on behalf of Respondent.

154. Respondent's overall conduct, acts and/or omissions, with regard to Patient E, as set forth in paragraphs 132 through 153 herein, constitutes unprofessional conduct through gross negligence and/or prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, pursuant to Business and Professions Code Sections 2234 subdivisions (b) and/or section 2242 and/or section 725, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient E as follows:

a. Respondent's records were incomplete and missing comprehensive documentation of the patient's complaints, assessments, progress, diagnoses, status, and response to treatment.

b. Respondent failed to document that informed consent was obtained and that Patient E was informed of the risks and benefits of each controlled substance prescribed, and the alternatives to the treatment.

c. Respondent failed to document a treatment plan with specific treatment goals.

d. Respondent prescribed and dispensed controlled substances and/or dangerous drugs without documented prior medical examinations and/or medical indications.

e. Respondent improperly delegated his physician responsibilities to treat, prescribe, evaluate and provide patient care to Patient E. Respondent allowed others to prescribe controlled substances, without written physician and health care extender supervision protocols.

f. Respondent failed to conduct an adequate periodic review and assessment of the effectiveness of the treatment of prescribing controlled substances on a chronic basis and/or in combinations of opiates and other central nervous system acting drugs and/or in dosages that exceed 90 morphine milligram equivalents (MME) daily.

g. Respondent failed to intervene and continued to prescribe controlled substances to Patient E after there was evidence of abuse and misuse.

h. Respondent did not monitor and/or enforce compliance with the patient prescribing agreement.

i. Respondent failed to conduct proper monitoring of the patient, such as random drug screens and CURES reports or pharmacy prescribing profiles.

j. Respondent excessively prescribed high doses of long-term opioids, in combination with other controlled substances to Patient E.

k. Respondent's records are incomplete and inadequate and fail to document a comprehensive and complete controlled substance medication history and the patient's daily medication use. The records do not provide sufficient information to identify and connect the diagnosis with the relevant controlled substance prescriptions.

l. Respondent failed to consult with and/or obtain records from other healthcare providers for patient E.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct re Patient F: Gross Negligence/Excessive Prescribing/Prescribing Without Exam/Medical Indication)

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

156. Paragraph 77 is incorporated herein by reference, as if fully set forth.

157. On or about June 14, 2010, Patient F, a 26-year-old male, began to see physicians at Respondent's APMG for evaluation and medical care for a worker's compensation injury incurred on May 22, 2007. The patient continued to have back pain with persistent left sciatica even after back surgery in September 2009. The plan was for an epidural steroid injection. It was noted that no Schedule II controlled substances were to be prescribed to Patient F until a transfer of care was completed. Patient F signed a Pain Center Prescribing Agreement.

158. Patient F continued to visit Respondent's clinic between every one to three months. Patient F visited Respondent's clinic for medical evaluations, treatments (acupuncture, PT/chiropractic), medications, and received injections and/or procedures at Respondent's North Coast Medical Center.

159. On or about July 21, 2010, Respondent first prescribed Schedule II controlled substance to Patient F: Oxycodone 30 mg. #120, along with Klonopin and Lidocaine patches.

160. During the course of about five years of treatment of Patient F, Respondent/APMG obtained only one CURES report and one urine toxicology test.

161. There was no documentation in Respondent's records for Patient F that informed consent was obtained and that the patient was informed of the risks and benefits of the treatment, and/or about alternatives to the treatment.

162. Patient F also would pick up prescriptions for controlled substances from Respondent's office, without having an appointment or office visit.

163. Respondent did not adequately and accurately document in Patient F's records the complete information about the medications that were dispensed to the patient from the clinic and/or the in-house pharmacy. Respondent also did not maintain a prescribing log or in-house pharmacy log for the prescriptions issued to Patient F.

164. Many of the progress notes for Patient F were not signed to indicate who evaluated the patient at a particular visit.

165. During the course of Respondent's treatment of Patient F, the patient received prescriptions from at least four different providers at Respondent's clinic. Patient F obtained controlled substances from three different pharmacies. The patient also obtained prescriptions for controlled substances from at least three other providers that were outside of Respondent's clinic.

166. According to a CURES report, between July 21, 2010 and March 18, 2015, Respondent issued to Patient F 79 prescriptions for controlled substances. But, Respondent's records for Patient F do not establish that Respondent evaluated the patient prior to issuing each prescription.

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167. Patient F was dispensed a combination of medications from the same class, e.g. oxycodone and methadone. During the course of treatment, Patient F was prescribed a combination of controlled substances, such as opioids, benzodiazepines, muscle relaxants, hypnotics, and NSAIDs.

168. In 2010 through at least 2014, prescriptions were issued to Patient F by Respondent for Oxycodone, Methadone, and Klonopin.

169. During the course of treatment, Patient F was prescribed and/or dispensed high doses of opioids and high doses of benzodiazepines.

170. During the course of treatment, Patient F's status and progress remained stagnate. There was no improvement in pain, function, or a return to work. The VAS and ADL function grossly remained unchanged or worsened. Many of the chart notes appear to repeat the same text for each visit.

171. The opioid Morphine Milligram Equivalent (MME) levels that were prescribed and/or dispensed to Patient F were very high. During the course of treatment by Respondent, the MME levels for Patient F ranged between about 180 mg. per day in July 2010 to 1,900 mg. per day in April 2014.

172. In or about 2015, the Worker's Compensation UR/medical reviewer started non-certification and modification of medications for Patient F. The reviewers determined that, while taking long-term controlled substances, Patient F was not showing improvement of function, a decrease in pain, or a return to work. The recommendation was to wean the patient off the long-term opioids and benzodiazepines.

173. During the course of treatment, Respondent continued to prescribe high doses of controlled substances to Patient F, even after the patient displayed negative or stagnate gains, evidence of tolerance, overuse and deterioration.

174. During the course of Patient F's treatment, Respondent performed approximately ten procedures, e.g. epidural steroid injections and other therapeutic injections, at his North Coast Surgery Center. There is no documentation that Respondent disclosed his financial interest to Patient F and/or that the patient was given the option to receive treatment from another provider.

175. Because of Respondent's poor medical record keeping for Patient F, the exact amounts of medications prescribed, administered, and/or dispensed directly to the patient are unknown.

176. Respondent's overall conduct, acts and/or omissions, with regard to Patient F, as set forth in paragraphs 155 through 175 herein, constitutes unprofessional conduct through gross negligence and/or prescribing without an appropriate prior examination and a medical indication and/or excessive prescribing, pursuant to Business and Professions Code Sections 2234 subdivisions (b) and/or section 2242 and/or section 725, and is therefore subject to disciplinary action. More specifically, Respondent is guilty of unprofessional conduct with regard to Patient F as follows:

a. Respondent's records were incomplete and missing comprehensive documentation of the patient's complaints, assessments, progress, diagnoses, status, response to treatment.

b. Respondent failed to document that informed consent was obtained and that Patient F was informed of the risks and benefits of each controlled substance prescribed, and the alternatives to the treatment.

c. Respondent failed to document a treatment plan with specific treatment goals.

d. Respondent prescribed and dispensed controlled substances and/or dangerous drugs without documented prior medical examinations and/or medical indications.

e. Respondent improperly delegated his physician responsibilities to treat, prescribe, evaluate and provide patient care to Patient F. Respondent allowed others to prescribe controlled substances, without written physician and health care extender supervision protocols.

f. Respondent failed to conduct an adequate periodic review and assessment of the effectiveness of the treatment of prescribing controlled substances on a chronic basis and/or in combinations of opiates and other central nervous system acting drugs and/or in dosages that exceed 90 morphine milligram equivalents (MME) daily.

g. Respondent failed to intervene and continued to prescribe controlled substances to Patient F after there was evidence of abuse and misuse.

h. Respondent did not monitor and/or enforce compliance with the patient prescribing agreement.

i. Respondent failed to conduct proper monitoring of the patient, such as random drug screens and CURES reports or pharmacy prescribing profiles.

j. Respondent excessively prescribed high doses of long-term opioids, in combination with other controlled substances to Patient F.

k. Respondent's records are incomplete and inadequate and fail to document a comprehensive and complete controlled substance medication history and the patient's daily medication use. The records do not provide sufficient information to identify and connect the diagnosis with the relevant controlled substance prescriptions.

l. Respondent failed to consult with and/or obtain records from other healthcare providers for Patient F.

SEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Repeated Negligent Acts: Patients A, B, C, D, E, F)

177. In the alternative, Respondent is subject to disciplinary action for unprofessional conduct under section 2234(c) for repeated negligent acts, jointly and/or severally, for his acts and/or omissions regarding Patient A, Patient B, Patient C, Patient D, Patient E, and/or Patient F, as alleged in paragraphs 35 through 176, which are incorporated herein by reference as if fully set forth.

EIGHTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Failure to Maintain Adequate and Accurate Records and/or Records of Schedule II Prescriptions: Patients A, B, C, D, E, F)

178. Respondent is subject to disciplinary action for unprofessional conduct under Business and Professions Code section 2266 for failure to maintain adequate and accurate records and/or Health and Safety Code section 11190 for failure to maintain adequate records for Schedule II prescriptions, jointly and/or severally, regarding Patient A and/or Patient B and/or Patient C and/or Patient D and/or Patient E and/or Patient F, as alleged in paragraphs 35 through 176, which are incorporated herein by reference as if fully set forth.

NINTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Improper Supervision of Physician Assistant and/or Nurse Practitioner)

179. Respondent Michael Long Tran, M.D. is subject to disciplinary action for unprofessional conduct under Business and Professions Code section 2234 through violations of sections 3502.1, 4170, and/or 4174 of the Business and Professions Code with regard to his improper and inadequate supervision of the dispensing and/or prescribing of drugs by physician assistants and/or nurse practitioners with regard to the care and prescribing of medications to Patient B and/or Patient C and/or Patient D and/or Patient E and/or Patient F, as alleged in paragraphs 51 through 176, 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 G85353, issued to Michael Long Tran, M.D.;

2. Revoking, suspending or denying approval of Michael Long Tran, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Michael Long Tran, 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: January 29, 2019

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

SF2016201936