

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

<b>In the Matter of the Accusation</b>	)	
<b>Against:</b>	)	
	)	
	)	
<b>John Edwin Parsons Jr., M.D.</b>	)	<b>Case No. 800-2015-018605</b>
	)	
<b>Physician's and Surgeon's</b>	)	
<b>Certificate No. G 78940</b>	)	
	)	
<b>Respondent</b>	)	
_____	)	


**DECISION**

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

**This Decision shall become effective at 5:00 p.m. on November 27, 2019.**

**IT IS SO ORDERED: October 30, 2019.**

**MEDICAL BOARD OF CALIFORNIA**

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

1 XAVIER BECERRA  
Attorney General of California  
2 STEVEN D. MUNI  
Supervising Deputy Attorney General  
3 RYAN J. YATES  
Deputy Attorney General  
4 State Bar No. 279257  
1300 I Street, Suite 125  
5 P.O. Box 944255  
Sacramento, CA 94244-2550  
6 Telephone: (916) 210-6329  
Facsimile: (916) 327-2247  
7

8 *Attorneys for Complainant*  
9

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

14 In the Matter of the Accusation Against:

15 **JOHN EDWIN PARSONS, JR., M.D.**  
16 **1123 S. Imperial Ave.**  
**El Centro, CA 92243**

17 **Physician's and Surgeon's Certificate No. G**  
18 **78940**

19 Respondent.

Case No. 800-2015-018605

OAH No. 2019080183

**STIPULATED SETTLEMENT AND  
DISCIPLINARY ORDER**

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

23 **PARTIES**

24 1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board  
25 of California (Board). She brought this action solely in her official capacity and is represented in  
26 this matter by Xavier Becerra, Attorney General of the State of California, by Ryan J. Yates,  
27 Deputy Attorney General.  
28

1           2.     Respondent John Edwin Parsons, Jr., M.D. (Respondent) is represented in this  
2 proceeding by attorney Chris A. Yturralde Esq., whose address is: 3755 Avocado Boulevard,  
3 #434, La Mesa, CA 91941.

4           3.     On or about May 25, 1994, the Board issued Physician's and Surgeon's Certificate  
5 No. G 78940 to John Edwin Parsons, Jr., M.D. (Respondent). The Physicians and Surgeon's  
6 Certificate was in full force and effect at all times relevant to the charges brought in Accusation  
7 No. 800-2015-018605, and will expire on September 30, 2019, unless renewed.

8    **JURISDICTION**

9           Accusation No. 800-2015-018605 was filed before the Board, and is currently pending  
10 against Respondent. The Accusation and all other statutorily required documents were properly  
11 served on Respondent on December 13, 2018. Respondent timely filed his Notice of Defense  
12 contesting the Accusation.

13           4.     A copy of Accusation No. 800-2015-018605 is attached as exhibit A and incorporated  
14 herein by reference.

15   **ADVISEMENT AND WAIVERS**

16           5.     Respondent has carefully read, fully discussed with counsel, and understands the  
17 charges and allegations in Accusation No. 800-2015-018605. Respondent has also carefully read,  
18 fully discussed with counsel, and understands the effects of this Stipulated Settlement and  
19 Disciplinary Order.

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

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

28     ///

1 CULPABILITY

2 Respondent does not contest that, at an administrative hearing, Complainant could establish  
3 a prima facie case with respect to the charges and allegations contained in Accusation No. 800-  
4 2015-018605 and that he has thereby subjected his license to disciplinary action.

5 9. Respondent further agrees that if an accusation is ever filed against him before the  
6 Medical Board of California, all of the charges contained in Accusation No. 800-2015-018605  
7 shall be deemed true, correct, and fully admitted by Respondent for purposes of any such  
8 proceeding or any other licensing proceeding involving Respondent in the State of California or  
9 elsewhere.

10 10. Respondent agrees that his Physician's and Surgeon's Certificate No. G 78940 is  
11 subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth  
12 in the Disciplinary Order below.

13 11. Respondent agrees the Disciplinary Order below, requiring the disclosure of  
14 probation pursuant to Business and Professions Code section 2228.1, serves to protect the public  
15 interest.

16 CONTINGENCY

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

27 ///

28 ///

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

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

7 **DISCIPLINARY ORDER**

8 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 78940 issued  
9 to Respondent John Edwin Parsons, Jr., M.D. is revoked. However, the revocation is stayed and  
10 Respondent is placed on probation for five (5) years on the following terms and conditions:

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

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

20 2. **PATIENT DISCLOSURE.** Before a patient's first visit following the effective date  
21 of this order and while the respondent is on probation, Respondent must provide all patients, or  
22 patient's guardian or health care surrogate, with a separate disclosure that includes the  
23 Respondent's probation status, the length of the probation, the probation end date, all practice  
24 restrictions placed on the respondent by the board, the board's telephone number, and an  
25 explanation of how the patient can find further information on the respondent's probation on the  
26 respondent's profile page on the board's website. Respondent shall obtain from the patient, or the  
27 patient's guardian or health care surrogate, a separate, signed copy of that disclosure. Respondent  
28

1 shall not be required to provide a disclosure if any of the following applies: (1) The patient is  
2 unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure  
3 and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the  
4 copy; (2) The visit occurs in an emergency room or an urgent care facility or the visit is  
5 unscheduled, including consultations in inpatient facilities; (3) Respondent is not known to the  
6 patient until immediately prior to the start of the visit; (4) Respondent does not have a direct  
7 treatment relationship with the patient.

8 3. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar  
9 days of the effective date of this Decision, Respondent shall enroll in a clinical competence  
10 assessment program approved in advance by the Board or its designee. Respondent shall  
11 successfully complete the program not later than six (6) months after Respondent's initial  
12 enrollment unless the Board or its designee agrees in writing to an extension of that time.

13 The program shall consist of a comprehensive assessment of Respondent's physical and  
14 mental health and the six general domains of clinical competence as defined by the Accreditation  
15 Council on Graduate Medical Education and American Board of Medical Specialties pertaining to  
16 Respondent's current or intended area of practice. The program shall take into account data  
17 obtained from the pre-assessment, self-report forms and interview, and the Decision(s),  
18 Accusation(s), and any other information that the Board or its designee deems relevant. The  
19 program shall require Respondent's on-site participation for a minimum of three (3) and no more  
20 than five (5) days as determined by the program for the assessment and clinical education  
21 evaluation. Respondent shall pay all expenses associated with the clinical competence  
22 assessment program.

23 At the end of the evaluation, the program will submit a report to the Board or its designee  
24 which unequivocally states whether the Respondent has demonstrated the ability to practice  
25 safely and independently. Based on Respondent's performance on the clinical competence  
26 assessment, the program will advise the Board or its designee of its recommendation(s) for the  
27 scope and length of any additional educational or clinical training, evaluation or treatment for any  
28 medical condition or psychological condition, or anything else affecting Respondent's practice of

1 medicine. Respondent shall comply with the program's recommendations.

2 Determination as to whether Respondent successfully completed the clinical competence  
3 assessment program is solely within the program's jurisdiction.

4 If Respondent fails to enroll, participate in, or successfully complete the clinical  
5 competence assessment program within the designated time period, Respondent shall receive a  
6 notification from the Board or its designee to cease the practice of medicine within three (3)  
7 calendar days after being so notified. The Respondent shall not resume the practice of medicine  
8 until enrollment or participation in the outstanding portions of the clinical competence assessment  
9 program have been completed. If the Respondent did not successfully complete the clinical  
10 competence assessment program, the Respondent shall not resume the practice of medicine until a  
11 final decision has been rendered on the accusation and/or a petition to revoke probation. The  
12 cessation of practice shall not apply to the reduction of the probationary time period.

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

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

25 5. EDUCATION COURSE. Within sixty (60) calendar days of the effective date of  
26 this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its  
27 designee for its prior approval educational program(s) or course(s) which shall not be less than  
28 forty (40) hours per year, for each year of probation. The educational program(s) or course(s)

1 shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category 1  
2 certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in  
3 addition to the Continuing Medical Education (CME) requirements for renewal of licensure.  
4 Following the completion of each course, the Board or its designee may administer an  
5 examination to test respondent's knowledge of the course. Respondent shall provide proof of  
6 attendance for sixty-five (65) hours of CME, of which forty (40) hours were in satisfaction of this  
7 condition.

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

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

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

25         7.     PROFESSIONALISM PROGRAM (ETHICS COURSE). Within sixty (60)  
26 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism  
27 program, that meets the requirements of Title 16; California Code of Regulations (CCR) section  
28 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall



1 provide any information and documents that the program may deem pertinent. Respondent shall  
2 successfully complete the classroom component of the program not later than six (6) months after  
3 Respondent's initial enrollment, and the longitudinal component of the program not later than the  
4 time specified by the program, but no later than one (1) year after attending the classroom  
5 component. The professionalism program shall be at Respondent's expense and shall be in  
6 addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

15 8. MONITORING – PRACTICE/BILLING. Within thirty (30) days of the effective  
16 date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a  
17 practice and billing monitor(s), the name and qualifications of one or more licensed physicians  
18 and surgeons whose licenses are valid and in good standing, and who are preferably American  
19 Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business  
20 or personal relationship with Respondent, or other relationship that could reasonably be expected  
21 to compromise the ability of the monitor to render fair and unbiased reports to the Board,  
22 including but not limited to any form of bartering, shall be in Respondent's field of practice, and  
23 must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

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

1 the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised  
2 monitoring plan with the signed statement for approval by the Board or its designee.

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

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

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

19         If the monitor resigns or is no longer available, Respondent shall, within five (5) calendar  
20 days of such resignation or unavailability, submit to the Board or its designee, for prior approval,  
21 the name and qualifications of a replacement monitor who will be assuming that responsibility  
22 within fifteen (15) calendar days. If Respondent fails to obtain approval of a replacement monitor  
23 within sixty (60) calendar days of the resignation or unavailability of the monitor, Respondent  
24 shall receive a notification from the Board or its designee to cease the practice of medicine within  
25 three (3) calendar days after being so notified Respondent shall cease the practice of medicine  
26 until a replacement monitor is approved and assumes monitoring responsibility.

27         In lieu of a monitor, Respondent may participate in a professional enhancement program  
28 approved in advance by the Board or its designee, that includes, at minimum, quarterly chart

1 review, semi-annual practice assessment, and semi-annual review of professional growth and  
2 education. Respondent shall participate in the professional enhancement program at Respondent's  
3 expense during the term of probation.

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

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

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

12 11. GENERAL PROBATION REQUIREMENTS.

13 Compliance with Probation Unit

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

15 Address Changes

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

21 Place of Practice

22 Respondent shall not engage in the practice of medicine in Respondent's place of residence.  
23 If Respondent engages in the practice of medicine at a patient's place of residence, Respondent  
24 shall maintain an office, where those patients' records are kept and made available to  
25 Respondent's practice monitor, as well as Board staff.

26 License Renewal

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

1           Travel or Residence Outside California

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

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

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

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

25           In the event Respondent's period of non-practice while on probation exceeds 18 calendar  
26 months, Respondent shall successfully complete the Federation of State Medical Board's Special  
27 Purpose Examination, or, at the Board's discretion, a clinical competence assessment program  
28 that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model

1 Disciplinary Orders and Disciplinary Guidelines” prior to resuming the practice of medicine.

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

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

4 Periods of non-practice for a Respondent residing outside of California will relieve

5 Respondent of the responsibility to comply with the probationary terms and conditions with the

6 exception of this condition and the following terms and conditions of probation: Obey All Laws;

7 General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or

8 Controlled Substances; and Biological Fluid Testing.

9 14. COMPLETION OF PROBATION. Respondent shall comply with all financial  
10 obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the  
11 completion of probation. Upon successful completion of probation, Respondent’s certificate shall  
12 be fully restored.

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

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

1 application shall be treated as a petition for reinstatement of a revoked certificate.

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

7 ACCEPTANCE

8 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully  
9 discussed it with my attorney, Chris A. Yturralde Esq.. I understand the stipulation and the effect  
10 it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement  
11 and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the  
12 Decision and Order of the Medical Board of California.

13  
14 DATED: 9-13-19 John Edwin Parsons, Jr. M.D.  
15 JOHN EDWIN PARSONS, JR., M.D.  
Respondent

16 I have read and fully discussed with Respondent John Edwin Parsons, Jr., M.D. the terms  
17 and conditions and other matters contained in the above Stipulated Settlement and Disciplinary  
18 Order. I approve its form and content.

19 DATED: 9/18/19 CHRIS A. YTURRALDE ESQ.  
20 Attorney for Respondent

21 ///  
22 ///  
23 ///  
24 ///  
25 ///  
26 ///  
27 ///  
28 ///

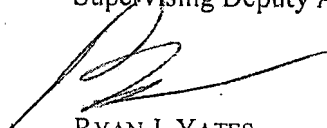
1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

**ENDORSEMENT**

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

DATED: 9/18/19

Respectfully submitted,  
XAVIER BECERRA  
Attorney General of California  
STEVEN D. MUNI  
Supervising Deputy Attorney General

  
RYAN J. YATES  
Deputy Attorney General  
*Attorneys for Complainant*

SA2018102614  
14055878.docx

**Exhibit A**

**Accusation No. 800-2015-018605**



1 XAVIER BECERRA  
Attorney General of California  
2 STEVEN D. MUNI  
Supervising Deputy Attorney General  
3 DEMOND L. PHILSON  
Deputy Attorney General  
4 State Bar No. 220220  
1300 I Street, Suite 125  
5 P.O. Box 944255  
Sacramento, CA 94244-2550  
6 Telephone: (916) 210-7548  
Facsimile: (916) 327-2247  
7 Attorneys for Complainant

FILED  
STATE OF CALIFORNIA  
MEDICAL BOARD OF CALIFORNIA  
SACRAMENTO November 13, 2018  
BY [Signature] ANALYST

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

13 In the Matter of the Accusation Against:

Case No. 800-2015-018605

14 **John Edwin Parsons, Jr., M.D.**  
15 **1123 S. Imperial Ave.**  
**El Centro, CA 92243**

**ACCUSATION**

16 **Physician's and Surgeon's Certificate**  
17 **No. G 78940,**

18 Respondent.

19  
20 Complainant alleges:

21 **PARTIES**

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

25 2. On or about May 25, 1994, the Medical Board issued Physician's and Surgeon's  
26 Certificate Number G 78940 to John Edwin Parsons, Jr., M.D. (Respondent). The Physician's  
27 and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought  
28 herein and will expire on September 30, 2019, unless renewed.

1 JURISDICTION

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

4 4. Section 2234 of the Code, states:

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

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

10 “(b) Gross negligence.

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

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

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

21 “(d) Incompetence.

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

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

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

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

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

7           6.     Section 725 of the Code states:

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

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

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

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

24     ///

25     ///

26     ///

27     ///

28     ///

1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Gross Negligence)**

3 7. Respondent is subject to disciplinary action under section 2234, as defined by section  
4 2234, subdivision (b), of the Code, in that respondent committed gross negligence in his care and  
5 treatment of patients A, B, C, D, and E.<sup>1</sup>

6 8. On or around November 15, 2015, the Medical Board of California (MBC) received a  
7 complaint against Respondent from the California Department of Health Care Services (DHCS).  
8 The complaint alleged various issues found during a focused review of Respondent's prescribing  
9 practices at Ampla Health in Oroville, CA, including substandard office visit documentation,  
10 substandard management of chronic pain, and quality of care issues. Controlled Substance  
11 Utilization Review and Evaluation System (CURES) reports were obtained on Respondent's  
12 prescribing. In Respondent's care and treatment of patients A, B, C, D, and E departures from the  
13 standard of care were identified as follows:

14 Patient A

15 9. Patient A is a male born in 1966 with history of hypertriglyceridemia, lumbar spinal  
16 stenosis with prior back surgery and failed back syndrome, anxiety, depression, chronic nausea,  
17 reported attention deficit disorder, and abdominal hernias with resulting surgeries. Patient A  
18 began seeing Respondent in December 2012 and saw him approximately every 2-3 months until  
19 December 2015, mostly for medication refills of Controlled Substances for chronic back pain.  
20 Respondent regularly prescribed non-controlled substances including numerous antibiotics, such  
21 as Phenergan for nausea, ProAir (albuterol) inhaler, and back braces and a TENS unit for back  
22 pain. Patient A also saw a psychiatrist who prescribed Xanax and Effexor although it is not clear  
23 how long he saw the other physician.

24 10. Patient A's "History of Present Illness" notations from April 2013 onward typically  
25 mention only "lumbar pain" with no discussion regarding the location of the pain, quality,  
26 provoking or palliating factors, radiation of the pain, pain level, or effect on patient A's function.

27 \_\_\_\_\_  
28 <sup>1</sup> The patients are referred to by letters in order to preserve their privacy. Their identity  
will be disclosed in the discovery provided to the respondent.

1 Patient A's vital signs were significant for a body mass index of 34-35 indicating obesity.  
2 Examination of Patient A is repeated verbatim at many visits and was noted as "palpable  
3 tenderness of the lumbar and thoracic spine, has difficulty forward flexing at the waist. Patient's  
4 lungs were clear, heart examination normal, abdomen significant for scarring" and mentation  
5 noted as "alert and oriented x 3, ambulatory."

6 11. On March 22, 2013, Respondent saw patient A for a visit noting that Patient A had a  
7 history of severe spine pain with history of spine surgery and was seeing a specialist who ordered  
8 a computed tomography (CT) scan of the spine. Patient A had failed two prior drug screenings  
9 in November of 2012 ordered by the Respondent's colleagues which were positive for  
10 methamphetamines. Patient A reported 10/10 on a pain scale, had anxiety and depression, and he  
11 was seeing a psychiatrist for these issues. Patient A reported nausea from his medications,  
12 requesting a transcutaneous electrical nerve stimulation (TENS) unit for his pain and the  
13 Respondent noted he was having difficulty finding a pain specialist who would see patient A.  
14 Respondent's note stated "...taking everything into consideration, I am going to attempt to  
15 reverse my decision for no-narcotics based on his positive drug screen with methamphetamines  
16 and I am going to attempt to give him a second chance. This is a controversial decision....I told  
17 the patient that he has to be able to pass future drug screens and he cannot be found to be  
18 habitually using methamphetamines....The patient has significant mental health issues and easily  
19 becomes very anxious and very depressed." Respondent further noted patient A had marked  
20 tenderness of his lumbar spine and was ambulatory. Respondent refilled Methadone<sup>2</sup> 10mg two  
21 tablets up to four times a day, maximum eight per day #240, oxycodone<sup>3</sup> IR 30 mg two tablets up  
22 to four times a day, maximum of eight per day #240. Respondent ordered a CT scan per the  
23 request of the surgeon and stated he would arrange for a TENS unit.

24 ///

25 <sup>2</sup> Methadone is a Schedule II controlled substance pursuant to Health and Safety Code  
26 section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code  
section 4022.

27 <sup>3</sup> Oxycodone, brand name OxyContin, is a Schedule II controlled substance pursuant to  
28 Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to  
Business and Professions Code section 4022.

1 12. Patient A was previously seen in January of 2013 and it was also noted at that time  
2 that he had a positive urine toxicology screening in November of 2012 but the Respondent agreed  
3 to continue to prescribe pain medications until the patient could be seen at a pain clinic. Patient A  
4 was also prescribed Ambien<sup>4</sup> at that visit. Patient A had previously had both physical therapy and  
5 epidural injections, neither of which were helpful for his pain. Respondent did order back brace  
6 and a TENS unit per patient A's request and also referred the patient to physical therapy again in  
7 October 2014.

8 13. The CURES report shows Respondent was prescribing patient A the following  
9 controlled substances on a regular basis: methadone 10 mg #240 per month December 2012  
10 through August 2013, then #120 per month until January 2016; oxycodone 30 mg #240 per month  
11 December 2012 through August 2013, following this #180 per month until January 2016;  
12 Oxycontin<sup>5</sup> 80 mg, #90 per month, September 2013 through January 2016; Alprazolam (Xanax)<sup>6</sup>  
13 2 mg #90 per month-prescribed by other physicians from 2011 through 2015, then by the  
14 Respondent beginning in March 2015, #60 per month.

15 14. Patient A had two controlled substance agreements on file signed by other providers  
16 within Ampla Health dated March 2011 and November 2012. There is a notation on March 17,  
17 2015 in the chart that patient A filled out an agreement that date with Respondent but there is no  
18 agreement on file. There are two unsigned versions in the medical record.

19 15. Patient A consulted with a number of surgeons over the time period reviewed,  
20 although the patient A did not have any further interventions or surgeries from 2013 through  
21 2015. At least two surgeons saw patient A and did not feel that he was a candidate for further  
22 ///

23 <sup>4</sup> Zolpidem, brand name Ambien, is a Schedule IV controlled substance pursuant to Health  
24 and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and  
Professions Code section 4022.

25 <sup>5</sup> Oxycodone, brand name OxyContin, is a Schedule II controlled substance pursuant to  
26 Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to  
Business and Professions Code section 4022.

27 <sup>6</sup> Alprazolam is a benzodiazepine. Alprazolam affects chemicals in the brain that may be  
28 unbalanced in people with anxiety. Alprazolam is used to treat anxiety disorders, panic disorders,  
and anxiety caused by depression. Alprazolam is a Schedule IV controlled substance pursuant to  
Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to  
Business and Professions Code section 4022.

1 surgery and should be managed medically. Patient A was initially on Methadone and Oxycodone  
2 when Respondent began seeing him.

3 16. In October of 2013, the Respondent added Oxycontin (long-acting oxycodone) in  
4 addition to the Methadone and oxycodone in hopes of eventually discontinuing the Methadone,  
5 which was never done. Respondent discussed the case with a Tele-health pain specialist who  
6 recommended urine toxicology screenings. Patient A was referred to the Chico pain clinic in  
7 February 2013 although it appears he never went. Respondent let the patient know about a pain  
8 clinic in January of 2015 but made no official referral and again the patient A was not seen  
9 elsewhere for pain management. Respondent again recommended referral in May 2015 and  
10 September 2015 but the patient declined.

11 17. Patient A had five urine toxicology screenings during between November 2012 and  
12 September 2015.

13 18. On November 1, 2012, patient A had a toxicology screening ordered by a Nurse  
14 Practitioner. Patient A tested positive for oxycodone, marijuana, hydrocodone<sup>7</sup>, amphetamine<sup>8</sup>  
15 and methamphetamine and negative for Xanax (alprazolam). Patient A's urine contained  
16 Methadone metabolites but not Methadone (indicating Methadone at either very low doses or  
17 taken a few days prior). Respondent noted "Failed testing. No more narcotics letter."

18 19. On November 28, 2012, patient A had a toxicology screening ordered by another  
19 Physician at Ampla. Patient A tested positive for opiates, morphine<sup>9</sup>, oxycodone, Methadone,  
20 alprazolam, amphetamines and methamphetamine. At the time patient A was being prescribed  
21 Kadian<sup>10</sup> and Oxycodone.

22 <sup>7</sup> Norco (acetaminophen and hydrocodone) is used to relieve moderate to severe pain.  
23 Norco (hydrocodone) is a Schedule II controlled substance pursuant to Health and Safety Code  
24 section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code  
25 section 4022.

24 <sup>8</sup> Amphetamine is a Schedule II controlled substance pursuant to Health and Safety Code  
25 section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code  
26 section 4022.

26 <sup>9</sup> Morphine is a Schedule II controlled substance pursuant to Health and Safety Code  
27 section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code  
28 section 4022.

27 <sup>10</sup> Morphine sulfate (Kadian) is an analgesic opiate agonist used for relief of moderate to  
28 severe acute and chronic pain. Morphine is a dangerous drug as defined in section 4022, a

1           20.    On December 12, 2013, patient A had a toxicology screening ordered by Respondent  
2 which was positive for morphine, hydrocodone, hydromorphone<sup>11</sup>, norhydrocodone<sup>12</sup>, oxycodone,  
3 oxymorphone<sup>13</sup> and noroxycodone<sup>14</sup> and negative for Methadone, benzodiazepines and  
4 amphetamines. Respondent made a handwritten notation to discuss it with Patient A the next  
5 visit. Patient A was next seen by the Respondent on January 10, 2014, and the urine toxicology  
6 results were not noted or discussed at that visit. Patient A was being prescribed Methadone,  
7 oxycodone and OxyContin at the time by the Respondent, as well as Xanax by the patient's  
8 psychiatrist.

9           21.    On June 4, 2014, patient A had a toxicology screening ordered by Respondent which  
10 was negative for oxycodone, Oxycontin, Norco and Methadone, all of which Patient A was  
11 reportedly prescribed and positive for oxymorphone (a metabolite of oxycodone). The sample  
12 was negative for benzodiazepines and methamphetamine. No notations are made on the results  
13 but Respondent discussed this at the visit on July 2, 2014, and noted that patient A ran out four  
14 days prior to the test, although it should have been detectable for up to two weeks. Respondent  
15 continued to prescribe the same medication regimen including Oxycontin, oxycodone and  
16 Methadone at the same dosage and amounts. Respondent noted patient A would need some serial  
17 drug screens for the next several visits. Patient A's next drug screen was not ordered until  
18 September of 2015, approximately 14 months later.

19           22.    On September 3, 2015, patient A had a toxicology screening ordered by Respondent  
20 which was positive for Methadone, alprazolam, oxymorphone, noroxycodone, and negative for  
21 OxyContin and oxycodone. Patient A was being prescribed oxycodone, OxyContin, Methadone  
22 and Xanax (alprazolam) at the time. This was not addressed by the Respondent.

23 \_\_\_\_\_  
24 schedule II controlled substance and narcotic as defined by Health and Safety Code section  
25 11055(b)(1), and a Schedule II controlled substance as defined by section 1308.12(b)(1) of Title  
26 21 of the Code of Federal Regulations.

25           <sup>11</sup> Hydromorphone, brand name Dilaudid, is a Schedule II controlled substance pursuant  
26 to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to  
27 Business and Professions Code section 4022.

26           <sup>12</sup> Norhydrocodone is the major metabolite of the opioid analgesic hydrocodone.

27           <sup>13</sup> Oxymorphone is a Schedule II controlled substance pursuant to Health and Safety Code  
28 section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code  
section 4022.

28           <sup>14</sup> Noroxycodone is the major metabolite of the opioid analgesic oxycodone.



1           23.    On December 19, 2012, patient A had an magnetic resonance imaging (MRI)  
2 ordered by Respondent with stable post-surgical changes and very mild canal stenosis at L3-4 and  
3 right neural foraminal stenosis at L4-5 and L5-S1. Patient A had a nerve conduction study  
4 performed on July 20, 2012, which was normal.

5           24.    Respondent repeatedly states in patient A's medical notes that the controlled  
6 substance dosages were high and it is a goal to bring them down yet continued to prescribe the  
7 same dosages and amounts of opiates for three years.

8           25.    On December 12, 2013, July 2, 2014, September 2, 2014, and October 1, 2014,  
9 patient A reported losing half a bottle of oxycodone down the sink.

10          26.    On September 2, 2014, patient A reported withdrawal symptoms when he ran out of  
11 medications early.

12          27.    On December 15, 2015, the patient had his last visit with Respondent. Respondent's  
13 chart notes indicate that patient A "is going to be referred to Oroville Pain Institute. I  
14 [Respondent] feel compelled to continue his current med doses at this time - he cannot tolerate  
15 decreasing the pain med doses at this time. Patient again states half his oxycodone bottle spilled  
16 into a sink and was damaged. The patient is in such a distressed mental state I am not going to  
17 argue with him out of fear he might harm himself." Respondent prescribed an extra two week  
18 bridging script of #90 oxycodone; and gave double script for oxycodone 6/day #180 and  
19 Methadone #120. Respondent referred patient A to tele-health psychiatry and prescribed Xanax  
20 (alprazolam). #60 plus 1 refill.

21          28.    Over the three years of care, Respondent never addressed the possibility patient A  
22 having a substance abuse addiction or opiate dependence disorder and never considered the  
23 possibility that patient A was diverting his medications, even though patient A had a number of  
24 inconsistent urine toxicology results. No Electrocardiography (EKG) was ever performed and no  
25 mention was ever made regarding smoking cessation or vaccinations during the course of care.

26          29.    Respondent committed gross negligence in his care and treatment of patient A, which  
27 included, but are not limited to, the following:

28    ///

1 (a) Paragraphs 9 through 28, above, are hereby incorporated by reference as if fully  
2 set forth herein; and,

3 (b) Respondent departed from the standard of care by prescribing two long-acting  
4 medications at a time, prescribing extremely high doses of opiates without good medical  
5 justification or informed consent, and without standard monitoring with CURES reports or more  
6 routine urine toxicology studies in a patient with known mental health issues and substance use;  
7 and

8 (c) Respondent departed from the standard of care by not addressing the patient's  
9 illicit substance use, not screening for or identifying Opiate Use Disorder, and continuing to  
10 prescribe high-dose high-risk narcotics even in light of inconsistent toxicology results.

11 Patient B

12 30. Patient B is a female born in 1971 with uncontrolled insulin-dependent diabetes,  
13 chronic back pain, carpal tunnel syndrome, asthma, bipolar disorder, anxiety, obesity, severe  
14 hypertension and a history of alcoholism. The Respondent saw the patient every two to three  
15 months from January 2013 through July of 2015 for treatment of her chronic pain issues, as well  
16 as her diabetes and hypertension. Respondent typically wrote prescriptions enough for two  
17 months at each visit.

18 31. The CURES report shows Respondent was prescribing patient B the following  
19 controlled substances on a regular basis: Oxycontin 80 mg #90 per month beginning January  
20 2013, increased to #180/month in March 2013, stopped in October of 2013; Oxycodone 30 mg  
21 #180 per month beginning in November 2013, decreased to #90/month in March of 2014, stopped  
22 November 2014 when Hydromorphone was started; Hydromorphone (Dilaudid) 8mg #120 per  
23 month November 2014 through July 2015; Methadone (Dolophine)10 mg #180 per month  
24 January 2013, then increased to #240 per month in April 2013, increased to #270 in February  
25 2014 and continued until September, 2015; Lorazepam (Ativan)<sup>15</sup> 2mg #30 January 2013,

26 <sup>15</sup> Lorazepam (generic name for Ativan) is a benzodiazepine used in the treatment of  
27 anxiety, insomnia, and status epilepticus. It is a dangerous drug as defined in section 4022, a  
28 schedule IV controlled substance as defined by Health and Safety Code section 11057(d), and a  
Schedule IV controlled substance as defined by section 1308.14(c) of Title 21 of the Code of

1 increased to #60 per month November 2013; Clonazepam (Klonopin)<sup>16</sup> 1mg January 2014 #60  
2 through July 2014; and Tramadol (Ultram)<sup>17</sup> 50 mg #150 per month starting in October 2, 2014,  
3 increased to #180 per month in November 2014 and continued until January 2016. Respondent  
4 prescribed the pain medications as above for chronic lumbar pain and bilateral carpal tunnel  
5 syndrome.

6 32. On December 20, 2012, patient B had an MRI of her lumbar spine which revealed  
7 mild degenerative changes in the lumbar spine and mild right neuroforaminal narrowing at 14-5.  
8 Respondent recommended that patient B see Dr. W, a pain interventionist, in the fall of 2014,  
9 however the patient canceled the referral. Patient B was also referred to physical therapy in 2014  
10 as well as tele-psychiatry for her anxiety and depression, although it is unclear if these referrals  
11 were ever carried out. Respondent noted at the visit on February 21, 2013, that the MRI does not  
12 explain very well the degree of narcotic medication that she needs, yet Respondent continued to  
13 prescribe her relatively high dose opiates.

14 33. Patient B's physical examinations were repeated verbatim at the visits on October 29,  
15 2014, January 19, 2015, March 13, 2015 and July 8, 2015 other than the vital signs which varied  
16 slightly. Most included no musculoskeletal examination whatsoever. A different template was  
17 used and repeated verbatim on July 10, 2013, September 4, 2013, October 1, 2013, October 28,  
18 2013, November 25, 2013, December 17, 2013, January 5, 2014, February 9, 2014, March 14,  
19 2014, June 10, 2014 and September 3, 2014. These noted only palpable tenderness of the lumbar  
20 spine with no assessment of the range of motion of the spine, any radicular symptoms or  
21 neurologic examination and over the three years of care, patient B's hands or wrists were never  
22 examined in regards to her carpal tunnel syndrome.

23 ///

24 ///

25 \_\_\_\_\_

26 Federal Regulations.  
27 <sup>16</sup> Clonazepam is a Schedule IV controlled substance pursuant to Health and Safety Code  
28 section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code  
section 4022.  
<sup>17</sup> Tramadol is a narcotic-like pain reliever. Tramadol is used to treat moderate to severe  
pain.

1           34. In patient B's medical chart there is one Controlled Substance Agreement on file  
2 signed and dated on May 19, 2011, by another provider. There are no CURES reports included or  
3 mentioned in the medical record.

4           35. In April 2013, Respondent increased patient B's Methadone dosage from 20 mg three  
5 times a day to 20 mg four times a day for no reason other than patient B requested an increase.

6           36. On November 25, 2013, Patient B had a toxicology screening ordered by Respondent  
7 which was positive for oxycodone and Methadone and negative for benzodiazepines. Patient B  
8 was prescribed oxycodone, Methadone and lorazepam at the time.

9           37. In January 2014, Respondent began to prescribe clonazepam in addition to lorazepam  
10 with no explanation. This was continued until July of 2014.

11           38. On June 10, 2014, patient B had a toxicology screening ordered by Respondent  
12 which was positive for opiates oxycodone and oxymorphone and negative for the expected  
13 noroxycodone (an oxycodone metabolite), Methadone, and benzodiazepines. Patient B was  
14 prescribed Methadone, oxycodone, lorazepam and clonazepam at the time. The discrepancy was  
15 never addressed by Respondent. At the visit, patient B reported she was so tired and was standing  
16 in kitchen and fell backwards hitting her head and buttocks.

17           39. At the visit in September 2014, patient B reportedly lost all three of her Controlled  
18 Substance medications and needed an early refill. Patient B was informed of pain contract policy  
19 of no replacements and was given a second chance by Respondent. The Respondent provided  
20 early refills of all three medications.

21           40. On September 9, 2014, patient B had one EKG performed and patient B had a  
22 corrected QT interval of 469 ms (normal <450 ms) and some minor other changes. Respondent  
23 referred patient B to a cardiologist although it is unclear if she ever saw one. Patient B had one set  
24 of laboratory studies performed on September 26, 2013 significant for elevated triglycerides of  
25 438, low HDL 37, elevated total cholesterol 206, Glycohemoglobin 13.4%, random glucose 385,  
26 normal renal and kidney function, and no anemia or evidence of infectious diseases including  
27 HIV, syphilis, and hepatitis. There is no documentation that these results were ever reviewed with  
28 patient B. Over the course of the over two years of care, patient B never had a pelvic examination,

1 referral to an eye doctor, neurologic evaluation for neuropathy, or microalbumin level ordered by  
2 Respondent.

3 41. At the visit on October 29, 2014, Respondent started prescribing Tramadol in addition  
4 to patient B's other narcotic pain medications. There is no documented reason in the chart notes.  
5 Respondent continued to prescribe Tramadol until the end of 2015.

6 42. In November of 2014, patient B requested a change from oxycodone to  
7 hydromorphone (Dilaudid) and Respondent complied with her request with no medical reason or  
8 documentation.

9 43. On July 8, 2015, patient B had a toxicology screening ordered by Respondent which  
10 was negative for opiates (including hydromorphone and tramadol which were being prescribed),  
11 and positive for Methadone, lorazepam and amphetamines including methamphetamine. At this  
12 point patient B was sent a letter from the administration that she would receive no more narcotics  
13 from Ampla health.

14 44. On September 4, 2015, Respondent wrote prescriptions for Methadone, Tramadol  
15 and Dilaudid (hydromorphone) and per the CURES report patient B continued to fill Tramadol  
16 and Lorazepam from Respondent until January 1, 2016, and December 27, 2014 respectively.

17 45. Respondent prescribed patient B multiple courses of anti-fungal medications for  
18 vaginal itch on April 17, 2013, January 15, 2014, February 9, 2014, March 14, 2014, and May 8,  
19 2014, without ever examining the patient's genitalia. Respondent prescribed patient B multiple  
20 courses of antibiotics for sinusitis and bronchitis although at most of these visits the physical  
21 examination was normal or noted only mild sinus tenderness without fever. These included  
22 azithromycin for bronchitis on January 29, 2013, Levaquin for severe sinusitis on March 6, 2013,  
23 even though no sinus examination was performed, Levaquin for bronchitis on October 28, 2013,  
24 Cipro for possible bacterial sinusitis on December 17, 2013, Levaquin for cough with yellow  
25 phlegm on January 5, 2014, Cipro for sinusitis on March 14, 2014, Levaquin on March 13, 2015  
26 for chronic bronchitis although the lung examination was normal.

27 46. Respondent committed gross negligence in his care and treatment of patient B, which  
28 included, but are not limited to, the following:

1 (a) Paragraphs 30 through 46, above, are hereby incorporated by reference as if  
2 fully set forth herein; and,

3 (b) Respondent departed from the standard of care by prescribing high doses of  
4 opiates without good medical justification or indication, nor informed consent, and without  
5 standard monitoring with CURES reports or appropriate management of urine toxicology findings  
6 in a patient with a known substance abuse history.

7 Patient C

8 47. Patient C is a male born in 1959 and presented with coronary artery disease,  
9 hypertension, asthma, and was seen regularly by the Respondent for chronic back and knee pain  
10 related to a prior fall and knee surgeries. Patient C saw an orthopedic surgeon Dr. B. in Redding,  
11 CA, as well as a cardiologist. He eventually had a repeat right knee replacement in November  
12 2015 which went well. In November of 2015 he was referred to a pain clinic because he was  
13 taking an excess of opiates. Patient C had intermittent issues with edema. Patient C was on  
14 Methadone, oxycodone and MS Contin<sup>18</sup> for knee and spine pain when the Respondent began  
15 seeing him in December 2012. Respondent did not have a pain agreement on file with patient C.

16 48. The CURES report shows Respondent was prescribing patient C the following  
17 controlled substances on a regular basis: MS Contin (Morphine) 100mg #90 per month December  
18 2012, increased to #120 per month in July 2013, decreased to #60 per month in October 2013, last  
19 filled October 16, 2015; Oxycodone 30mg #90 per month December 2012, increased to #120 per  
20 month in July 2013, increased to #150 per month in July 2015 through November 2015;  
21 Methadone 10mg #270 per month December 2012, increased to #360 per month in May, 2013  
22 through November 2015; Valium (diazepam)<sup>19</sup> 10mg #30 per month March 2013 through

23  
24 <sup>18</sup> Morphine sulfate (generic name for MS Contin) is an analgesic opiate agonist used for  
25 relief of moderate to severe acute and chronic pain. Morphine is a dangerous drug as defined in  
26 section 4022, a schedule II controlled substance and narcotic as defined by Health and Safety  
27 Code section 11055(b)(1), and a Schedule II controlled substance as defined by section  
28 1308.12(b)(1) of Title 21 of the Code of Federal Regulations.

<sup>19</sup> Diazepam (Valium) is a benzodiazepine used in the treatment of anxiety, muscle  
spasms, and seizures. It is a dangerous drug as defined in section 4022, a schedule IV controlled  
substance as defined by Health and Safety Code section 11057(d), and a Schedule IV controlled  
substance as defined by section 1308.14(c) of Title 21 of the Code of Federal Regulations.

1 October 2015; Androgel (testosterone)<sup>20</sup>; and Phentermine<sup>21</sup> #30 per month intermittently for  
2 weight loss from February 2014 through April 2015.

3 49. The CURES report shows Respondent was prescribing patient C the following non-  
4 controlled substances on a regular basis: Nexium (esomeprazole)<sup>22</sup>; Lasix (furosemide)<sup>23</sup> a  
5 diuretic usually prescribed for heart failure and edema; Lopressor (metoprolol tartrate)<sup>24</sup> for blood  
6 pressure, heart disease, and potassium replacement; Advair and ProAir<sup>25</sup> inhalers for breathing  
7 problems; and nitroglycerin for heart disease. Patient C completed a few physical therapy visits  
8 for his knee pain in early 2015.

9 50. Most of patient C's History of Present Illness sections of his medical records state he  
10 only "comes to clinic today to continue the following medications". Patient C's Physical  
11 examination portion in his medical record is often repeated verbatim from visit to visit.

12 51. In patient C's medical records there are two pain management agreements on file that  
13 are initialed but not dated or signed.

14 52. In patient C's medical records there was only one urine toxicology test performed on  
15 July 8, 2015, ordered by the Respondent which was positive for oxycodone, morphine, and  
16 Methadone, as well as codeine, nordiazepam<sup>26</sup>, temazepam<sup>27</sup> and oxazepam<sup>28</sup>. There is a

17  
18 <sup>20</sup> Androgel is used to treat conditions in men that result from a lack of natural  
testosterone.

19 <sup>21</sup> Phentermine is a Schedule IV controlled substance pursuant to Health and Safety Code  
20 section 11057, subdivision (f), and a dangerous drug pursuant to Business and Professions Code  
section 4022. It is a stimulant and an appetite suppressant.

21 <sup>22</sup> Nexium (esomeprazole magnesium) is a proton pump inhibitor (PPI) that blocks acid  
22 production in the stomach and is used to treat stomach and duodenal ulcers, gastroesophageal  
reflux disease (GERD), and Zollinger-Ellison syndrome.

23 <sup>23</sup> Lasix (furosemide) is used to reduce extra fluid in the body (edema) caused by  
24 conditions such as heart failure, liver disease, and kidney disease.

25 <sup>24</sup> Lopressor (metoprolol tartrate) is a prescription drug used to treat high blood pressure,  
26 angina, abnormal rhythms of the heart, and some neurological issues.

27 <sup>25</sup> Albuterol (Advair and ProAir) is used to prevent and treat wheezing and shortness of  
28 breath caused by breathing problems (such as asthma, chronic obstructive pulmonary disease).

<sup>26</sup> Nordiazepam is the major metabolite of the benzodiazepine diazepam.

<sup>27</sup> Temazepam is an intermediate-acting 3-hydroxy hypnotic of the benzodiazepine class  
of psychoactive drugs. Temazepam is used to treat insomnia.

<sup>28</sup> Oxazepam is a short-to-intermediate-acting benzodiazepine. Oxazepam is used for the  
treatment of anxiety and insomnia and in the control of symptoms of alcohol withdrawal  
syndrome. It is a metabolite of diazepam, prazepam, and temazepam, and has moderate amnesic,  
anxiolytic, anticonvulsant, hypnotic, sedative, and skeletal muscle relaxant properties compared  
to other benzodiazepines.

1 handwritten notation written by Respondent indicating he was going to discuss the results with  
2 patient C on the next visit.

3 53. On December 4, 2013, patient C was given a lab order for serum testing for morphine  
4 and oxycodone quantitative measurements, and another on September 11, 2014 for serum  
5 Methadone measurement. These lab orders were never performed. No CURES reports were  
6 obtained or referenced during the time period that the Respondent was seeing patient C.

7 54. In March of 2013, the Respondent began to prescribe Valium because patient C  
8 wanted to add diazepam at bedtime for muscle spasms in his leg. Respondent did not conduct an  
9 examination of patient C's legs or back. Respondent does not mention any existing muscle spasm.  
10 Respondent did not document that he counseled patient C regarding the added risks of  
11 benzodiazepines in combination with high-dose opiates.

12 55. On May 10, 2013, Patient C's chart note stated that the patient needed Ameritox urine  
13 screening and CURES review yet these were never done. At this visit, the Methadone was  
14 increased from 30 mg three times daily to 40mg four times a day reportedly because of continued  
15 pain. Respondent did not provide any other medical justification for the increase and the  
16 following visits made no notation of any improvement or change in function related to the  
17 increased dose.

18 56. On September 10, 2013, Respondent increased patient C's oxycodone from #90 to  
19 120 per month in anticipation of starting physical therapy. Respondent noted that on patient C's  
20 next visit he would discuss patient C giving up the oxycodone again and that he needed Ameritox  
21 and CURES review. Respondent did not follow up with patient C as planned.

22 57. In May of 2014, patient C had a consultation with a tele-medicine pain specialist.  
23 The specialist felt that the patient C was taking too much pain medication and recommended that  
24 Respondent begin to wean down patient C's Methadone, especially given his cardiac history. The  
25 specialist also recommended a sleep study, adding tizanidine<sup>29</sup> at night to replace Valium and to  
26 complete urine toxicology screenings at every visit. Respondent encouraged patient C to decrease  
27

28 <sup>29</sup> Tizanidine is used to treat muscle spasms caused by certain (such as multiple sclerosis, spinal cord injury). It works by helping to relax the muscles.



1 the Methadone to 30mg three times a day yet continued to prescribe the higher dose and patient C  
2 never weaned down. Patient C also did not have a urine toxicology screening again for another  
3 year and continued to receive Valium regularly. No sleep study was ever performed on patient C  
4 and he continued to receive the same doses of pain medications and Valium over the next 18  
5 months. Only one urine toxicology screening was ever performed on patient C which was in June  
6 of 2015.

7 58. On December 31, 2013, patient C reported medications were stolen and that a police  
8 report was made. Patient C requested refills a week early.

9 59. On September 1, 2015, patient C reported a stolen prescription of Methadone. No  
10 police report was noted or requested. Per the CURES report, patient C filled Methadone  
11 prescriptions on August 8, #360, September 1, 2015, #84 and September 10, 2015, #360. At that  
12 visit patient C also reported falling down a set of stairs.

13 60. In October of 2013 patient C was hospitalized after a fall and the admission summary  
14 noted that patient C stated he often falls about every two weeks when catching his right foot on  
15 the carpet at home. The emergency room physician advised patient C to stop his Methadone or  
16 oxycodone given his concern regarding the high doses and frequent falls. The emergency room  
17 physician noted in the hospital summary that he was concerned that patient C's high-dose  
18 narcotics may be contributing also to his falls. This notation was copied to the Respondent and  
19 included in the patient's medical chart.

20 61. For most of 2014 patient C repeatedly postponed his knee surgeries. Patient C  
21 continued to take high doses of opiate narcotics which were never changed by Respondent even  
22 after the pain specialist's recommendations. Respondent noted in patient C's medical record that  
23 he could not decrease the doses because patient C did not want to decrease the dosage at that  
24 time. Respondent did not provide medical justification or note change in patient C's medical  
25 condition or function. Respondent repeatedly put in his notes "refer to tele-medicine pain" yet  
26 never complied with any of their recommendations.

27 62. Patient C's medical records do not show that laboratory studies nor orthopedic or  
28 other consultations were provided. There is only one mention of laboratory studies in the chart

1 notations on June 17, 2015, where Respondent notes low iron, normal blood sugar, normal  
2 BUN/creatinine (kidney function), normal CBC, urinalysis normal and Vitamin D was low at 23.  
3 Patient C had two EKGs on file on March 10, 2015, and June 17, 2015. Patient C's corrected QT  
4 intervals<sup>30</sup> were normal and the EKGs revealed only some old QRS<sup>31</sup> changes.

5 63. Respondent also prescribed Androgel repeatedly throughout his treatment of patient C  
6 although he never discussed this in the notes. There is no indication for this nor any  
7 documentation of the associated side effects, risks or efficacy to patient C. Respondent also  
8 prescribed phentermine on a number of occasions for weight loss again without any real mention  
9 of discussion of the medication's purpose, risks or side effects other than a mention that his  
10 cardiologist cleared patient C to use the medication. Respondent did not discuss vaccines or any  
11 cholesterol or prostate examination or testing with patient C.

12 64. Respondent committed gross negligence in his care and treatment of patient C, which  
13 included, but are not limited to, the following:

14 (a) Paragraphs 47 through 63, above, are hereby incorporated by reference as if  
15 fully set forth herein; and,

16 (b) Respondent departed from the standard of care by prescribing two long-acting  
17 opioid medications at a time, prescribed extremely high doses of opiates without good medical  
18 justification or informed consent, and without standard monitoring with CURES reports or  
19 routine urine toxicology studies even after clear guidance from a pain specialist.

20 Patient D

21 65. Patient D is a female born in 1953 with a history of fatty liver, hiatal hernia,  
22 recurrent blood clots on chronic blood thinners, chronic back and neck pain with sciatica, anxiety,  
23 depression and bowel issues. Patient D saw the Respondent regularly from August of 2013  
24

25 <sup>30</sup> A QT interval is a measure of the time between the start of the Q wave and the end of  
26 the T wave in the heart's electrical cycle. The QT interval represents electrical depolarization and  
27 repolarization of the ventricles. A lengthened QT interval is a marker for the potential of  
ventricular tachyarrhythmias like torsades de pointes and a risk factor for sudden death.

28 <sup>31</sup> The QRS complex is a name for the combination of three of the graphical deflections  
seen on a typical electrocardiogram (EKG or ECG). It is usually the central and most visually  
obvious part of the tracing.

1 through February 2016. Patient D is a non-smoker, was not working because of her pain issues  
2 and denied alcohol use. She had gastric bypass surgery in 1978.

3 66. Most of patient D's History of Present Illness sections report only that the patient is  
4 being seen for medication refills. Patient D's medical records never mention symptoms of thyroid  
5 disease, anxiety or depression, or occasional mentions of diarrhea. Patient D had a body mass  
6 index (BMI) of 32-34 (obese) and normal blood pressures. Most of patient D's physical  
7 examinations are copied verbatim from visit-to-visit. The only musculoskeletal examinations are  
8 statements such as palpable tenderness of the lumbar spine. No neurologic examination, thyroid  
9 examination or comments on patient D's affect are included in the two and a half years she was  
10 treated by the Respondent. Patient D's diagnoses related to her pain typically included chronic  
11 severe lumbago, cervicalgia and for her benzodiazepines, the diagnosis of anxiety was used.

12 67. Patient D's CURES report and pharmacy records reveals Respondent was  
13 prescribing the patient the following controlled substances on a regular basis: Phentermine #30  
14 per month August 2013 until July 2015 to prevent obesity; Norco (hydrocodone bitartrate-  
15 acetaminophen) 10-325 #90 per month August 2013, increased to #180 per month in October  
16 2014, prescribed regularly until January 2016; Fentanyl<sup>32</sup> 100mcg/hr #20 per month, August  
17 2013 until July 2014 when it was decreased to #10 per month; prescribed regularly until January  
18 2016; Soma (carisoprodol<sup>33</sup>) 350mg #90 per month August 2013 until October 2014; Diazepam  
19 (Valium) 10mg #60 per month August 2013 until December 2015; and Temazepam (Restoril)  
20 30mg #30 per month October 2013 until March 2015.

21 68. Patient D's CURES report and pharmacy records reveals Respondent was  
22 prescribing patient D the following non-controlled substances on a regular basis: Gabapentin  
23 (Neurontin) and pregabalin (Lyrica) for pain; Duloxetine (Cymbalta) for depression;  
24 Levetiracetam (Keppra) for epilepsy; Levothyroxine thyroid supplementation 175 mcg per day;

25 \_\_\_\_\_  
26 <sup>32</sup> Fentanyl, brand name Duragesic, is a Schedule II controlled substance pursuant to  
27 Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to  
28 Business and Professions Code section 4022.

<sup>33</sup> Soma is the brand name for Carisoprodol, a Schedule IV controlled substances pursuant  
to 21 C.F.R. § 1308, and a dangerous drug pursuant to Business and Professions Code section  
4022.

1 Cyclobenzaprine (Flexeril) a muscle relaxant, beginning in 2015; Warfarin (Coumadin) a blood  
2 thinner to prevent blood clots, monitored at a separate Coumadin clinic; Diphenoxylate/Atropine  
3 (Lomotil) for diarrhea; Ondansetron (Zofran) for nausea; Omeprazole and Nexium  
4 (esomeprazole) for gastritis; Trazodone for sleep for a short time; and Pramipexole (Mirapex) for  
5 restless legs.

6 69. In patient D's medical records there is one controlled substance agreement on file  
7 dated 2005 with another provider. In patient D's medical records there are a few notations stating  
8 patient C was aware of the risks of her high dose fentanyl and she assumed the risks.

9 70. On August 1, 2013, Patient D had a toxicology screening ordered by Respondent. At  
10 the time, patient D was prescribed Fentanyl, Soma, Vicoden and Diazepam and per CURES  
11 report was filling these. Patient D's was negative for Vicoden and Diazepam and positive for  
12 Fentanyl and Soma. The result of patient D's test is initialed by Respondent. Respondent  
13 considered this a pass as it did not contain any illicit substances.

14 71. On December 2, 2013 a serum Fentanyl test was performed patient D which was  
15 positive for Fentanyl and the metabolite norfentanyl.<sup>34</sup>

16 72. On June 10, 2014, patient D had a toxicology screening ordered by Respondent.  
17 Patient D was being prescribed Norco, Fentanyl, Phentermine, Soma, diazepam and temazepam  
18 at the time. Patient D's test was positive for Norco, Fentanyl, Soma, morphine, temazepam,  
19 amphetamines and metabolites of diazepam. Morphine was detected and not prescribed and is  
20 not a metabolite of any of her prescribed medications. Respondent's chart notations state that  
21 patient D passed her drug screen.

22 73. On August 7, 2015, patient D had a toxicology screening ordered by Respondent  
23 which was positive for fentanyl, hydrocodone, temazepam and diazepam metabolites and  
24 negative for amphetamines. There is a handwritten note from Respondent stating discuss next  
25 visit. At the time the Respondent was prescribing Norco, Phentermine, Diazepam, and Fentanyl.  
26 Per the CURES report, the last temazepam prescription was filled by patient D was filled in  
27 March 2015.

28 <sup>34</sup> Norfentanyl is a metabolite of fentanyl.

1           74.    From August of 2013 through February 2016, no lumbar x-rays or MRIs, Pap  
2 smears, mammograms, hepatitis C testing, colon cancer screening or immunizations were ever  
3 ordered for or discussed with patient D.

4           75.    Patient D saw Respondent approximately every two months, mostly for refills of  
5 medications. Over the course of Respondent's care from 2013 to 2016, no imaging studies were  
6 ever performed of the patient D's low back nor any referenced from previous providers, nor any  
7 referrals to physical therapy or any orthopedic or neurosurgeons.

8           76.    On December 30, 2013, Respondent ordered a pain consult with Dr. P. Patient D  
9 claimed she lost the appointment and the consultation was ever completed. Patient D was seeing a  
10 psychiatry nurse practitioner who repeatedly recommended decreasing benzodiazepine use and in  
11 her notations states she discussed this with the Respondent. The psychiatry nurse practitioner  
12 recommended that Respondent refer patient D for psychotherapy to help with her anxiety,  
13 depression and insomnia.

14          77.    Patient D was hospitalized in June 2014 for seizures and low magnesium levels. At  
15 the visit on July 10, 2014 following this hospitalization, patient D agreed to decrease her Fentanyl  
16 dose from 200 mcg/h to 100 mcg/hour. Following this, there was no reported change in patient  
17 D's pain levels or functioning, even though her opioid dose was cut by half. At discharge from  
18 the hospital, patient D was also advised to discontinue her Phentermine but she declined to do so.

19          78.    Patient D's medication regimen changed little over the course of care. Her Norco  
20 was increased from 90 to 180 tablets per month in October 2014. This was not specifically  
21 discussed in patient D's chart notations but is around the time that her fentanyl dosing was cut in  
22 half. Patient D did stop Soma in October of 2014 and was eventually started on the muscle  
23 relaxant Flexeril (cyclobenzaprine) in 2015. Patient D was on two benzodiazepines diazepam and  
24 temazepam between October 2013 and March 2015 and diazepam alone during the other time  
25 periods reviewed. Other than the one-time decrease in the fentanyl dose, no other efforts were  
26 made to attempt to decrease Patient D medications or attempt other treatment modalities.

27          79.    On May 6, 2015, patient D was seen by Respondent and reported withdrawal  
28 symptoms if she did not take her Fentanyl. Patient D also insisted Respondent prescribe

1 temazepam in addition to her diazepam. Respondent notified the patient of the risk of breathing  
2 problems and noted patient says she is not concerned about that and assumed the risk. Patient D  
3 also requested Phentermine that she had been taking for years to prevent obesity after having  
4 gastric bypass surgery.

5 80. Respondent committed gross negligence in his care and treatment of patient D, which  
6 included, but are not limited to, the following:

7 (a) Paragraphs 65 through 79, above, are hereby incorporated by reference as if  
8 fully set forth herein; and,

9 (b) Respondent departed from the standard of care by prescribing high doses of  
10 opiates without any objective evidence of pathology, without standard monitoring with CURES  
11 reports nor a documented Controlled Substances Agreement, and without considering safer  
12 alternatives or that the patient had an Opiate use disorder.

13 Patient E

14 81. Patient E is a female born in 1975 who saw the Respondent regularly from July 2012  
15 through November 2015. Patient E had a number of health issues including chronic neck and  
16 back pain, migraines, obesity, bipolar illness, hypertension, reported narcolepsy, attention deficit  
17 disorder and sleep apnea with the use of a continuous positive airway pressure (CPAP) machine.  
18 Patient E was originally seen by a pain specialist at Feather River Clinic and was on Methadone,  
19 Norco and Soma for chronic neck pain. Patient E failed a drug screen there and they were no  
20 longer willing to prescribe her pain medications, so she presented to the Respondent for  
21 medication refills in 2012. Patient E reported at the first visit with the Respondent that the illicit  
22 drugs detected at Feather River were a one-time thing after going to a swingers' club. Patient E  
23 reported using medical marijuana and the Respondent notified patient E that if she continued this,  
24 she would need to bring in a copy of her medical marijuana card which she never did.

25 82. Patient E saw Respondent approximately every one to two months for refills of  
26 medications for pain, narcolepsy and attention deficit hyperactivity disorder (ADHD).  
27 Respondent's notes alternate between cervical and lumbar pain as the diagnosis and indication for  
28 pain medications. Most of Patient E's History of Present Illness sections report only "here to

1 continue medications” or “follow up L-spine pain...” with little or no other reports of the patient  
2 E’s symptoms, function, response to medications, or side effects. In Patient E’s medical record  
3 there is no mention of spasms, mood changes, mania symptoms or symptoms related to  
4 concentration or attention. Most of the physical examinations are scant and include vital signs  
5 with BMI of 35 indicating obesity and occasional elevations in blood pressure of up to 190/100.  
6 The only musculoskeletal examinations are repeated verbatim from visit-to-visit and state  
7 tenderness on palpation of lumbar spine and occasional notation of tenderness over the cervical  
8 spine. The only evaluation of the range of motion was performed at the initial visit on July 10,  
9 2012, when Respondent notes patient E’s forward flexion at the waist is limited to about 40  
10 degrees. There is no evaluation of the patient E’s affect or mental status other than Respondent  
11 noting she is alert and “oriented x 3”. No neurological examination was ever given to patient E.

12 83. Respondent repeatedly discussed ordering an MRI of patient E’s cervical spine and  
13 referring the patient to an interventionist pain specialist. Neither of these were ever completed.

14 84. Respondent refilled the medication Provigil (modafinil) regularly for narcolepsy. In  
15 patient E’s medical records there is no discussion of this other than the patient self-report of the  
16 diagnosis and the report that she needed the medication to stay awake. There is no indication of a  
17 sleep study or sleep specialist evaluation ever being requested or reviewed by the Respondent.  
18 Respondent refilled patient E’s prescription for amphetamine salts (Adderall) on a regular basis  
19 for ADHD. None of patient E’s History of Present Illness sections ever comment on symptoms of  
20 decreased attention or concentration and no attention deficit symptoms scales are included nor  
21 referenced. Respondent treated Patient E for depression and bipolar disorder. In patient E’s chart  
22 notes Respondent never discusses the patient’s symptoms and there was no discussion regarding  
23 patient E’s symptoms of mania. Respondent ordered tele-health psychiatry evaluations on a  
24 number of occasions but it appears this was never performed.

25 85. Patient E’s CURES report and pharmacy records reveals Respondent was prescribing  
26 patient E the following controlled substances on a regular basis: Methadone 10mg #270 per  
27 month beginning July 2012 and prescribed until December 2015; Amphetamine salts (Adderall)  
28 for Attention Deficit disorder 30mg #120-150 per month beginning July 2012 and prescribed until

1 December 2015; Soma (carisoprodol) 350mg #30 per month, beginning July 2012, increased to  
2 #60 per month in September 2013, prescribed until October, 2014; Modafinil (Provigil)<sup>35</sup> 200mg  
3 #60 per month beginning August, 2012, decreased to #30 per month in June 2015 and continued  
4 until September 2015; and Hydrocodone-acetaminophen 10-500 #120 per month beginning  
5 September 2013 until December 2015. No CURES reports were included or referenced in the  
6 medical record. One Controlled Substance agreement is included but it is not dated or signed.

7 86. Patient E's CURES report and pharmacy records reveals Respondent was prescribing  
8 the patient the following non-controlled substances on a regular basis: Ibuprofen 600 alternating  
9 with Naproxen<sup>36</sup> 500 mg for back pain; Topamax (topiramate)<sup>37</sup> and Nadolol<sup>38</sup> for migraine  
10 prophylaxis and blood pressure control; Sumatriptan<sup>39</sup> for migraine treatment; Promethazine<sup>40</sup> 25  
11 mg up to 4 times a day #120 at a time for nausea; Chantix for smoking cessation; of note there is  
12 no documentation regarding the potential psychiatric side effects when this was started on August  
13 20, 2014; Abilify 2mg for bipolar disorder; Paroxetine (Paxil)<sup>41</sup> and Pristiq off and on for  
14 depression; Baclofen<sup>42</sup> prescribed in October 2014 when he stopped prescribing Soma; the patient  
15 stopped this after two months.

16 87. On August 8, 2012, patient E had a toxicology screening ordered by another provider  
17 while she was prescribed Methadone, Adderall, Soma, and Modafinil. The test was negative for  
18 Soma, Norco (hydrocodone), and amphetamine salts and positive for Methadone. There is no

19 <sup>35</sup> Modafinil (Provigil) is a medication to treat sleepiness due to narcolepsy, shift work  
20 sleep disorder, or obstructive sleep apnea.

21 <sup>36</sup> Naproxen is a nonsteroidal anti-inflammatory drug (NSAID) of the propionic acid class  
22 that relieves pain, fever, swelling, and stiffness.

23 <sup>37</sup> Topamax is the brand name of topiramate, an anticonvulsant drug used to prevent  
24 seizures and reduce the frequency of migraines.

25 <sup>38</sup> Nadolol is a non-selective beta blocker used in the treatment of high blood pressure and  
26 chest pain.

27 <sup>39</sup> Sumatriptan is a medication used for the treatment of migraine headaches. It is a  
28 synthetic drug belonging to the triptan class.

<sup>40</sup> Promethazine is used to treat several conditions, including allergies, motion sickness,  
nausea and vomiting, anxiety before surgery, and pain after surgery.

<sup>41</sup> Paxil (paroxetine) is an antidepressant belonging to a group of drugs called selective  
serotonin reuptake inhibitors (SSRIs). Paroxetine affects chemicals in the brain that may be  
unbalanced in people with depression, anxiety, or other disorders.

<sup>42</sup> Baclofen acts on the spinal cord nerves and decreases the number and severity of  
muscle spasms caused by multiple sclerosis or spinal cord diseases. It also relieves pain and  
improves muscle movement.



1 review or discussion of the results at the following visit. However, at the next visit on November  
2 2, 2012, the Respondent noted that patient E had Ameritox<sup>43</sup> done in August of 2012 and she  
3 passed that Ameritox screen. However, patient E was being prescribed Soma and Adderall yet  
4 these were not detected.

5 88. On February 3, 2012, an MRI of patient E's lumbar spine was performed which  
6 revealed multilevel degenerative disc problems and neuroforaminal narrowing with mild to  
7 moderate spinal stenosis at L4-5.

8 89. Respondent ordered labs for patient E in January 2013 and December 2014 but they  
9 were never done.

10 90. On October 23, 2013, Respondent ordered a lumbar spine X-ray which was never  
11 performed. Respondent ordered physical therapy but patient E declined because she had it in the  
12 past and it worsened her pain.

13 91. On May 20, 2014, patient E had a toxicology screening ordered by Respondent. The  
14 test was positive for Soma, Methadone, norhydrocodone (a metabolite of hydrocodone indicating  
15 usage in the last 72 hours) and negative for amphetamine salts. At the time patient E was being  
16 prescribed Adderall which should have been detected; this was never addressed or discussed.

17 92. Patient E's arthritis panel on March 11, 2015, was significant for elevated C-reactive  
18 protein (CRP)<sup>44</sup> and sedimentation rate and this was never addressed by Respondent.

19 93. On May 8, 2015 patient E reported running out early of her medications and took her  
20 husband's Dilaudid. The Respondent decided to give her a second chance.

21 94. On November 30, 2015, patient E reportedly washed her Methadone script in the  
22 washer. Per CURES, she filled prescriptions for #270 Methadone on October 2, October 30,  
23 November 30 and December 29, 2015.

24 95. Respondent ordered a cervical spine MRI and sleep study repeatedly for patient E and  
25 these were never performed. Other than urine testing and one arthritis panel, no laboratory studies

26 <sup>43</sup> Ameritox was a company that provided physicians with urine drug monitoring and  
27 reporting services.

28 <sup>44</sup> C-reactive protein (CRP) is an acute phase reactant, a protein made by the liver and  
released into the blood within a few hours after tissue injury, the start of an infection, or other  
cause of inflammation.

1 were ever performed. No EKGs, Pap smears or immunizations were ever performed on patient E  
2 or discussed by Respondent.

3 96. Respondent committed gross negligence in his care and treatment of patient E, which  
4 included, but are not limited to, the following:

5 (a) Paragraphs 81 through 95, above, are hereby incorporated by reference as if  
6 fully set forth herein; and,

7 (b) Respondent departed from the standard of care by prescribing high doses of  
8 opiates without insisting on safer alternatives or compliance with recommendations for specialist  
9 evaluations, without standard monitoring with CURES reports, routine drug testing, nor a  
10 documented controlled substances agreement, and without considering safer alternatives or that  
11 the patient had an Opiate use disorder.

12 97. Respondent's conduct, as described above, constitutes gross negligence in the  
13 practice of medicine in violation of section 2234(b) of the Code and thereby provides cause to  
14 discipline Respondent's license.

15 **SECOND CAUSE FOR DISCIPLINE**

16 **(Repeated Negligent Acts)**

17 98. Respondent is subject to disciplinary action under section 2234, as defined by section  
18 2234, subdivision (c), of the Code, in that respondent committed repeated acts of negligence in  
19 his care and treatment of patients A, B, C, D, and E.

20 **Patient A**

21 99. Paragraphs 9 through 28 as more particularly alleged above, are hereby incorporated  
22 by reference and realleged as if fully set forth herein.

23 100. Respondent committed acts of repeated negligence in his care and treatment of patient  
24 A, which included, but are not limited to, the following:

25 (a) Respondent departed from the standard of care by not offering adequate  
26 medical justification for prescribing Methadone, especially in conjunction with another long-  
27 acting narcotic. Also, Respondent did not monitor the patient's EKG nor take into consideration

28 ///

1 the potential for QT prolongation with the patient's other medications represents a lack of  
2 knowledge; and

3 (b) Respondent departed from the standard of care by not adequately assessing the  
4 patient's anxiety symptoms, not offering safer alternatives to benzodiazepines, and prescribing  
5 relatively large quantities of benzodiazepines to a patient on high-dose opiates with a history of  
6 depression, potential suicidality and known substance abuse issues and inconsistent toxicology  
7 screenings without any informed consent regarding the risks of the medications.

8 Patient B

9 101. Paragraphs 30 through 46 as more particularly alleged above, are hereby incorporated  
10 by reference and realleged as if fully set forth herein.

11 102. Respondent committed acts of repeated negligence in his care and treatment of patient  
12 B, which included, but are not limited to, the following:

13 (a) Respondent departed from the standard of care by not adequately assessing the  
14 patient's anxiety symptoms, not offering safer alternatives to benzodiazepines, and prescribing  
15 relatively large quantities of benzodiazepines to a patient on high-dose opiates with a history of  
16 alcoholism and inconsistent toxicology screenings without any informed consent regarding the  
17 risks of the medications; and

18 (b) Respondent departed from the standard of care by failing to keep timely, legible  
19 and accurate medical records. Respondent's documentation for this patient is sparse and often not  
20 accurate; and

21 (c) Respondent departed from the standard of care in his management of the  
22 patient's diabetes which did not include standard monitoring of glycohemoglobin, creatinine or  
23 microalbumin, nor appropriate use of medications to optimize the patient's cholesterol or sugar,  
24 representing a lack of knowledge; and

25 (d) Respondent departed from the standard of care by repeatedly prescribing  
26 antimicrobial agents without a thorough physical examination and clear medical indications for  
27 antibiotics.

28 ///

1           Patient C

2           103. Paragraphs 47 through 63 as more particularly alleged above, are hereby incorporated  
3 by reference and realleged as if fully set forth herein.

4           104. Respondent committed acts of repeated negligence in his care and treatment of patient  
5 C, which included, but are not limited to, the following:

6                   (a) Respondent departed from the standard of care by failing to screen for or  
7 identify Opiate Use Disorder. Respondent's failure also shows lack of knowledge; and

8                   (b) Respondent departed from the standard of care by prescribing benzodiazepines  
9 in a patient taking high dose narcotics without counseling the patient regarding specific risks of  
10 the medications nor considering safer alternatives, even after specific recommendations from the  
11 pain specialist; and

12                   (c) Respondent departed from the standard of care prescribing second-line  
13 Methadone in conjunction with another long-acting opioid without medical justification and did  
14 not seem aware of nor counsel or screen the patient for cardiac effects of Methadone until after  
15 almost three years of care; and

16                   (d) Respondent departed from the standard of care by prescribing the controlled  
17 substance Androgel without a clear indication, any chart documentation regarding indication,  
18 efficacy or side effects and without appropriate monitoring.

19           Patient D

20           105. Paragraphs 65 through 79 as more particularly alleged above, are hereby incorporated  
21 by reference and realleged as if fully set forth herein.

22           106. Respondent committed acts of repeated negligence in his care and treatment of patient  
23 D, which included, but are not limited to, the following:

24                   (a) Respondent departed from the standard of care by prescribing high doses of  
25 opiates without any objective evidence of pathology, without standard monitoring with CURES  
26 reports nor a documented controlled substances agreement, and without considering safer  
27 alternatives or that the patient had an Opiate use disorder; and

28           ///

1 (b) Respondent departed from the standard of care by failing to screen the patient  
2 for or identify Opiate Use Disorder; and

3 (c) Respondent departed from the standard of care by failing to properly document  
4 justification for the benzodiazepines, not offering safer alternatives, not attempting to decrease  
5 the benzodiazepine use when other medications were added, and not monitoring CURES reports  
6 or address the fact that benzodiazepines were not detected in the 2013 toxicology screening; and

7 (d) Respondent departed from the standard of care by prescribing the high-risk  
8 medication Soma for over 18 months to a patient with no clear indication for such and without  
9 appropriate consideration of safer alternatives; and

10 (e) Respondent departed from the standard of care by failing to appropriately  
11 interpret or take into account the results of aberrant urine drug testing represent a lack of  
12 knowledge; and

13 (f) Respondent departed from the standard of care by failing to address  
14 preventative measure in the he regularly treated for over three years; and

15 (g) Respondent departed from the standard of care by failing to appropriately  
16 manage or monitor the patient's thyroid disease.

17 Patient E

18 107. Paragraphs 81 through 95 as more particularly alleged above, are hereby incorporated  
19 by reference and realleged as if fully set forth herein.

20 108. Respondent committed acts of repeated negligence in his care and treatment of patient  
21 E, which included, but are not limited to, the following:

22 (a) Respondent departed from the standard of care by failing to offer adequate  
23 medical justification for prescribing Methadone, not monitoring the patient's EKG or taking into  
24 consideration the potential for QT prolongation with the patient's other medications  
25 represents a Lack of Knowledge; and

26 (b) Respondent departed from the standard of care by failing to appropriately treat  
27 the patient's spine pain with safer alternatives and modalities, or insist on definitive evaluation  
28

1 and treatment by more qualified specialists and did not perform adequate physical examination in  
2 regards to the patient's pain; and

3 (c) Respondent departed from the standard of care by failing to screen the patient  
4 for or identify Opiate Use Disorder; and

5 (d) Respondent departed from the standard of care by prescribing the high-risk  
6 medication Soma for over two years to a patient with no clear indication for such and without  
7 appropriate consideration of safer alternatives; and

8 (e) Respondent departed from the standard of care by not appropriately assessing  
9 or evaluating the patient's mental health symptoms, not asking about suicidal ideation or mania,  
10 prescribing medications that may have worsened her symptoms without adequately discussing  
11 potential risks and side effects, not insisting on appropriate consultation with mental health  
12 providers and not prescribing appropriate dosages of Abilify, all of which constitute a lack of  
13 knowledge; and

14 (f) Respondent departed from the standard of care by his lack of adequate history  
15 taking in relation to the complaints of attention, nor review of the DSM criteria or monitoring of  
16 stimulant therapy; and

17 (g) Respondent departed from the standard of care by prescribing modafanil  
18 without a definitive diagnosis, and without considering safer alternatives and in conjunction with  
19 other high-risk medications.

20 109. Respondent's conduct, as described above, constitutes repeated acts of negligence in  
21 the practice of medicine in violation of section 2234(c) of the Code and thereby provides cause to  
22 discipline Respondent's license.

23 **THIRD CAUSE FOR DISCIPLINE**

24 **(Excessive Prescribing)**

25 110. Respondent is subject to disciplinary action under section 725 of the Code, in that  
26 respondent excessively overprescribed in his care and treatment of patients A, B, C, D, and E, as  
27 more particularly alleged in paragraphs 9 through 95 above, which are hereby incorporated by  
28 reference and realleged as if fully set forth herein.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

**FOURTH CAUSE FOR DISCIPLINE**

**(Failure to Maintain Adequate and Accurate Medical Records)**

111. Respondent is subject to disciplinary action under section 2234, as defined by section 2266, of the Code, in that respondent failed to maintain adequate and accurate records regarding his care and treatment of patient B as more particularly alleged in paragraphs 30 through 46 above, which are hereby incorporated by reference and realleged as if fully set forth herein.

**FIFTH CAUSE FOR DISCIPLINE**

**(Incompetence)**

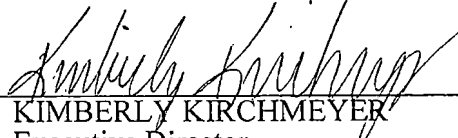
112. Respondent is subject to disciplinary action under section 2234, as defined by section 2234, subdivision (d), of the Code, in that respondent was incompetent in his care and treatment of patients A, B, C, D, and E, as more particularly alleged in paragraphs 9 through 95 above, which are hereby incorporated by reference and realleged as if fully set forth herein.

**PRAYER**

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

- 1. Revoking or suspending Physician's and Surgeon's Certificate Number G 78940, issued to John Edwin Parsons, Jr., M.D.;
- 2. Revoking, suspending or denying approval of John Edwin Parsons, Jr., M.D.'s authority to supervise physician assistants and advanced practice nurses;
- 3. Ordering John Edwin Parsons, Jr., 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:  
November 13, 2018

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