

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

In the Matter of the Accusation)
Against:)
)
)
Blaise Philip Vinc DeSouza, M.D.)
)
Physician's and Surgeon's)
Certificate No. A 37917)
)
Respondent)
_____)

Case No. 800-2016-020340

DECISION

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

This Decision shall become effective at 5:00 p.m. on December 12, 2019.

IT IS SO ORDERED December 5, 2019.

MEDICAL BOARD OF CALIFORNIA

By: 
Christine J. Lally
Interim Executive Director

1 XAVIER BECERRA
Attorney General of California
2 STEVE DIEHL
Supervising Deputy Attorney General
3 SARAH J. JACOBS
Deputy Attorney General
4 State Bar No. 255899
California Department of Justice
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7 *Attorneys for Complainant*

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

12 In the Matter of the Accusation Against:

Case No. 800-2016-020340

13 **BLAISE PHILIP VINC DESOUZA, M.D.**
14 **P.O. Box 1040**
Foresthill, CA 95631-1040

**STIPULATED SURRENDER OF
LICENSE AND ORDER**

15 **Physician's and Surgeon's Certificate No. A**
16 **37917**

17 Respondent.

18
19 In the interest of a prompt and speedy settlement of this matter, consistent with the public
20 interest and the responsibility of the Medical Board of California of the Department of Consumer
21 Affairs, the parties hereby agree to the following Stipulated Surrender and Disciplinary Order
22 which will be submitted to the Board for approval and adoption as the final disposition of the
23 Accusation.

24 **PARTIES**

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

1 CULPABILITY

2 8. Respondent understands and agrees that the charges and allegations in Accusation
3 No. 800-2016-020340, if proven at a hearing, constitute cause for imposing discipline upon his
4 Physician's and Surgeon's Certificate.

5 9. For the purpose of resolving the Accusation without the expense and uncertainty of
6 further proceedings, Respondent agrees that, at a hearing, Complainant could establish a prima
7 facie factual basis for the charges in the Accusation, and that Respondent hereby gives up his
8 right to contest those charges. Respondent agrees that if he ever petitions for reinstatement of his
9 Physician's and Surgeon's Certificate No. A 37917, all of the charges and allegations contained
10 in Accusation No. 800-2016-020340 shall be deemed true, correct and fully admitted by
11 Respondent for purposes of that reinstatement proceeding or any other licensing proceeding
12 involving Respondent in the State of California.

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

16 CONTINGENCY

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

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

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

3 **ORDER**

4 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 37917, issued
5 to Respondent Blaise Philip Vinc DeSouza, M.D., is surrendered and accepted by the Board.

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

10 2. Respondent shall lose all rights and privileges as a physician and surgeon in
11 California as of the effective date of the Board's Decision and Order.

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

14 4. If Respondent ever files an application for licensure or a petition for reinstatement in
15 the State of California, the Board shall treat it as a petition for reinstatement. Respondent must
16 comply with all the laws, regulations and procedures for reinstatement of a revoked or
17 surrendered license in effect at the time the petition is filed, and all of the charges and allegations
18 contained in Accusation No. 800-2016-020340 shall be deemed to be true, correct and admitted
19 by Respondent when the Board determines whether to grant or deny the petition.

20 5. If Respondent should ever apply or reapply for a new license or certification, or
21 petition for reinstatement of a license, by any other health care licensing agency in the State of
22 California, all of the charges and allegations contained in Accusation, No. 800-2016-020340 shall
23 be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of
24 Issues or any other proceeding seeking to deny or restrict licensure.

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ACCEPTANCE

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

DATED: 02/11/2019 
BLAISE PHILIP VINC DESOUZA, M.D.
Respondent

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

DATED: 10/15/19 
DOMINIQUE A. POLLARA
Attorney for Respondent

ENDORSEMENT

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


DATED: 10-24-2019 Respectfully submitted,
XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General

SARAH J. JACOBS
Deputy Attorney General
Attorneys for Complainant

Exhibit A

Accusation No. 800-2016-020340

1 XAVIER BECERRA
Attorney General of California
2 STEVEN D. MUNI
Supervising Deputy Attorney General
3 State Bar No. 073567
1300 I Street, Suite 125
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5 Telephone: (916) 210-7249
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6

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO *May 16* 20 *19*
BY *[Signature]* ANALYST

7 *Attorneys for Complainant*

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. 800-2016-020340

14 **Blaise Philip Vinc DeSouza, M.D.**

ACCUSATION

15 P.O. Box 1040
Foresthill, CA 95631-1040

16 **Physician's and Surgeon's Certificate**
17 **No. A 37917,**

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 January 11, 1982, the Medical Board issued Physician's and Surgeon's
26 Certificate No. A 37917 to Blaise Philip Vinc DeSouza, M.D. (Respondent). The Physician's and
27 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought
28 herein and will expire on October 31, 2019, unless renewed.

JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

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

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

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

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

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

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

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

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1 5. Section 2234 of the Code, states:

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

5 "...

6 "(b) Gross negligence.

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

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

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

17 "..."

18 6. Section 725 of the Code states:

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

26 "(b) Any person who engages in repeated acts of clearly excessive
27 prescribing or administering of drugs or treatment is guilty of a misdemeanor and
28 shall be punished by a fine of not less than one hundred dollars (\$100) nor more

1 than six hundred dollars (\$600), or by imprisonment for a term of not less than 60
2 days nor more than 180 days, or by both that fine and imprisonment.

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

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

8 7. Section 2266 of the Code states:

9 “The failure of a physician and surgeon to maintain adequate and accurate records
10 relating to the provision of services to their patients constitutes unprofessional conduct.”

11 8. Section 2229 of the Code states that the protection of the public shall be the highest
12 priority for the Board in exercising their disciplinary authority. While attempts to rehabilitate a
13 licensee should be made when possible, Section 2229, subdivision (c), states that when
14 rehabilitation and protection are inconsistent, protection shall be paramount.

15 PERTINENT DRUGS

16 9. **Ativan**, the trade name for lorazepam, is used for anxiety and sedation in the
17 management of anxiety disorder for short-term relief from the symptoms of anxiety or anxiety
18 associated with depressive symptoms. It is a dangerous drug as defined in section 4022 and a
19 Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code.
20 Lorazepam is not recommended for use in patients with primary depressive disorders. Sudden
21 withdrawal from lorazepam can produce withdrawal symptoms including seizures.

22 10. **Diazepam**, known by the trade name Valium, is a medicine of the benzodiazepine
23 class of drugs commonly used to treat anxiety, alcohol withdrawal, and seizures. It is a dangerous
24 drug as defined in Business and Professions Code section 4022 and a schedule IV controlled
25 substance as defined by section 11057 of the Health and Safety Code. It produces central nervous
26 system depression and should be used with caution with other central nervous system depressant
27 drugs. Like other benzodiazepines, it can produce psychological and physical dependence.
28 Withdrawal symptoms similar to those noted with barbiturates and alcohol have been noted upon

1 abrupt discontinuance. The Drug Enforcement Administration (DEA) has identified
2 benzodiazepines, such as diazepam, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide
3 (2011 Edition), at p. 53.)

4 11. **Dilaudid** is a trade name for hydromorphone hydrochloride. It is a dangerous drug
5 as defined in Business and Professions Code section 4022 and is a Schedule II controlled
6 substance as defined by Health and Safety Code section 11055(b). It is primarily used as a pain
7 reliever. Psychic dependence, physical dependence, and tolerance may develop upon repeated
8 administration of narcotics; therefore, Dilaudid should be prescribed and administered with
9 caution. Physical dependence, the condition in which continued administration of the drug is
10 required to prevent the appearance of a withdrawal syndrome, usually assumes clinically
11 significant proportions after several weeks of continued use. Side effects include drowsiness,
12 mental clouding, respiratory depression, and vomiting. The usual starting dosage for injections is
13 1-2 mg. The usual oral dose is 2 mg every two to four hours as necessary. Patients receiving
14 other narcotic analgesics, anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, tricyclic
15 antidepressants and other central nervous system depressants, including alcohol, may exhibit an
16 additive central nervous system depression. When such combined therapy is contemplated, the
17 use of one or both agents should be reduced.

18 12. **Fentanyl** (Actiq, Fentora, and Duragesic) is a powerful synthetic opioid that is
19 similar to morphine but is 50 to 100 times more potent. Like morphine, it is a medication
20 ordinarily used to treat patients with severe pain, especially after surgery. When properly
21 prescribed and indicated, fentanyl is at times used for the management of pain in opioid-tolerant
22 patients, severe enough to require daily, continuous, long term opioid treatment, and for which
23 alternative treatment options are inadequate. Fentanyl is a Schedule II controlled substance
24 pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug
25 pursuant to Business and Professions Code section 4022. The FDA has issued several black box
26 warnings about fentanyl, including, but not limited to, the risks of addiction, abuse and misuse;
27 life threatening respiratory depression; accidental exposure; neonatal opioid withdrawal
28 syndrome; and the risks associated with the concomitant use with benzodiazepines or other CNS

1 depressants. Fentanyl comes in several forms, including as an injection, intrathecal
2 administration (an injection around the spinal canal), a transdermal patch that is placed on the
3 skin, or as a lozenge that is sucked like a cough drop (Actiq).

4 13. **Hydrocodone APAP** (Vicodin, Lortab, and Norco) is a hydrocodone combination of
5 hydrocodone bitartrate and acetaminophen which was formerly a Schedule III controlled
6 substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous
7 drug pursuant to Business and Professions Code section 4022. On August 22, 2014, the DEA
8 published a final rule rescheduling hydrocodone combination products (HCP's) to schedule II of
9 the Controlled Substances Act, which became effective October 6, 2014. Schedule II controlled
10 substances are substances that have a currently accepted medical use in the United States, but also
11 have a high potential for abuse, and the abuse of which may lead to severe psychological or
12 physical dependence. When properly prescribed and indicated, HCP's are used for the treatment
13 of moderate to severe pain. In addition to the potential for psychological and physical
14 dependence there is also the risk of acute liver failure which has resulted in a black box warning
15 being issued by the Federal Drug Administration (FDA). The FDA black box warning provides
16 that "[a]cetaminophen has been associated with cases of acute liver failure, at times resulting in
17 liver transplant and death. Most of the cases of liver injury are associated with use of the
18 acetaminophen at doses that exceed 4000 milligrams per day, and often involve more than one
19 acetaminophen containing product."

20 14. **Methadone hydrochloride** is a synthetic narcotic pain reliever with multiple actions
21 quantitatively similar to those of morphine. It is a dangerous drug as defined in section 4022 and
22 a Schedule II controlled substance as defined by Health and Safety Code section 11055(c).
23 Methadone can produce drug dependence of the morphine type and, therefore, has the potential
24 for abuse. Psychological and physical dependence can develop with repeated administration, and
25 it should be prescribed and administered with the same degree of caution as with morphine.

26 15. **MS Contin** (morphine sulfate), an opioid analgesic, is a Schedule II controlled
27 substance pursuant to Health and Safety Code section 11055, subdivision (e), and a dangerous
28 drug pursuant to Business and Professions Code section 4022. When properly prescribed and

1 indicated, it is used for the management of pain that is severe enough to require daily, around-the-
2 clock, long-term opioid treatment and for which alternative treatment options are inadequate. The
3 Drug Enforcement Administration has identified MS Contin, as a drug of abuse. (Drugs of
4 Abuse, A DEA Resource Guide (2011 Edition), at p. 39.) The Federal Drug Administration has
5 issued a black box warning for MS Contin which warns about, among other things, addiction,
6 abuse and misuse, and the possibility of life-threatening respiratory distress. The warning also
7 cautions about the risks associated with concomitant use of MS Contin with benzodiazepines or
8 other central nervous system (CNS) depressants.

9 16. **Oxycodone** (Percocet), an opioid analgesic, is a Schedule II controlled substance
10 pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug
11 pursuant to Business and Professions Code section 4022. When properly prescribed and
12 indicated, it is used for the management of moderate to moderately severe pain. The Drug
13 Enforcement Administration has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A
14 DEA Resource Guide (2011 Edition), at p. 41.) The Federal Drug Administration has issued a
15 black box warning for Percocet® which warns about, among other things, addiction, abuse and
16 misuse, and the possibility of “life-threatening respiratory distress.”

17 17. **Soma**, a trade name for carisoprodol tablets, is a muscle-relaxant and sedative. It is a
18 dangerous drug as defined in section 4022 and is a Schedule IV controlled substance as defined
19 by Health and Safety Code section 11057. It can be habit forming and its side effects may impair
20 thinking or reactions; it can increase dizziness and drowsiness.

21 18. **Zolpidem** (Ambien), a Schedule IV controlled substance, is a sedative primarily
22 used to treat insomnia. It is an addictive substance and users should avoid alcohol as serious
23 interactions may occur.

24 **FIRST CAUSE FOR DISCIPLINE**

25 **(Gross Negligence)**

26 19. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined
27 by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care
28 and treatment of patients A, B, C, and D, as more particularly alleged hereinafter:

1 **PATIENT A**

2 20. Respondent first started treating Patient A,¹ a then 41-year-old male, on or about
3 October 9, 2014, for a rash due to poison oak, musculoskeletal pain, carpal tunnel syndrome on
4 the right side, and pain in his right limb due to overuse from congenital absence of his left
5 forearm.² Respondent indicated that he conducted Phalen's test to assess for carpal tunnel
6 syndrome.³ It is noted that Patient A suffered from anxiety and depression. Respondent started
7 the patient on hydrocodone, 10/325 mg, three times daily (#180), in conjunction with a controlled
8 substance contract. Respondent indicated that he checked CURES, but does not provide a
9 discussion as to why he increased the dosage from the patient's previous prescription for
10 hydrocodone by another physician. Despite the patient complaining of a skin rash, Respondent
11 did not document a history of skin rash or note the location in the physical exam.

12 21. On or about November 7, 2014, Patient A is seen by Respondent, but the note was
13 largely an exact copy from the previous office visit. On or about December 8, 2014, the patient
14 presented with high blood pressure, extremity pain, and rash. The medical note again appeared to
15 be a duplicate from the previous office visit. On or about February 6, 2015, the patient was
16 scheduled for carpal tunnel surgery, and reported pain in his knees, right upper extremity with
17 numbness, and numbness of his right hand. However, Respondent stated no paresthesia⁴ in the
18 CNS section of the note. On or about March 6, 2015, Respondent indicated that the patient was
19 recovering from carpal tunnel surgery; but continued to have pain due to an absence of his left
20 upper extremity. On or about May 7, 2015, Respondent mistakenly identified Patient A's
21 atrophic limb on his right side, which recurred numerous times in subsequent notes.

22
23 ¹ The patients listed in this document are unnamed to protect their privacy. Respondent
24 knows the name of the patients and can confirm their identity through discovery.

25 ² Throughout subsequent office visits, Respondent incorrectly noted in the medical record
26 that Patient A had a congenital absence of his right forearm.

27 ³ Phalen's test is generally conducted by applying force between a patient's two hands, yet
28 Patient A only had one hand.

⁴ Paresthesia, or "pins and needles," is an abnormal skin sensation (e.g., a tingling,
pricking, chilling, burning, or numb sensation on the skin) with no apparent physical cause.

1 22. On or about July 7, 2015, the patient presents with high blood pressure and a cough.
2 Respondent noted the correct atrophied left limb in the assessment section, but the subjective
3 section is duplicated from the previous notes referencing the atrophied limb on the right limb. On
4 or about May 17, 2016, Respondent indicated that Patient A stopped his medication and lost a
5 significant amount of swelling, however, it is noted that the patient is to "continue on his
6 narcotics as prescribed." On or about June 17, 2016, it was noted that Patient A had lost over 30
7 pounds and had a significant decrease in blood pressure. There was no change to his treatment
8 plan.

9 23. On or about August 22, 2016, Respondent noted that the patient was experiencing
10 severe anxiety due to his wife's new diagnosis of breast cancer. However, it was also noted that
11 the "patient's mental and emotional functioning are clinically normal." There was no mental
12 health examination conducted to determine mental health status. It was documented that the
13 patient still had high blood pressure even though it was also noted that patient's blood pressure
14 had improved. It was documented that the patient's pain was adequately controlled and he had
15 chronic lymphatic insufficiency. On or about December 22, 2016, Respondent indicated that the
16 patient was being treated for musculoskeletal pain of the right upper extremity and had congenital
17 atrophy of the right upper extremity. While it was noted that the patient had chronic lymphatic
18 insufficiency, Respondent did not note a disease of the lymphatics under the ROS-Lymphatics
19 section.

20 24. Between approximately October 9, 2014, and July 13, 2018, Patient A was seen by
21 Respondent approximately 44 times. During this period, the patient is prescribed 8,613 tablets of
22 hydrocodone, 10 mg, 630 tablets of lorazepam, 1 mg, and 1,150 tablets of Soma, 30 mg. Patient
23 A's average morphine equivalent dose (MED) is 60, which is a moderate dose. Many of the
24 medical notes were largely duplicates of previous notes, including exact misspellings and syntax
25 errors. Respondent did not classify the patient's risks and benefits, provide a sufficient treatment
26 plan, or appropriately modify treatment due to likely reported side effects during the patient's
27 long-term opioid use. Absent from the record was a discussion regarding the risks of combining
28

1 opioids with other prescribed respiratory depressants, a risk-benefit discussion regarding
2 medications, as well as efforts to ensure adequate compliance monitoring.

3 25. Respondent committed gross negligence in his care and treatment of Patient A which
4 included, but was not limited to, the following:

5 (a) Respondent failed to undertake or document risk assessment for
6 continued prescribing and long-term use of opioids, such as various
7 screening and monitoring tools, and he failed to adequately evaluate
8 the potential risks of combining opiate therapy with other respiratory
9 depressants such as benzodiazepines (lorazepam) and barbiturates
10 (Soma);

11 (b) Respondent failed to properly modify treatment after reported side
12 effects of narcotics, benzodiazepines and barbiturate use, and
13 Respondent failed to adequately evaluate the patient's progress
14 toward functional goals and positive changes in pain status;

15 (c) Respondent failed to implement a comprehensive treatment plan with
16 objectives and measurable goals for controlled substances, as well as
17 an exit strategy for discontinuing opioid therapy;

18 (d) Respondent failed to undertake or document appropriate compliance
19 monitoring of controlled substances, such as urine drug testing or pill
20 counting; and

21 (e) Respondent failed to document clear, detailed and accurate medical
22 records, including a history of present illness for various complaints
23 made by the patient, the rationale for a diagnosis, and a discussion
24 with the patient regarding the risks, benefits, and side effects of
25 starting or discontinuing medication; Respondent largely duplicated
26 the same review of systems notes for each office visit, including the
27 same physical exam findings and inaccuracies within notes.
28

1 **PATIENT B**

2 26. On or about August 22, 2011, Respondent began treating Patient B,⁵ a then-57-year
3 old male, primarily for treatment of chronic musculoskeletal pain COPD, chronic pain, and
4 anxiety. Patient B also had a personal history of methamphetamine use, pain, and addiction
5 issues. According to CURES, Respondent prescribed the patient fentanyl 100 mcg per hour
6 (#15), lorazepam, 1 mg (#30), and hydrocodone, 7.5 mg (#90). On or about February 12, 2012, a
7 consultant note was sent to Respondent indicating that Patient B has lost his driver's license due
8 to a DUI, and that he was medication noncompliant, smelled of THC, appeared medicated, and
9 had been in and out of jail. An emergency room report from August 2011 indicated that the
10 patient had been seen in the ER three times with multiple requests for narcotics or anti-anxiety
11 medication. Respondent's initial medical note for the patient occurred on or about June 6, 2013.
12 Respondent was not prescribing controlled substances to patient at this time as the patient was on
13 criminal drug probation.

14 27. On or about February 17, 2014, the patient is seen for episodic chest pain, COPD, and
15 hypogonadism. The patient indicated that he had abstained from drugs and alcohol for
16 approximately two years and he was taking methadone. On or about April 29, 2014, Respondent
17 began prescribing hydrocodone, 5/300 mg, every four hours, lorazepam, 1mg, every eight hours,
18 and methadone, 10 mg, every four hours, to Patient B on a regular basis. Respondent noted that
19 he was taking over patient care of Patient B, who had previously been under the care of a pain
20 management specialist. Absent from the note was any indication that Respondent initiated tools
21 to assess this high-risk patient for concerns of use, misuse, or diversion of medication. On or
22 about May 15, 2014, the patient's pain had reportedly worsened and he was still without a pain
23 management specialist. On or about May 29, 2014, Respondent noted that there were no red flags
24 regarding opioid use, but did not indicate how this was determined.

25 28. On or about June 30, 2014, Respondent noted "...chronic complex patient with severe
26 social problems including chronic pain, hands are shaking due to withdrawal from pot."

27 _____
28 ⁵ Conduct occurring more than seven (7) years from the filing date of this Accusation is
for informational purposes only and is not alleged as a basis for disciplinary action.

1 However, there was no discussion regarding this finding, and it was conflictingly noted that the
2 patient was stable. Further, the CNS section listed the patient as normal rather than reflecting the
3 tremor. While the note indicated the patient had worsened, much of the note was largely
4 duplicated from previous notes. On or about December 22, 2014, Respondent started the patient
5 on Percocet, 10/325 mg, in addition to the regular methadone prescription. Hydrocodone had
6 been discontinued at this time. On or about January 22, 2015, Respondent documented that the
7 patient had left-sided weakness that was almost resolved, however, there was no mention of this
8 in the plan, CNS, or Physical-exam Neurological notes.

9 29. On or about February 20, 2015, the patient indicated that he was still smoking
10 marijuana, yet it was noted that he is a former drug user. Percocet is continued for pain
11 secondary to skin infection, in addition to methadone and lorazepam. On or about March 19,
12 2015, Respondent noted that he discussed the limitations of chronic pain treatment with the
13 patient, including the pros and cons, and attempts to wean him off controlled substances.
14 However, there exists no prior documentation of attempts to wean the patient off controlled
15 substances. On or about May 15, 2015, the patient reported abrasions sustained to his nose and
16 face from a lamp falling on his face. There lacked any discussion of the patient receiving
17 hydromorphone from another physician at this visit.

18 30. On or about May 15, 2015, the patient filled three different prescriptions for
19 methadone prescribed by Respondent at two different pharmacies. On or about May 27, 2015,
20 Patient B filled two different prescriptions for lorazepam prescribed by Respondent at two
21 different pharmacies. On or about June 8, 2015, Patient B requested an early refill of methadone
22 because he was reportedly going out of town for the week. He filled two prescriptions for
23 methadone at two different pharmacies the same day. According to CURES, the patient received
24 540 tablets of methadone on or about May 15, 2015, which was a 3-month supply, and just
25 approximately three weeks later received 360 tablets of methadone.⁶ Therefore, the patient
26 received a 5-month supply of methadone within approximately three weeks. This is in addition to
27 180 tablets of lorazepam and 20 tablets of Percocet filled during the same period.

28 ⁶ Patient B's intended dosage of methadone, 10 mg, was 180 tablets every 30 days.

1 31. On or about August 6, 2015, Respondent noted that he reviewed CURES for Patient
2 B and confirmed the patient was only receiving medication from him. That same day, the patient
3 filled two separate prescriptions for 180 tablets of methadone, 10 mg, from two different
4 pharmacies. On or about September 3, 2015, the patient reported dizziness and memory
5 problems, although there was no follow-up discussion by Respondent. On or about October 29,
6 2015, the patient again received an early refill for methadone after having just filled his monthly
7 prescription on or about October 6, 2015.

8 32. On or about May 18, 2016, Patient B was required to undergo a drug screening by
9 another provider. The results were negative for both opiates and benzodiazepines, even though
10 the patient had recently filled prescriptions for methadone and lorazepam. The results indicated
11 misuse or diversion by the patient. Respondent admitted that he had reviewed the test results.
12 Approximately one week later, Patient B signed a pain contract. However, there lacked any
13 discussion by Respondent regarding inconsistencies in the drug screening result at this visit or in
14 future office visits. In fact, Respondent noted on or about June 27, 2016, that the patient was
15 medication and pain contract compliant.

16 33. On or about August 17, 2018, Respondent noted that he reviewed CURES for the
17 patient, whose skin had been itching as a side effect from narcotics. Respondent ordered a drug
18 urine screening for the patient, which tested positive for benzodiazepines, methadone, and
19 alcohol. One week later, Respondent discharged the patient from his practice for violating the
20 controlled substances contract by consuming alcohol.

21 34. Throughout the duration of Respondent's care of Patient B, he displayed extensive
22 and recurring disconcerting signs and symptoms related to use, misuse and diversion of long-term
23 controlled substance therapy. The patient demonstrated numerous instances of drug-seeking
24 behavior and aberrant drug use, including utilizing multiple pharmacies to fill multiple
25 prescriptions, continually requesting early refills, negative test results for opiates and
26 benzodiazepines, and being on criminal drug probation.

27 35. Between approximately September 22, 2011, and August 17, 2018, the patient was
28 seen a minimum of 70 times by Respondent. During this period, the patient was provided with

1 10,080 tablets of methadone, 10 mg, 90 tablets of hydrocodone, 7.5 mg, 30 tablets of
2 hydrocodone, 5 mg, 15 fentanyl patches, 100 mcg/hour, 44 tablets of hydromorphone, 4 mg, 56
3 tablets of oxycodone, 325/10 mg, 450 tablets of diazepam, 5 mg, and 3630 tablets of lorazepam,
4 1.0 mg. Patient B's average dose during this period was approximately 160 MED's.

5 36. Many of the medical notes were largely duplicates of previous notes. Respondent did
6 not classify the patient's risks and benefits, provide a sufficient treatment plan, or appropriately
7 modify treatment due to likely reported side effects or aberrant drug behavior during the patient's
8 long-term opioid use. Absent from the record was a discussion regarding the risks of combining
9 opioids with other prescribed respiratory depressants, a risk-benefit discussion regarding
10 medications, as well as efforts to ensure adequate compliance monitoring.

11 37. Respondent committed gross negligence in his care and treatment of Patient B which
12 included, but was not limited to, the following:

13 (a) Respondent failed to document clear, detailed and accurate medical
14 records, including a history of present illness for various complaints
15 made by the patient, the rationale for a diagnosis, and a discussion
16 with the patient regarding the risks, benefits, and side effects of
17 starting or discontinuing medication; Respondent largely duplicated
18 the same review of systems notes for each office visit, including the
19 same physical exam findings.

20 (b) Respondent failed to undertake or document risk assessment for
21 continued prescribing and long-term use of opioids, such as
22 classifying the patient's risk initially or during continued monitoring
23 using various screening and monitoring tools when the patient
24 revealed a substantial risk of controlled substance abuse, misuse or
25 diversion; Respondent failed to adequately evaluate the potential risks
26 of combining opiate therapy with other respiratory depressants such
27 as benzodiazepines (lorazepam and diazepam);
28

- 1 (c) Respondent failed to properly modify treatment after concerning
2 reports of likely side effects of narcotics and benzodiazepines use
3 indicating aberrant drug behavior, such as reported falls, changes in
4 mental status, memory loss, early refills, refills at multiple pharmacies
5 with multiple prescriptions, and inconsistent results on urine drug
6 screening;
- 7 (d) Respondent failed to implement a comprehensive treatment plan with
8 objectives and measurable goals for controlled substances, a well as
9 an exit strategy for discontinuing opioid therapy; and
- 10 (e) Respondent failed to undertake or document appropriate compliance
11 monitoring of controlled substances, such as urine drug testing or pill
12 counting, despite evidence that the patient was misusing or diverting
13 medication.

14 **PATIENT C**

15 38. On or about August 25, 2015, Respondent began treating Patient C, a then-55-year
16 old male, primarily for treatment of chronic pain, and pain of the neck, mid-back, and lumbar
17 region. The patient's MRI also showed moderate canal narrowing and mild ventral cord
18 compression and myelopathy. The patient had just been terminated by a pain clinic, yet the
19 reason was unclear whether it was due to noncompliance or another factor. It was noted that
20 Patient C was a poor historian due to being under the influence of narcotics, as exhibited by his
21 slurred speech and drowsiness. Respondent noted that he did not feel comfortable prescribing
22 large quantities of narcotics to the patient. It was noted that the patient was depressed and in
23 withdrawal from narcotics. Respondent agreed to take over Patient C's pain management and
24 prescribed diazepam, 10 mg (#60), methadone, 10 mg (#60), and morphine, 10 mg (#30).
25 Respondent reported that he reviewed CURES and the patient signed a pain contract.

26 39. On or about October 21, 2015, Respondent noted that the patient was "very much"
27 under the influence of narcotics, tended to ramble, and was at times delusional. On or about
28 November 20, 2015, Respondent noted that the patient was awake, alert, and not impaired due to

1 narcotics, yet conflictingly documented in the ROS section that the patient was very much under
2 the influence of narcotics. On or about December 17, 2015, Respondent again noted that the
3 patient has slurred speech and was impaired due to narcotics. In the abdominal examination
4 section, Respondent noted that Patient C had no scars, despite just having abdominal surgery. On
5 or about February 22, 2016, the patient indicated that morphine was no longer covered by his
6 insurance, so Respondent removed morphine and increased methadone from 60 to 90 tablets
7 monthly. On or about April 7, 2016, Respondent again conflictingly noted that the patient was
8 not intoxicated, but also that he had slurred speech and was under the influence of narcotics. On
9 or about May 6, 2016, it was noted that Respondent counseled the patient regarding gallstones
10 causing some of his discomfort even though the patient had his gall bladder previously removed.

11 40. On or about May 19, 2016, Patient C reported that he fell and injured his wrist. On or
12 about July 19, 2016, Respondent indicated that he checked CURES, but made no reference to the
13 patient recently changing pharmacies. On or about August 31, 2016, the patient filled an early
14 refill for methadone. On or about May 4, 2017, it was noted that the patient's pain had been
15 masked for a number of months due to large doses of narcotics for chronic pain, as well as urinary
16 symptoms and obstruction. On or about June 8, 2017, Patient C was seen at urgent care for a fall
17 sustained at his home where he hit his right eye on a table. He also complained of wrist pain due
18 to multiple spider bites. The urgent care physician noted that the patient had delusions regarding
19 the source of his injury. Later that month, Respondent noted that the patient had wrist pain
20 secondary to spider bites, but there was no further discussion of this issue.

21 41. On or about March 8, 2018, the patient was seen at urgent care for a possible
22 infection and reported that one year ago spiders walked on him, crawled up his nose, and bit him.
23 The urgent care physician documented potential delusional thinking. During Patient C's next
24 visit with Respondent on or about April 5, 2018, there was no discussion regarding spiders or the
25 urgent care visit. On or about May 3, 2018, Respondent noted that the patient complained of
26 spider bites and that he was delusional about spiders crawling up his forearms. However, this
27 impression was not documented in the psychiatric section of the note. On or about July 18, 2018,
28

1 the patient reported to another provider that he was bitten in the nose by a brown recluse spider,
2 and was diagnosed with a deviated septum.

3 42. On or about August 21, 2018, Patient C is seen by a cardiologist, who noted that the
4 patient had an inability to focus on his thoughts and was dwelling on the notion that his EKG was
5 abnormal due to a history of spider bites. The patient believed that 10 spiders had crawled up his
6 nose, and that he had a swollen leg because his wife "opened a letter from Saddam and let the
7 dust out." It was noted that the patient had tangential thought with possible paranoid ideas and
8 delusions.

9 43. Between approximately August 25, 2015, and July 2, 2018, the patient was seen
10 approximately 48 times by Respondent. During this period, the patient was provided with 2,700
11 tablets of methadone, 10 mg, 180 tablets of morphine, 10 mg, and 1320 tablets of diazepam, 10
12 mg. Patient C's average dose during this time was approximately 100 MED's.

13 44. Throughout the duration of Respondent's care of Patient C, he displayed significant
14 and repeated concerning signs and symptoms related to long-term controlled substance therapy.
15 The patient exhibited slurred speech, drowsiness, and memory issues. He was a poor historian,
16 tended to ramble, and changed pharmacies. Most importantly, he demonstrated delusional
17 thoughts and paranoid ideas. The patient believed his health problems were caused by spider
18 bites, and that his leg had swollen because of "dust" from a letter sent by "Saddam."

19 45. The patient was concurrently being treated by Respondent for both anxiety and pain,
20 which may increase the patient's risk for abuse, misuse or addiction. Respondent had prescribed
21 large quantities of benzodiazepines to the patient to treat his mental illness. Many of the medical
22 notes were largely duplicates of previous notes. Respondent did not classify the patient's risks
23 and benefits, provide a sufficient treatment plan, or appropriately modify treatment due to likely
24 reported side effects or aberrant drug behavior during the patient's long-term opioid use. Absent
25 from the record was a discussion regarding the risks of combining opioids with other prescribed
26 respiratory depressants, a risk-benefit discussion regarding medications, as well as efforts to
27 ensure adequate compliance monitoring.

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1 46. Respondent committed gross negligence in his care and treatment of Patient C which
2 included, but was not limited to, the following:

- 3 (a) Respondent failed to undertake or document risk assessment for
4 continued prescribing and long-term use of opioids, such as various
5 screening and monitoring tools, especially when the patient
6 demonstrated significant risk of controlled substance misuse;
7 Respondent failed to adequately evaluate the potential risks of
8 combining opiate therapy with other respiratory depressants such as
9 benzodiazepines (diazepam);
- 10 (b) Respondent failed to properly modify treatment after reported side
11 effects of long-term narcotics and benzodiazepine use, including
12 aberrant drug behavior and deeply concerning warning signs and
13 symptoms, and Respondent failed to adequately evaluate the patient's
14 progress toward functional goals and positive changes in pain status;
- 15 (c) Respondent failed to implement a comprehensive treatment plan with
16 objectives and measurable goals for controlled substances, as well as
17 an exit strategy for discontinuing opioid therapy;
- 18 (d) Respondent failed to undertake or document appropriate compliance
19 monitoring of controlled substances, such as urine drug testing or pill
20 counting; and
- 21 (e) Respondent failed to document clear, detailed and accurate medical
22 records, including a history of present illness for various complaints
23 made by the patient, the rationale for a diagnosis, and a discussion
24 with the patient regarding the risks, benefits, and side effects of
25 starting or discontinuing medication; Respondent largely duplicated
26 the same review of systems notes for each office visit, including the
27 same physical exam findings and inconsistencies within notes.

1 **PATIENT D**

2 47. On or about June 2, 2012, Respondent began treating Patient D, a then-59-year old
3 male, primarily for treatment of chronic pain stemming from an injury sustained in a car accident
4 30 years prior. According to CURES, Respondent began prescribing morphine sulfate, 100 mg,
5 three times daily, morphine sulfate, 60 mg, three times daily, morphine sulfate, 30 mg, three times
6 daily, and Zolpidem 10 mg, once daily. On or about September 4, 2012, the patient reported his
7 pain was 2 out of a possible 10 in severity, yet the same prescriptions for large quantities of
8 narcotics continued. In fact, Respondent increased the number of tablets of morphine sulfate, 30
9 mg, from 90 to 100 at that time. On or about September 17, 2013, the patient's pain level
10 remained at 2/10 and he entered into a pain contract. Approximately one year later, the patient's
11 pain had worsened due to degenerative joint disease. On or about February 23, 2015, the patient
12 was still being prescribed high quantities of morphine sulfate by Respondent. The patient
13 reported his pain level was 9/10 in his back when not medicated and 2/10 when on medication.

14 48. On or about March 23, 2015, Respondent noted that the patient was still on "massive
15 doses of morphine," and Respondent recommended tapering of the patient's medication to check
16 its efficacy, as well as avoid tolerance. Respondent failed to include any information regarding
17 methods of tapering or objectives. Approximately one month later, Respondent indicated that the
18 patient was still on large doses of morphine after he tried to taper, but was unsuccessful. On or
19 about May 22, 2015, the patient submitted for a urine test, which was negative for illicit drugs
20 and positive for the prescribed opiates. On or about July 23, 2015 and August 21, 2015,
21 Respondent noted confusion as to which pharmacy to send medication.

22 49. On or about February 16, 2016, Respondent requested that the patient bring in his
23 medication bottle to monitor his use. Notes dated on or about April 14, 2016, and May 13, 2016,
24 are exact duplicates from previous notes, including syntax errors. On or about January 6, 2017,
25 Respondent conducted a pill count of Patient D's medication. On or about April 7, 2017, the
26 patient was advised by Respondent to taper off his medication and prescribed Narcan.⁷ On or

27 _____
28 ⁷ Narcan is a drug used to treat opioid overdose.

1 about November 2, 2017, the patient was still on very high doses of morphine despite
2 Respondent's previous note to taper opiates. There was a note to order Narcan at this office visit,
3 as well on or about December 1, 2017, and July 24, 2018, but there was no evidence it was
4 actually ordered for these office visits. On or about March 1, 2018, Patient D was again advised
5 to taper his medication, yet Respondent continued to prescribe the same dosage. On or about
6 April 27, 2018, the patient was diagnosed with Hepatitis C and Respondent conducted a pill
7 count. On or about August 21, 2018, Respondent discontinued the 60 mg dose of morphine. This
8 was Patient D's last appointment with Respondent.

9 50. Between approximately June 4, 2012, and August 21, 2018, Patient D was seen
10 approximately 58 times by Respondent. During this period, the patient was provided with 6,800
11 tablets of morphine sulfate, 30 mg, 6,120 tablets of morphine sulfate, 60 mg, 6,720 tablets of
12 morphine sulfate, 100 mg, and 2040 tablets of Zolpidem, 10 mg. Patient D's average dose during
13 this time was approximately 580 MED's, which is considered a high dose.⁸

14 51. The patient was concurrently being treated by Respondent for both anxiety and pain,
15 which may increase the patient's risk for abuse, misuse or addiction. Respondent had prescribed
16 Zolpidem, a sedative-hypnotic, known to cause respiratory depression, and has an increased risk
17 of respiratory depression when combined with opiates such as morphine. Many of the medical
18 notes were largely duplicates of previous notes. Respondent did not classify the patient's risks
19 and benefits, provide a sufficient treatment plan, or appropriately modify treatment due to likely
20 reported side effects or aberrant drug behavior during the patient's long-term opioid use. Absent
21 from the record was a discussion regarding the risks of combining opioids with other prescribed
22 respiratory depressants, a risk-benefit discussion regarding medications, as well as efforts to
23 ensure adequate compliance monitoring.

24 52. Respondent committed gross negligence in his care and treatment of Patient D which
25 included, but was not limited to, the following:

- 26 (a) Respondent failed to undertake or document risk assessment for
27 continued prescribing and long-term use of opioids, such as various

28 ⁸ A dose greater than 200 mg MED per day is considered a high dose.

1 screening and monitoring tools, and he failed to adequately evaluate
2 the potential risks of combining opiate therapy with other respiratory
3 depressants such as sedatives/hypnotics (Zolpidem);

4 (b) Respondent failed to properly modify treatment after reported side
5 effects of narcotics and sedative/hypnotic use, including aberrant drug
6 behavior, and Respondent failed to adequately evaluate the patient's
7 progress toward functional goals and positive changes in pain status;

8 (c) Respondent failed to implement a comprehensive treatment plan with
9 objectives and measurable goals for controlled substances, as well as
10 an exit strategy for discontinuing opioid therapy;

11 (d) Respondent failed to undertake or document appropriate compliance
12 monitoring of controlled substances;

13 (e) Respondent failed to document clear, detailed and accurate medical
14 records, including a history of present illness for various complaints
15 made by the patient, the rationale for a diagnosis, and a discussion
16 with the patient regarding the risks, benefits, and side effects of
17 starting or discontinuing medication; Respondent largely duplicated
18 the same review of systems notes for each office visit, including the
19 same physical exam findings and syntax errors within notes.

20 **SECOND CAUSE FOR DISCIPLINE**

21 **(Repeated Negligent Acts)**

22 53. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
23 defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent
24 acts in his care and treatment of patients A, B, C, and D, as more particularly alleged herein.

25 **PATIENT A**

26 54. Respondent committed repeated negligent acts in his care and treatment of Patient A
27 which included, but were not limited to, the following:
28

1 (a) Paragraphs 20 through 25, above, are hereby incorporated by reference
2 and realleged as if fully set forth herein.

3 **PATIENT B**

4 55. Respondent committed repeated negligent acts in his care and treatment of Patient B
5 which included, but were not limited to, the following:

6 (a) Paragraphs 26 through 37, above, are hereby incorporated by reference
7 and realleged as if fully set forth herein;

8 (b) Respondent failed to adequately provide informed consent to Patient B.

9 **PATIENT C**

10 56. Respondent committed repeated negligent acts in his care and treatment of Patient C
11 which included, but were not limited to, the following:

12 (a) Paragraphs 38 through 46, above, are hereby incorporated by reference.
13 and realleged as if fully set forth herein.

14 **PATIENT D**

15 57. Respondent committed repeated negligent acts in his care and treatment of Patient D
16 which included, but were not limited to, the following:

17 (a) Paragraphs 47 through 52, above, are hereby incorporated by reference
18 and realleged as if fully set forth herein;

19 (b) Respondent failed to adequately provide informed consent to Patient
20 D.

21 **THIRD CAUSE FOR DISCIPLINE**

22 **(Repeated Acts of Clearly Excessive Prescribing)**

23 58. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
24 defined by section 725, of the Code, in that he has committed repeated acts of clearly excessive
25 prescribing of drugs or treatment to Patient B, as determined by the standard of the community of
26 physicians, as more particularly alleged in paragraphs 26 through 37, above, which are hereby
27 incorporated by reference and realleged as if fully set forth herein.

28

1 **FOURTH CAUSE FOR DISCIPLINE**

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

3 59. Respondent is further subject to disciplinary action under sections 2227 and 2234, as
4 defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate
5 records regarding his care and treatment of patients A, B, C, and D, as more particularly alleged
6 in paragraphs 20 through 52, above, which are hereby incorporated by reference and realleged as
7 if fully set forth herein.

8 **DISCIPLINARY CONSIDERATIONS**

9 60. To determine the degree of discipline, if any, to be imposed on Respondent Blaise
10 Philip Vinc DeSouza, M.D., Complainant alleges that on or about July 5, 1999, in a prior
11 disciplinary action entitled *In the Matter of the Disciplinary Proceeding Against Blaise Philip*
12 *DeSouza, M.D.*, before the Medical Board of California, in Case No. 02-1998-92430,
13 Respondent's license was placed on probation for a period of five (5) years for engaging in
14 unprofessional conduct, including entering into a sexual relationship with a patient, abusing
15 alcohol, and self-administering Xanax and Prozac without a valid prescription. That decision is
16 now final and is incorporated by reference as if fully set forth herein.

17 **PRAYER**

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

- 20 1. Revoking or suspending Physician's and Surgeon's Certificate No. A 37917, issued to
21 Blaise Philip Vinc DeSouza, M.D.;
- 22 2. Revoking, suspending or denying approval of Blaise Philip Vinc DeSouza, M.D.'s
23 authority to supervise physician assistants and advanced practice nurses;
- 24 3. Ordering Blaise Philip Vinc DeSouza, M.D., if placed on probation, to pay the Board
25 the costs of probation monitoring; and

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

DATED: May 16, 2019


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

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