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

In the Matter of the Second Amended Accusation Against:	)	
BRADLEY HOWARD CHESLER, M.D.	)	Case No. 800-2014-008851
Physician's and Surgeon's Certificate No. A43963	)	
Respondent	)	

ORDER DENYING PETITION FOR RECONSIDERATION

The Petition filed by David Rosenberg, Esq. and Chad F. Edwards, Esq., attorneys for BRADLEY HOWARD CHESLER, M.D., for the reconsideration of the decision in the above-entitled matter having been read and considered by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on **December 6, 2019.**

IT IS SO ORDERED: December 6, 2019.

Ronald H. Lewis, M.D., Chair
Panel A

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

In the Matter of the Second Amended Accusation Against: BRADLEY H. CHESLER, M.D. Physician's and Surgeon's Certificate No. A43963 Petitioner	)	MBC No. 800-2014-008851 **ORDER GRANTING STAY** (Government Code Section 11521)

David Rosenberg, Esq. and Chad F. Edwards, Esq. on behalf of Petitioner BRADLEY H. CHESLER, M.D., has filed a Request for Stay of execution of the Decision in this matter with an effective date of November 27, 2019, at 5:00 p.m.

Execution is stayed until December 6, 2019, at 5:00 p.m.

This stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: November 26, 2019

Christine J. Lally
Interim Executive Director
Medical Board of California

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

In the Matter of the Second Amended Accusation Against:	)	
BRADLEY HOWARD CHESLER, M.D.	)	**Case No. 800-2014-008851**
Physician's and Surgeon's Certificate No. A 43963	)	**OAH No. 2018010827**
Respondent	)	

DECISION

The attached Proposed Decision is hereby amended, pursuant to Government Code section 11517(c)(2)(c) to correct technical or minor changes that do not affect the factual or legal basis of the proposed decision. The proposed decision is amended as follows:

1. **Page 2, 1st paragraph, 8th line: "accurate" at the end of the line is changed to "adequate."**
2. **Page 6, 1st paragraph, 1st line: "respondent" at the end of the line is changed to "Patient A."**
3. **Page 23, 3rd paragraph, 4th line: "2015" is changed to "2013."**
4. **Page 53, 2nd paragraph, 3rd line: "mediation" is changed to "medication."**
5. **Page 57, 3rd paragraph, 1st line: "required" should be removed.**
6. **Page 59, footnote 29, 3rd line: comma after "pain" and "a" before "management" should be removed.**
7. **Page 63, 2nd paragraph, 1st line: "controlling" is changed to "controlled."**
8. **Page 77, paragraph 31, 2nd line: "not" should be added after "had" at the end of the line.**
9. **Page 87, paragraph 53, 3rd line: "mediation" is changed to "medication."**
10. **Page 97, paragraph 61, 6th line: "a peform" should be removed.**
11. **Page 111, 1st paragraph, 2nd line: "and" is changed to "an."**
12. **Page 112, 3rd paragraph, 3rd line: parentheses should be removed after "refills."**
13. **Page 137, 3rd paragraph, 5th line: "E" after "for" is changed to "respondent."**

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

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

IT IS SO ORDERED: October 29, 2019.

MEDICAL BOARD OF CALIFORNIA

Ronald H. Lewis, M.D., Chair
Panel A

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

In the Matter of the Second Amended Accusation Against:

BRADLEY HOWARD CHESLER, M.D., Respondent

Physician's and Surgeon's Certificate No. A 43963

Case No. 800-2014-008851

OAH No. 2018010827

PROPOSED DECISION

Abraham M. Levy, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on December 6 and 7, 2018, March 18 through 21, 2019, and August 26 through 29, 2019, in San Diego, California.

Karolyn M. Westfall, Deputy Attorney General, represents complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California (Board).

David Rosenberg and Chad Edwards, Attorneys at Law, Rosenberg, Shpall, and Zeigen, APLC, represent respondent Brian Howard Chesler, M.D., who was present.

The matter was submitted on August 30, 2019.

SUMMARY

Complainant asserts that respondent's license should be disciplined because he committed gross negligence in his care and treatment of five opioid prescription pain management patients, including one patient who died from a combination of opioids and benzodiazepines respondent prescribed and alcohol while under his care. Complainant also asserts that respondent committed repeated negligent acts with respect to these patients, demonstrated incompetency in his care of one of his patients, excessively prescribed drugs to three of them, prescribed drugs to two patients without an appropriate prior examination, and failed to maintain accurate and accurate records, in addition to other violations of the Medical Practice Act. Complainant proved most of the allegations contained in the second amended accusation by clear and convincing evidence based on the credible testimony of two experts in the field of pain management.

Respondent presented credible evidence that he has substantially changed his practice of prescribing opioids and controlled substances and improved his monitoring of patients. Revocation of his license is thus not required to ensure public protection. A three-year period of probation with terms and conditions including requirements that he successfully complete a clinical competency training program and have a practice monitor will ensure public protection. Respondent's request that his license be publicly reprimanded is denied.

PROTECTIVE ORDER

A protective order was issued on complainant's motion sealing Exhibit 5 to 18, 20 to 25, and 27 and 31 and these exhibits are sealed. On the Administrative Law

Judge's motion, respondent's Exhibits A through E, which contain patient medical records, have also been placed under seal. A reviewing court, parties to this matter, and a government agency decision maker or designee under Government Code section 11517 may review materials subject to the protective order provided that this material is protected from disclosure to the public.

FACTUAL FINDINGS

Jurisdictional Matters

1. On July 18, 2018, complainant filed the Second Amended Accusation. Respondent had previously timely filed a Notice of Defense to the initial October 5, 2017 accusation.

The second amended accusation alleges nine causes to impose discipline on respondent's license: respondent committed gross negligence regarding his treatment of patients A, B, C, D and E (First Cause for Discipline) and repeated negligent acts regarding his treatment of patients A, B, C and D (Second Cause for Discipline), he excessively prescribed drugs to patients A, B, and C (Third Cause for Discipline), he prescribed drugs to patients B and C without requiring adequate or appropriate prior exams (Fourth Cause for Discipline), he failed to maintain adequate and accurate medical records regarding patients A, B, C, D and E (Fifth Cause for Discipline), he violated federal and/or state laws governing the prescription of controlled substances (Sixth Cause for Discipline), he engaged in unprofessional conduct (Seventh Cause for Discipline), he violated the Medical Practice Act (Eighth Cause for Discipline), and he demonstrated incompetence in his care and treatment of patient E (Ninth Cause for Discipline).

License History

2. On August 31, 1987, the Board issued Physician's and Surgeon's Certificate Number A 43963 to respondent. The certificate is current and will expire on August 31, 2021, unless renewed. Respondent has no history of discipline.

Prehearing Motions

3. Before the hearing, the parties filed the following motions: Complainant filed motions to exclude duplicative expert testimony and limit the number of respondent's character witnesses. Respondent filed motions to dismiss a vague allegation in the accusation relating to Patient C and exclude the introduction of evidence of conduct before October 5, 2010, relating to Patients A, B and C, since the initial accusation in this matter was filed on October 5, 2017, and such evidence was barred by the seven-year statute of limitations under Business and Professions Code section 2230.5, subdivision (a).[1] Respondent also asked that evidence of conduct related to Patients D and E before March 21, 2011, be barred under this seven-year statute of limitations since the first amended accusation that included allegations involving respondent's care of both these patients was filed on March 21, 2018. The second amended accusation was filed on July 18, 2018.

The motions were heard at the start of the hearing on December 6, 2018. Complainant's motion to limit the number of witnesses was granted in part and denied in part; complainant's motion to exclude duplicative testimony of respondent's expert

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[1] All subsequent references are to the Business and Professions Code unless otherwise stated.

witnesses was denied without prejudice. Respondent's motion to bar the introduction of evidence beyond the seven-year time period was granted, and during the hearing the parties identified allegations in the amended accusation that were beyond the seven-year period and stipulated to remove these allegations from the second amended accusation. Respondent's motion to dismiss a vague allegation was granted in part in the context of respondent's motion to exclude the introduction of evidence outside the seven-year statute of limitations.

Summary of Respondent's Treatment and Care of Patients A through C and Dr. Kirpalani's Testimony Regarding Patients A, B and C

4. Complainant called two expert witnesses. Complainant's first expert, Dhiruj Kirpalani, M.D., addressed issues relating to respondent's care and treatment of Patients A, B and C. Complainant called Michael H. Verdolin, M.D., as a second expert to address issues relating to respondent's care of Patients D and E. For organizational purposes, respondent's care and treatment of Patients A, B and C as found in respondent's records, and Dr. Kirpalani's testimony are first summarized. Respondent's care and treatment of Patients D and E, also as found in respondent's records, and Dr. Verdolin's testimony are summarized later.

PATIENT A

5. On February 7, 2005, Patient A ("Patient A" or "A"), a 50-year old female, began treating with respondent for pain management due to chronic neck pain following a motor vehicle accident and neck surgery. In the Patient Registration form she completed at her initial visit in 2005, A reported she suffered from "severe chronic pain". Patient A also underwent surgery, in 2005, to remove a tumor in her a right upper extremity. However, the record does not show that A was diagnosed with cancer

and/or was in treatment for cancer. Respondent assessed respondent for pain management treatment purposes related to the following conditions: Shoulder impingement, pain cervical with radiation, radiculopathy cervical, rotator cuff syndrome, and tendinitis patellar. A pathology report complainant submitted into the record dated October 20, 2005, was negative for cancer. As discussed below, Patient A reported to a Health Quality Investigation Unit investigator that in July 2014 she was diagnosed with a brain tumor but there is no substantiation in the record that she was diagnosed with this condition. In 2007, A underwent additional surgery to remove hardware in her right arm due to ongoing pain.

From the start of her treatment with respondent, respondent treated Patient A with a pain medication regimen that included a variety of opioid medications and a benzodiazepine. For purposes of this matter, the relevant time period is respondent's treatment of A after October 5, 2010, seven years before the filing of the accusation. Respondent documented his treatment of A in contemporaneous notes, reports, medical records and other documents which were part of A's records.

As part of his effort to monitor A's compliance with her medication program during the relevant period of time at issue here, on June 26, 2008, July 18, 2011, and September 16, 2014, Patient A signed patient pain agreements. Under the terms of each of these agreements she was advised that "evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions or failure to follow the agreement may result in termination of the doctor/patient relationship." She was further advised that one doctor should be responsible for prescribing all opioid medications and adjunctive analgesics and she should use one pharmacy to obtain all opioid prescriptions and adjunctive analgesics.

She identified Savon in her June 26, 2008, agreement, Drug Company in her July 18, 2011, agreement, and Palomar Pharmacy in her July 16, 2014. agreement as the designated pharmacies she would use. The agreements Patient A signed did not advise her of the risks of taking too much acetaminophen.

Under the terms of the July 18, 2011, agreement, Patient A agreed to go to only one Emergency Room visit per month for pain exacerbations and obtain medications only from the agreed upon pharmacy.

6. A review of A's contemporaneous records and notes, starting October 21, 2010, shows the following, in relevant part:

In a note dated October 21, 2010, respondent documented that Patient A wanted to reapply for federal disability. On this date, he described A's goals as to "[i]ncrease the patient's ability to self-manage pain and related problems. Maximize and maintain optimal physical activity and function. Reduce subjective pain intensity." He also wrote he reviewed her CURES report and wanted to discuss with her "some issues".[2] Respondent did not, however, document what he discussed with her. He

[2] "CURES" is the acronym for The Controlled Substance Utilization Review and Evaluation System, which is maintained by the California Department of Justice. CURES is a database of prescriptions for controlled substances that reports data regarding prescriptions filled by patients, including the prescribing physician, the date the drug is dispensed, and the pharmacy that filled the prescription. As one of complainant's experts, Michael Verdolin, M.D., noted in his testimony, CURES reports have been available to doctors online since 2011.

prescribed 120 pills of Percocet 10/325 mg, 90 pills of Dilaudid 4 mg and a Fentanyl Transdermal Patch.[3]

At her next visit after November 18, 2010, respondent documented in his note of this date that "Her evaluation is extended to discuss and arrange all of her medications." She said that she was having more pain with moving and respondent noted that she "appears nervous about her pending surgery." Respondent noted that he was not going to make any changes in her medication program. He refilled the medications he prescribed to her on October 21, 2010, but he added 90 pills of Valium[4] with a three-time refill supply, which appears to represent a change in her medication program contrary to what respondent wrote in his note. In addition, he

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[3] Percocet is the brand name for oxycodone with acetaminophen and is a Schedule II controlled substance and dangerous drug under Health and Safety Code section 11055, and dangerous drug under Section 4022. It is a short acting opioid medication. In this decision Percocet is referred to both by its brand and generic names consistent with the evidence of record. Dilaudid is also a Schedule II controlled substance and dangerous drug with its generic name Hydromorphone Hydrochloride and is a short acting opioid medication. A Fentanyl Transdermal Patch is similarly a Schedule II controlled substance and dangerous drug.

[4] Valium is a benzodiazepine and a Schedule IV controlled substance under Health and Safety Code section 11057 and dangerous drug. Its generic name is Diazepam. In this decision Valium and its generic name are used interchangeably consistent with the record.

added Lortab 7.5/500 mg in the amount of 180 pills[5] with three refills. Respondent did not document that he discussed the risks of taking the benzodiazepine and opioid medications. In the plan respondent wrote that he wanted A to submit to urine drug testing (UDT) "to assure compliance and prevent diversion." He added that "It is consistent," though it is unclear why respondent stated this given that A had not yet submitted to the UDT.

Respondent submitted to a UDT screen at her subsequent visit on December 14, 2010. In his plan respondent wrote that he wanted A to submit to UDT "to assure compliance and prevent diversion." The test results which were reported on December 16, 2010, were consistent with the medications she was taking. Respondent issued prescriptions for A for the Percocet, Dilaudid 4 mg and Fentanyl Patch and in the same doses he previously ordered. It is noted that on November 18, 2010, in his prescription of Lortab to A he had authorized three refills.

On January 11, 2011, respondent had A submit to another UDT and the sample was sent to Millennium Labs. According to the results of this urine screen dated January 13, 2011, A did not have Percocet in her system when it was expected that she should have tested positive for this drug. This could mean she was taking more Percocet than she should have been taking, not taking the medication as prescribed,

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[5] Lortab is the brand name for Hydrocodone Bitartrate and Acetaminophen and is a Schedule II controlled substance and dangerous drug. It is a short acting opioid medication. Its brand name and generic name are used interchangeably in this decision consistent with the record.

or she was diverting the Percocet. At the bottom of the first page of the lab report respondent placed his initials.

Oddly, at her next visit with respondent on February 3, 2011, respondent reported that the UDT results were "consistent" despite the absence of Percocet in A's system, per the January 13, 2011, lab results. Respondent did not document whether he discussed the urine screen results with respondent; he noted that she was "stable on her present program."[6] Respondent again prescribed 120 pills of Percocet 10/325 mg, 90 pills of Dilaudid 4 mg and a Fentanyl Transdermal Patch.

Before her next scheduled visit, A called respondent's office on March 2, 2011, to advise respondent that a clinician at Scripps emergency room accused her of engaging in "drug seeking" behavior. According to respondent's record of her call, A said she went to the ER after she fell on February 27, 2011, and she wanted to discuss the matter with respondent at her next scheduled appointment. At this appointment, on March 3, 2011, A told respondent she fell when she was walking in the snow and had shoulder pain. A said she was not happy with her ER experience or the ER doctor. Respondent refilled her medications, including Valium with three refills. Respondent

[6] As discussed below, next to the lab results for the patients discussed in this decision who were administered UDTs respondent placed his initials, or "ok" or "prn." He did not, except on two occasions, document in patient records that he discussed inconsistent results with the patients or record why he considered results that were inconsistent, according to the lab, to be consistent.

also added Cyclobenzaprine[7] 10 mg, 90 pills, a non-narcotic muscle relaxant. Respondent again noted that the UDT results were "consistent." It is not clear what respondent means here, given the January 13, 2011 urine screen results which showed the absence of Percocet in A's system.

At her April 21, 2011, appointment with respondent, A told respondent that she had been in the hospital for pain, she saw a "pharmacy specialist", and was "going for surgery next week." The type of surgery was not described. Respondent reported that he reviewed all of the issues with her hospitalization, he emphasized that she must take her medications as prescribed, and he did not give her refills for any of her medications. He stated further that all of her refills will be made on paper at each visit. Respondent reviewed with her the pain treatment agreement. He noted that he spent significant time with A. In his plan, respondent stated, in bold, "ER notes reviewed." The Scripps ER note he reviewed documented A presented to the Scripps ER with severe pain which left her "frozen." The note further documented that she was admitted for observation in a non-telemetry bed. As his final impression of A, Russell L. Reinbolt, M.D., reported that she has intractable thoracic pain, and chronic cervical pain by history. For a procedure, Dr. Reinbolt wrote, "Administration of multiple IM medications without adequate relief of her pain."

In apparent contradiction to respondent's comment in his note regarding refilling A's meds, on this same date, respondent provided A with prescriptions for Dilaudid, the Fentanyl patch and the Cyclobenzaprine. He did not provide her a

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[7] Cyclobenzaprine is the generic name for Flexeril, a non-narcotic muscle relaxant.

prescription for Valium this date and he did not provide her with a prescription for Percocet this date. However, he prescribed 120 pills of Oxycodone 30 mg.[8]

On July 18, 2011, A advised respondent in her visit with him that she wanted a new pain agreement. She appeared to want this in order to obtain treatment at the ER. Respondent cautioned her that going to the ER was an intervention of last resort. She wanted further thoracic evaluation and she asked about her refill schedule. It is not clear from the note what she was asking respondent to address about her refill schedule. Respondent commented that her multiple medical problems made treatment of her condition "complex," and he spent a significant amount of time counseling her on her condition and its management.

In response to her problems and concerns, A entered into a new "Agreement for Opioid/Medication Maintenance Therapy for Pain" dated July 18, 2011. This pain agreement allowed her to "seek periodic care [at the] ER for exasperations." It added that she was to "contact provider," apparently referring to respondent.

At this visit respondent prescribed A 120 pills of Percocet 10/325, 90 pills of Dilaudid 4 mg, a Fentanyl Patch, Cyclobenzaprine, 90 pills of Valium, and 180 pills of Lortab 7.5/500 mg. In May and June 2011, he had prescribed these same medications. He discontinued the Oxycodone. Respondent instructed A that she may take the Percocet and Lortab once four times a day as needed.

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[8] Oxycodone is a short acting opioid medication and is a Schedule II controlled substance and dangerous drug.

The next day, July 19, 2011, a Scripps ER doctor contacted respondent to report that he gave A Dilaudid 1 mg IM, but he did not admit A as A asked him to do.

On September 1, 2011, A reported that she was dealing with the stress of her kids, she wanted her medication refilled, she did not like the patches, and she identified the pharmacy where she was obtaining medications. She told respondent she had been receiving acupuncture treatment. Respondent reported that her office visit was "dramatically prolonged dealing with all of her individual issues," and he tried to focus her on her specific problems including her complaints about other services and providers. Respondent gave A a note "regarding the frequency of evaluation behaviors in her interacting with the ER." This note reflected that she would have one visit every 30 days at the ER. Respondent provided A with prescriptions for the medications in the amounts and dosages he previously prescribed.

Patient A next saw respondent on September 21, 2011, sooner than the 30 days she typically saw respondent to refill her meds. At this visit, she stated she was traveling to a funeral and respondent gave her early refills of her medication for her to fill before she went. Respondent at this point did not document that he discussed with A the number of pills she was taking. In fact, respondent did not document at any time any discussion he had with A regarding the number of pills she was taking daily. Respondent provided A with prescriptions for the medications in the amount and dosages he previously prescribed.

Respondent documented at A's October 25, 2011, visit that A "has some issues with the medicine." He did not describe what these issues were. Respondent noted that A was subject to UDT "to address compliance and diversion." But respondent did not require A to submit to a UDT that day. Respondent again provided A with prescriptions for the medications in the amount and dosages he previously prescribed.

On November 22, 2011, A submitted to a UDT. The lab results dated November 25, 2011, were negative for Lortab and Fentanyl indicating that these drugs were not in her system on November 22, 2011. As noted earlier, this raised the possibility that Patient A was either taking more of these medications than she should have or she was diverting them.

The next day, November 23, 2011, respondent documented that he talked to an ER doctor who refused to give Patient A a pain injection. This doctor told respondent that Patient A said she did not have a pain agreement. After the doctor refused to give her a pain medication injection, Patient A called respondent. Respondent advised her to take her medications as prescribed. Respondent noted he sent Patient A's CURES report and pain agreement to the ER doctor.

At A's December 20, 2011, visit, respondent noted that she had "a recent setback" and was evaluated at the emergency room. He stated he discussed with her the situation and would restore her medications. Respondent did not detail the nature of the setback or what he discussed with her to warrant restoring her medications. Respondent also did not record that he discussed with A the November 25, 2011 inconsistent UDT results. Respondent added that A was asking for refills on her medications "but he will not provide that for her. She's [*sic*] had issue with triggering refills early." Respondent issued her the prescriptions for her medications in the same dosages and amounts. This visit was preceded by two calls A made to respondent. A December 13, 2011, note recorded that A called respondent to tell him she got her foot stuck in a baby gate and has been in pain for the last six days, and she could not walk or drive or sleep. She said she needed an x-ray and none of her meds were working. Respondent documented that he was not providing her with new medicine. A December 14, 2011, note documented that A went to the ER where she received 1 mg

of Dilaudid for pain and had a foot x-ray. Respondent commented in the note that he spoke to A by phone and "[s]he'll keep to her medication program." He further noted that A was "still looking for results from the x-ray. . . taken in the emergency room." The record does not indicate that respondent stopped her medications between December 14 and the December 20, 2011, so it is unclear what respondent meant regarding restoring A's medications.

A's next appointment to refill her medications was January 12, 2012, which was again sooner than the 30-day intervals for scheduled visits she typically had. A reported that she was changing her primary care doctor. Respondent advised her that she was going to the ER too many times, she was described as frustrated by her insurance situation, she was wearing heeled boots because she believed they helped her posture, and she told respondent she was going to have to file bankruptcy. A also said she saw her neurosurgeon. Respondent noted that he educated A "about her ER situation" but did not detail what this meant. He stated he spent significant time reviewing her medication program. He emphasized to her that she must take her medications as prescribed. In his plan respondent did not make changes in her medicines, and he refilled her medications in the same dosages and amounts he previously ordered. However, it is not clear from this record whether respondent in fact prescribed medications to A since there is no record of prescriptions for January 12, 2012.

Respondent also stated he wanted A to return to complete Supplemental Security Income disability paperwork he received from her attorney. On January 16, 2012, he completed this paperwork with A.

In the February 2, 2012 note, respondent documented that A had a root canal "two weeks ago," she was going to see a "Dr. Hanlon," she needed her medications

refilled, and she was taking "ibuprofen 800 TID." Parenthetically, respondent described her "medical condition" as remaining "significantly complex," a phrase he had previously used. He reviewed her entire medication program with her, and he stated he was would "no longer provide refills secondary to some irregularities at the pharmacy."[9] It is not clear what these "irregularities" reference. It is also not clear what respondent meant here when he referred to not providing refills because, according to his plan for respondent, he recorded that there was "[n]o change in medicine", and "[m]edication refills as listed above." The medications listed in this note were in the same dosages and amounts respondent previously ordered. He issued prescriptions for Lortab, Valium, Dilaudid, Percocet and the Fentanyl patch in the same dosages and amounts previously ordered.

In a note dated February 17, 2012, A reported that her "safe was stolen out of her room" in which she kept her medications. She reported that she only had a small amount of meds she kept in her purse. As a result, she was out of Valium, Percocet, and Dilaudid. A added that the pharmacist told her she might go into withdrawals without these meds. In comments to this note, respondent advised A to go to the ER.

At A's February 21, 2012, appointment respondent "severely counseled" her regarding her medications. He continued her on the medications in the same dosages and amounts he previously ordered. On this date, respondent had A submit a urine sample to address compliance and diversion. The test outcome for Percocet was negative and respondent initialed the report section to indicate he reviewed it. This again raised the possibility that A was either overusing this med or was diverting it.

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[9] Respondent stopped allowing refills for Valium at some point, but he never authorized refills of the other meds he prescribed A.

Otherwise, the test outcomes were positive for the medications A was taking. On this date, respondent issued prescriptions for Lortab, Valium, Dilaudid, Percocet and the Fentanyl patch in the same dosages and amounts previously ordered.

At her next scheduled visit on March 19, 2012, A reported that she had an "exacerbation" due to the recent snow and she was to undergo dental procedures, including an implant and crowns. Respondent noted that A "is needing some assistance with the present program." It is not clear what respondent meant by this. A further claimed "that the dentist wants her to take more medication." Respondent told A that he would not "offer her anything different unless I here [*sic*] directly from her dentist." At any rate, respondent documented that he reviewed "expectations of her medications" and "[no] significant changes are proposed." He continued her on the same medication regimen.

At A's June 11, 2012, visit, respondent first discussed "a tapering program," meaning reducing the amount of medications A was taking, and he discussed non-medication treatment with her.[10] In this note respondent described A as "stable on her program." In his plan he did not address tapering A's program and he continued her on the same medication regimen. He issued prescriptions for her that day.

On August 6, 2012, respondent stated that A was planning to go on vacation to Hawaii in September. He noted that she was compliant with the program, he discussed a tapering program with her, and he noted that in the coming months he was going to be "pushing" her to "consolidate her medications." He continued her on the same

[10] According to A's records, this is the first time respondent discussed tapering down A's medications. A has been on opioids since 2005.

medication regimen including the Fentanyl patch and wrote prescriptions for her that day. Respondent also had A submit to a urine screen. The lab results were negative for Fentanyl which appeared to not be consistent with her prescription. Respondent did not document whether he discussed the lab results with A.

At A's August 31, 2012, appointment respondent again discussed consolidating her medications but did not taper down her medications or consolidate them. He continued her on the same medication regimen. Respondent, further, did not discuss the results of the August 6, 2012, lab results with patient A which were negative for Fentanyl in her system.

At her next appointment on September 25, 2012, A reported that she was going to Maui, was nervous about it, and needed her meds refilled. Respondent counseled her on "safeguarding her medications." He "altered" the "fill dates" for A's prescriptions to accommodate her travel plans, but it is not clear from this note what respondent meant by this accommodation since the prescriptions for the meds were in the same dosages and amounts.

At her October 23, 2012, appointment, A told respondent that her daughter "was taking her pills." Respondent added she was very depressed, and she planned to see a psychologist that day. Respondent wrote the following comment: "I review [*sic*] her situation and give [*sic*] her some hope that there is going to be resolution in the future."[11] His plan consisted of the same language from respondent's August 6, 2012,

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[11] By this comment in his note, where he expressed empathy for A's "situation" and wanted to give her "hope," respondent appeared to ignore the seriousness of the diversion of A's pills by her daughter considering A reported that her pills were previously stolen, the amount of opioids respondent was prescribing her, A's negative

plan because it referenced her return from vacation in Hawaii in September. At this visit, A submitted a urine sample which interestingly was negative for Fentanyl and Percocet according to the lab October 25, 2012, lab result. Respondent initialed this report indicating he reviewed it. Respondent continued her on the same medications and issued prescriptions for these meds this date.

At her November 20, 2012, appointment, A reported that her daughter was in rehab, she was now "hopeful for her daughter and her future," and she was going to place her meds in a safe to safeguard them. She also told respondent that she was functioning well "with less medicine" and stopped taking her Fentanyl patch because she could not wear them in Hawaii due to the humidity.[12] He did not write respondent

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urine screens for Percocet and Fentanyl, and the fact that he cautioned her on September 25 to safeguard her meds, which she appeared to have ignored. Without discounting the value of respondent's empathy for A as a matter of his doctor/patient relationship to A, his failure to promptly address the implication of A's daughter stealing the pills he was prescribing A is striking. For his plan he merely repopulated in the note the plan he previously made. Tragically, on February 3, 2015, A reported to respondent that her daughter died. Respondent did not document the cause of her daughter's death. No conclusion is made regarding the death of A's daughter as it relates to respondent's care of A.

[12] On December 17, 2012, respondent ran a CURES report of A's prescriptions from December 17, 2011, to December 17, 2012. For the period from August 2012 through November 2012, when she said she was doing well with less medicine, A was in fact obtaining 180 pills of Percocet and 60 pills of Valium monthly from two other

a prescription for Fentanyl this date and he issued prescriptions for the other meds in the same dosages and amounts he had previously ordered despite A telling respondent that she was functioning well with less meds. Respondent, further, did not document he discussed with A the urine screen that was negative for Fentanyl and Percocet.

Respondent documented at A's December 17, 2012, visit that she was having a lot of anxiety with her daughter's situation. He counseled her about proper medicine use and provided her refills, discussed with her a consolidation program, and stated he was going to initiate a reduction program the next year. Respondent's concerns about A's medicine use appeared to have been triggered by the December 17, 2012, CURES report he ran on her which showed that respondent was obtaining 180 pills of Percocet and 90 pills of Valium monthly from two other providers. In his plan, respondent mentioned that he "counseled" A about the CURES report. He did not note, however, A's response, if any, to obtaining Percocet and Valium from other doctors, why she was in need of this amount of meds or what her relationship to these providers were. (One of them appeared to be her primary doctor.) Respondent did not have A submit to a urine screen that date. Despite the CURES report, respondent issued her prescriptions for the meds, including Percocet and Valium, in the same amount and dosages he previously ordered. He issued a prescription for the Fentanyl patch which he previously had discontinued in November.[13]

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doctors. (Exhibit 7, AGO-0667-0669.) This highlights the degree to which A had large quantities of opioids that were accessible to her daughter.

[13] In the December 17, 2012, note respondent copied one of the doctors, T.B., M.D., who was prescribing Percocet and Valium to respondent. He continued to

Respondent had A submit to a UDT at her next visit on January 14, 2013. The results, as documented in a January 15, 2013, report were again negative for Percocet and Fentanyl. Respondent noted that A was experiencing stress due to her daughter's personal and legal situation. He reviewed her medications and counseled A on "appropriate usage" of meds. His plan contained the same language from the December 2012 note. Respondent refilled A's medications in the same dosages and amounts previously ordered.

At her February 11, 2013, respondent discussed with her a consolidation and reduction program. He cautioned her that if she was unable to remain compliant with the program "dismissal is likely." His plan consisted of the same language he used in prior notes. Respondent refilled A's prescriptions in the same amounts and dosages previously ordered.

In a note dated April 8, 2013, A told respondent that her daughter tried to turn in a prescription given to A and "is now [in] a legal process," suggesting her daughter was criminally charged. A wanted her meds refilled and respondent described her as under a lot of stress. Respondent said he talked to A's primary doctor and provided her a copy of a previous note. At this point he noted that A was in violation of her pain agreement. His plan provided as follows: "No change in medicine. She is subject to UDT to address compliance and diversion. [¶] Medication refills as listed above. Safeguarding of medicine discussed. Counseled with CURES report review. [¶] Stable dosing. Reduction program commenced today. Discussed prescribing situation with her primary doctor." This tapering program consisted of discontinuing the Lortab

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document that he copied this doctor in subsequent notes through February 2013. It appears from these subsequent notes that this doctor was A's primary care doctor.

prescription but, otherwise, respondent issued prescriptions to A in the same amounts and dosages for the other meds he had previously issued. A urine screen taken from A that day was negative for Percocet. Respondent did not document in subsequent notes that he discussed this result with A.

A note dated April 15, 2013, documented a call A made to respondent in which she asked respondent to see her for "chronic pain and takes her medication as directed and her and her husband are able to take care of her grandson until [her daughter] is released [from jail]." She called again on April 18 and wanted respondent to give her that note by Friday of that week. If he was unable to write the note she asked that respondent call her. The note further documented that respondent "will not write letter he can not [*sic*] confirm she is fit for child care not his specialty."

A returned to see respondent on May 6, 2013, with her granddaughter. She said she needed to discuss her daughter's situation and she wanted her meds refilled. Respondent said he was going to reduce her medications and consolidate "over time." His plan consisted of the exact same language from his prior note. Regarding the reduction of her meds, respondent again did not prescribe Lortab but otherwise issued prescriptions to A in the same amounts and dosages previously ordered.

At A's May 30, 2013, visit, respondent asked for refills, respondent added back the Lortab he had previously discontinued under the tapering and/or consolidation program and he issued prescriptions for the meds in the same amounts and dosages he previously ordered. At this point, respondent did not explain why he added back the Lortab or why A's meds were neither reduced nor consolidated. He wrote that he counseled her regarding appropriate usage. His plan contained the same language from prior notes including language that he was commencing a reduction program "today."

At her June 27, 2013, appointment, A reported that she was having more back pain, she was doing more lifting at home, and she was receiving massage therapy every week with good results. Respondent stated that he spent significant time with A going over her medications to make sure she understood "the medications appropriately behaved and prescribing." He added that she was going "to consolidation reduction program requiring significant additional time and effort for education." His plan consisted of the same language he used in the April and May 2013 notes. Despite stating he was going to consolidate or reduce her meds, respondent continued her on all the same meds, including Lortab, in the same amounts and dosages he previously ordered.

On July 23, 2013, A told respondent that she was stopping her Fentanyl patches and needed meds "to restore her oral medicine." Respondent noted he supported her effort here, she was "under close medical scrutiny," and "she has been consolidating her medications." It is not clear what respondent meant when he wrote that she was "consolidating her medications." Respondent discontinued the Fentanyl patch but continued all her oral meds in the same amounts and dosages he previously ordered. His plan used same language as in the notes starting in April 2013.

From this date in July 2013 through October 2013 respondent continued to write prescriptions for A for Lortab, Dilaudid, Percocet, Valium and Cyclobenzaprine in the same amounts and dosages he previously ordered. In August A reported that she had her gallbladder removed and on October 15, 2015, she came to his office with her grandson and reported that she was having some low level abdominal pain and "some bleeding." She said she was found to have an enlarged appendix, had a colonoscopy and was found to have colitis and was treated with antibiotics. At this visit A underwent a urine screen which tested negative for Dilaudid, Hydrocodone and

Lortab, according to a report dated October 17, 2013. Respondent did not record whether he discussed these specific results with A in subsequent notes. His plan for the October 15, 2013, visit was in the same language he used in A's notes for April, May and June 2013 and indicated he was commencing a reduction program "today."

At A's March 4, 2014, appointment respondent recorded the following:

> She is asking about zohydro[14] and we discuss it. I explained that I am not comfortable with this medication for her. I'm trying to work in a strategy to consolidate and reduce her [medications]. I do not feel that this medication is appropriate. I refill her usual medications with instructions. I challenge her with the urinary drug testing results. She indicates that she has been using her medications less often. I have explained to her that we will be increasing surveillance for her utilization.

According to A's urine screen taken this date, she tested negative for Dilaudid, Hydrocodone, and Lortab. Notably, for the first time, respondent documented he questioned A specifically about the inconsistent urine screen results. Despite numerous prior inconsistent screens, he had not previously recorded that he asked A about the results. Notwithstanding his concerns about A's med use, and A's comment that she was taking less meds, respondent's plan was essentially the same plan he had

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[14] Zohydro (Hydrocodone Bitartrate) is an extended-release opioid oral formulation of hydrocodone without acetaminophen. It is a controlled substance and dangerous drug.

previously provided for A's care and treatment. He provided respondent with prescriptions for 120 pills of Percocet, 90 pills of Dilaudid, 90 pills of Cyclobenzaprine, 90 pills of Valium. In place of Lortab he prescribed A 90 pills of Hydrocodone-Acetaminophen 5/325 mg.

On May 1, 2014, per respondent's record, A called and stated that after knee surgery "somebody came in and stole all of her medications." She said that usually the meds were in a safe, but she kept the meds "under her couch cushion and now they are gone." She wanted respondent to replace her meds. Respondent documented that he refused to do so consistent with her pain agreement.

At her next appointment after this call, on May 27, 2014, she came to her appointment with her grandson, told respondent she was not recovering well after her knee surgery and wanted her meds refilled. She told respondent she now has an alarm system to safeguard her meds. Respondent noted that A was not wearing her knee brace. He provided her with prescriptions for 120 pills of Percocet, 90 pills of Dilaudid, 90 pills of Hydrocodone-Acetaminophen, and 90 pills of Diazepam.[15] He did not provide her with Cyclobenzaprine or Valium. A urine screen taken that day was negative for Percocet. He did not document discussing this result with her at any time.

Respondent in June and July 2014 reinstated A's prescriptions for Cyclobenzaprine and Valium and provided her with prescriptions for Percocet,

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[15] These prescriptions were handwritten, as opposed to computer generated prescriptions that respondent typically made. (Exhibit 7, AGO 299-301.) Hydrocodone-Acetaminophen, another short-acting opioid, is the generic name for Norco. Norco is a Schedule II controlled substance.

Dilaudid, and Hydrocodone-Acetaminophen. A reported to an HQIU investigator that in July 2014 she was transported to Palomar Hospital for a headache and a "brain tumor" was discovered. However, respondent's July 22, 2014, and August 15, 2014, notes for his treatment of A do not record that she told respondent this. On December 9, 2014, according to the note from this date, she told respondent she had a "tumor near her pituitary." At her August 15, 2014, visit with respondent, A told respondent she was going on vacation to Mexico and, in effect, wanted an early refill of her prescriptions which respondent gave her. He wrote that he emphasized to her that she must be compliant with the program.

On August 16, 2014, respondent had A submit to a UDT which tested negative in a Millennium lab report dated August 19, 2014, for Percocet. Respondent initialed next to the lab results "ok" and "prn".[16] He did not document he discussed these results in subsequent notes.

A note dated September 5, 2014, documents that Palomar Pharmacy called respondent to inform him that another pharmacy informed Palomar that A was not going to treat with respondent anymore. Palomar wanted to verify that A had no appointments with respondent. Respondent documented this call.

Another doctor called respondent, as recorded in a note dated September 8, 2014, and advised respondent that A went to his office and told the doctor that she was no longer treating with respondent and wanted prescriptions because she was

[16] In the lab results discussed in this decision, respondent wrote "ok," "prn" or his initials next to the inconsistent results. Except for select instances, respondent did not document he discussed these results with his patients.

about to run out. This doctor stated that he considered A to be a "high risk" patient based on a CURES report the doctor had run on her. The doctor's office advised respondent that they wanted him to know that the doctor had treated A and refused to provide her with prescriptions. Interestingly, a CURES report that respondent pulled in November 2014 that covered this period showed that A was obtaining hydrocodone and Diazepam from numerous other providers. Respondent wrote the following in the note: "The above information is noted. Surveillance will continue."

At her next visit on September 16, 2014, respondent showed her the CURES report, dated September 16, 2014, which showed that A was obtaining Hydrocodone - Acetaminophen and Diazepam from numerous other providers between September 2013 and September 2014, including R.B., M.D.; G.L, D.D.S.; T.K, M.D.; R.S., M.D.; M.S., M.D.; F.A., M.D.; and J.H., M.D., in addition to respondent. (Exhibit 7, AGO 0224-0228.) Respondent had her sign a new pain agreement that day which he documented he reviewed extensively with her. He issued prescriptions for her for the meds he previously had ordered in the same amounts and dosages previously ordered.

Despite his September 16, 2014, consult with her, a note dated October 2, 2014, stated respondent received a call from another doctor to advise him that A was "doctor shopping"; this doctor suggested that respondent should run a CURES on her, and this doctor further advised respondent that he had given A a prescription in September. Respondent documented he was aware of the situation and "Close surveillance will take place."

At her next appointment on October 14, 2014, respondent documented he gave A "another epidural injection," and that he reviewed appropriate prescribing behavior and the September 16, 2014, CURES report with her. He again issued prescriptions for her for the meds he previously had ordered in the same amounts and dosages

previously ordered. For some reason this note did not contain a plan for monitoring her treatment and medications.

On November 11, 2014, respondent had A submit to another UDT which tested negative for Dilaudid, Hydrocodone/APAP and Percocet in a report dated November 13, 2014. At the bottom of the lab result report he placed his initials and wrote "11/24/14 out of meds." In this note, he recorded that result was not "acceptable" and he counseled A.[17]

From this date to December 9, 2014, respondent continued to issue prescriptions for meds in the same amounts and dosages respondent previously ordered. In his December 9, 2014, note, respondent notated that he "confronted" A "with her negative urine screen for her normal medicine." This was a reference to the urine screen taken of A at her November 11, 2014, appointment, which tested negative for Dilaudid, Hydrocodone, and Percocet. Respondent also noted that that A told him that a CT Scan of her head taken at a hospital revealed "a tumor near her pituitary." Respondent did not seek corroboration from any other providers regarding whether A had a tumor or was being treated for cancer. For his plan respondent stated he educated A regarding compliance and that "noncompliance could lead to untoward health outcomes." He issued prescriptions for her in the same amounts and dosages previously ordered.

The December 9, 2014, visit is notable because it occurred after respondent ran a CURES report on November 6, 2014, which documented A's prescription history from November 2013 through November 2014. This report shows that during this period A

[17] Respondent electronically signed the result on March 9, 2015.

obtained large quantities of Hydrocodone and Diazepam from numerous other providers, including R.B, M.D.; G.L, D.D.S; T.K, M.D.; R.S., M.D.; M.S., M.D.; F.A., M.D.; and J.H., M.D., in addition to respondent. (Exhibit 7, AGO 0404-0408.) This is also after the September 16, 2014, CURES report he obtained which showed the same behavior. Notwithstanding the information he gained from reviewing CURES reports, respondent continued to prescribe to A opioids.

7. During her treatment with respondent, A obtained prescriptions from other doctors for the same medications respondent was prescribing her and from pharmacies other than listed in her pain agreements with respondent. The large quantify of medications A obtained was notable. To highlight the extent of A's ability to obtain opioids and benzodiazepines from different doctors, several times A filled prescriptions for these drugs at different pharmacies the same day or within several days written by different doctors. On April 25, 2011, she filled a prescription for 105 tablets of Diazepam at CVS Pharmacy written by Dr. K.M. That same day, she filled a prescription for 40 tablets of Diazepam at a different pharmacy, Balboa Pharmacy, written by Dr. W. U. Just four days earlier, on April 21, 2011, she filled a prescription at Leo's Pharmacy for 90 tablets of Diazepam written by respondent.

As another example, on October 28, 2011, she filled a prescription for Diazepam, 10 mg, 60 tablets, as prescribed by a Doctor R.N. at Costco Pharmacy. On November 11, 2011, she filled prescriptions for Diazepam, 10 mg, 30 tablets, and Alprazolam,[18] 1 mg, 90 tablets, as prescribed by Dr. C.G. at a Sav-On Pharmacy. As another example, on July 23, 2013, she filled a prescription respondent wrote for her

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[18] Alprazolam is a benzodiazepine and a Schedule IV controlled substance. It has the brand name Xanax.

for Diazepam, 10 mg, 90 tablets at Mercy Care Pharmacy. On July 31, 2013, she filled a prescription for Diazepam, 2 mg, 15 tablets at Costco Pharmacy, from a prescription by Dr. D.M. On August 4, 2013, she filled a prescription for Alprazolam, .5 mg at CVS Pharmacy prescribed by Dr. R.J., an osteopath. Two days later, on August 6, 2013, Patient A filled a prescription for Diazepam, 10 mg, 30 tablets, at Target, prescribed by Dr. P.R., and Hydrocodone Bitartrate Acetaminophen, 500 mg-5 mg, prescribed by Dr. R.B, an osteopath. Less than two weeks earlier, Patient A filled a prescription respondent had written for Hydrocodone Bitartrate Acetaminophen, 500 mg-7.5 mg, 90 tablets, which she filled at Mercy Care Pharmacy.

On October 15, 2013, Patient A filled yet another prescription for Hydrocodone Bitartrate Acetaminophen, 500 mg-7.5 mg, 90 tablets, respondent had written for her at Mercy Care Pharmacy. That same time she also filled a prescription at Target for Hydrocodone Bitartrate Acetaminophen, 500 mg-5 mg, written by Dr. P.R.

8. As discussed earlier, between 2010 and 2014, many of Patient A's urine drug test results were inconsistent with the medications respondent prescribed to her. Throughout that time on approximately 14 occasions, Patient A's urine test results showed the absence of medications respondent prescribed to her, including on or about November 11, 2014, when A's drug test detected no controlled substances in her system. This suggested either she was not taking the meds as respondent directed or she was diverting them. Respondent failed to document and/or adequately document any detailed discussion with Patient A regarding these inconsistencies and continued to prescribe controlled substances to her.

9. Despite obtaining large quantities of high-dose opioids during the time A treated with respondent, A reported a lack of adequate analgesia, continued chronic pain, and decreased function. She, further, as detailed above, presented to multiple

emergency departments for pain relief; she made requests for early refills of medications; reported medications lost or stolen; and she obtained medication refills from 10 prescribers at seven different pharmacies, according to one CURES report. (Exhibit 9.)

10. From 2011 to 2013, respondent prescribed to A a daily combination of medications that contained acetaminophen as follows: six Hydrocodone Bitartrate-Acetaminophen 7.5/500 mg pills (based on 180 pills prescribed in a 30-day supply monthly divided by 30 days) and four Oxycodone-HCL and Acetaminophen 10/325 pills daily (based on 120 pills prescribed monthly divided by 30). Thus, during this entire time frame, respondent prescribed to A 4,300 mg of acetaminophen per day.

11. However, during a more select time frame, from December 1, 2011, through the end of November 2012, respondent wrote 29 prescriptions for medications containing acetaminophen to Patient A as follows: 15 prescriptions of 120 tablets of Percocet (Oxycodone-HCL and Acetaminophen 10/325 mg) and 14 prescriptions of 180 tablets of Lortab (Hydrocodone Bitartrate-Acetaminophen 7.5/500 mg).

During this one-year time period, considering the amount of acetaminophen in the doses of these meds, respondent prescribed to A a daily average of 5,052 mg of acetaminophen daily.[19]

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[19] During this one-year period, according to a CURES report (Exhibit 9), another doctor wrote nine prescriptions to A for 180 pills of Hydrocodone Bitartrate-Acetaminophen 5/325 mg. A second other doctor wrote one prescription for 16 pills of Hydrocodone Bitartrate-Acetaminophen 7.5/200 mg.

PATIENT B

12. Patient B ("Patient B" or "B") was 47 years old when she began treating with respondent on February 27, 2013, for pain management. At her initial visit she brought her medical records, including a letter from J. Carl Luistro, M.D., a Kaiser doctor, dated November 30, 2012, and clinic records from HealthNet. In his letter Dr. Luistro stated that B had a chronic pain condition that was then stable on her regimen of Norco and morphine. Dr. Luistro added that B was taking Norco 10/325 tablets and long acting morphine 30 mg, two in the morning, one in the afternoon and two in the evening for pain control. In his note documenting her first visit with him, respondent reported that B had six c-sections, had abdominal reconstruction and for pain she did well with long acting morphine.

At this initial visit respondent went over a CURES report he printed out on the day of her visit and made this report part of B's chart. It showed that Dr. Luistro was for the most part writing B's prescriptions at the time. Respondent recorded that he performed a physical examination of B, but he did not record a pain score to identify the pain level B believed she had, and he did not have B sign a pain agreement. Respondent did document that he discussed the importance of compliance with the course of action and that "non-compliance could lead to untoward health outcomes" as a general matter, but he did not record that he discussed with her the specific risks and benefits of taking opioid pain meds. Respondent identified B's goals as follows: "Increase the patient's ability to self-manage pain and related problems. Maximize and maintain optimal physical activity and function. Reduce subjective pain intensity."

In his notes, respondent did not document that he conducted an appraisal of prior non-opioid treatments for chronic pain, and/or an assessment of B's psychological and/or addiction risk, and a baseline urine drug screen. Under the

"General Exam" category respondent documented B's Orientation/Mood/Affect as follows: Oriented to person, place, time and present circumstances. Mood and affect appropriate."

Respondent, further, identified B's plan as follows: "CURES report, Medicine provided as listed. Medicine checked for conflict." Respondent provided B with prescriptions for 90 tablets of MS Contin[20] 30 mg and 180 pills of Hydrocodone-Acetaminophen 10/325 mg. She was scheduled for a follow-up appointment 30 days from the date of this visit.

At her March 21, 2013, appointment B stated that's she "has had to take 6-8" Norco pills per day and she needs a change in her program. He increased her prescription of Hydrocodone-Acetaminophen 10-325 mg from 180 pills for a 30-day period to 240 pills with three refills.

At her April 18, 2013, appointment B reported that she needed "better pain control." In response respondent noted that he "will give her a trial of oxycodone 10 mg up to 2 times a day as an alternate to Norco." He thus added a prescription for a second short acting pain medication 90 pills of Oxycodone 500 mg to be taken up to three times a day in addition to the short acting pain medication, Hydrocodone-Acetaminophen 10-325 mg, which he prescribed to B on March 21, 2013, with three refills.

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[20] MS Contin is a Schedule II controlled substance. It is a controlled release or long acting opioid medication.

At B's May 16, 2013, appointment respondent issued prescriptions for 90 pills of MS Contin and 60 pills of Oxycodone.

Following this appointment, on June 6, 2013, he issued a prescription for 240 pills of Hydrocodone-Acetaminophen 10-325 mg with 3 refills, 90 pills of MS Contin and 60 pills of Oxycodone.

Respondent next saw B on July 13, 2013. B reported that she was very stressed by her father's health situation and she stated she had to travel. She went to respondent's office with her son. B told respondent she had "four days of medicine left." Respondent documented that he discussed with her appropriate dosing. He added "Her pain condition will not be responding to any other intervention. She has been successful in managing her situation with medication. She has remained stable and functional during the day." Respondent provided B with prescriptions for 90 pills of MS Contin and 60 pills of Oxycodone.

B's next visit with respondent was on August 1, 2013. Respondent noted that B's father was still alive, respondent had only four days of medicine left, and he again discussed with her appropriate dosing. Respondent noted that he discussed with her "reduction consolidation" but postponed such a program for now. He issued prescriptions for 60 pills of Oxycodone and 90 pills of MS Contin.

On August 13, 2013 B's pharmacy sent a fax to respondent to report to him that "[B] is wanting us to contact you to release for early refills respondent's prescription of 240 pills of Hydrocodone-Acetaminophen 10-325 mg." A note at the bottom of the fax with the date August 14, 2013 states "May fill now."

Ten days after this fax, at her August 23, 2013, appointment, respondent noted that "She is going to get to her father who is still quite ill. . . She has four days of

medicine left. She needed to fill today." Respondent discussed with her "appropriate dosing," and he noted that "her pain condition will not be responding to any other intervention. She has been successful in managing her situation with medications. She has remained stable and functional during the day." He wrote prescriptions for her of 90 pills of MS Contin and 60 pills of Oxycodone on this date.

At her next appointment on September 18, 2013, B stated that she had to leave to take care of her father's remains, and she asked for an early refill. Respondent stated that her medication program was "resected," appropriate teaching takes place," and "she is showing good analgesia with good function," and he noted she continued to have significant pelvic and abdominal pain secondary to multiple surgeries. Respondent provided her with a prescription for 60 pills of Oxycodone.

At B's appointment on October 15, 2013, respondent reported that he reviewed her medication program. He stated that she was showing good analgesia with good function and she still had significant pelvic pain and abdominal pain secondary to multiple surgeries. Respondent reported that she showed good daytime function with her medications. He issued prescriptions to her for 90 pills of MS Contin and 60 pills of Oxycodone.

At B's November 20, 2013, appointment B reported that she had been in the hospital with an unspecified infection. Respondent wrote that, "Her medications are discussed with appropriate expectations." Respondent again recorded that he discussed with her in general terms the importance of compliance with the course of action and that "non-compliance could lead to untoward health outcomes." Respondent provided B with prescriptions for 90 pills of MS Contin and 60 pills of Oxycodone.

At her December 12, 2013, appointment, B reported that she was having gall bladder issues, exacerbation of her abdominal issues, and was throwing up her medicine. Respondent reviewed her medication program with her and stated that appropriate pain medications were being provided to B with instructions. He documented he spent significant additional time with B assessing her daily function. On this date he provided her with prescriptions for MS Contin, Oxycodone, and three refills of 240 pills of Hydrocodone-Acetaminophen 10/325 mg.

At her January 7, 2014, appointment, B stated that she was needing more help "with post op pain control with her gall bladder removal." Respondent counseled her regarding appropriate medication usage and "reviewed" her "pain agreement." This is the first (and only) reference in the records to indicate that she had entered into a pain agreement. However, this pain agreement is not in B's records. Respondent noted B had "fair" analgesia. He provided B with prescriptions for 90 pills of Oxycodone and 90 pills of MS Contin. He increased the dosage of Oxycodone from 60 pills to 90 pills at this visit.

B next saw respondent to refill her medications on January 30, 2014. Respondent noted that B was at the appointment early "due to a car issue." From this comment it appears that respondent meant that B had an appointment sooner than the 30 days after her January 7, 2014, appointment because of this car issue. Respondent gave her prescriptions and noted that B said she would fill the prescriptions the following week. He said she had fair analgesia with no side effects, and he counseled her regarding safeguarding her meds. In his plan respondent noted "UDT to be considered." Respondent wrote prescriptions for the MS Contin and Oxycodone in the same amounts and dosages he previously ordered.

On February 19, 2014, B called respondent's office to tell him that she lost "her Norco on a ride at Disneyland" and wanted an early refill. Respondent called in a 12-day supply of Hydrocodone 10/325 mg.

One week later, respondent's office received another call that respondent needed a resupply of Hydrocodone because she was going to be out of the medication in one day and her next office visit was on March 4, 2014. From the note it is not clear if the pharmacist or B called respondent's office. Respondent called in a six-day supply of 50 pills of the medication.

At B's March 4, 2014, visit, B reported that her back-pack was taken, and she needed to have her medications replaced. Respondent did not document that he discussed with B the situation or her compliance with the medication regimen she was under. He issued prescriptions for 240 pills of Hydrocodone-Acetaminophen with three refills, 90 pills of MS Contin, and 90 pills of Oxycodone. Respondent again noted in the plan that "UDT to be considered" and added "Request auth to perform for compliance."

On March 26, 2014, B's pharmacy called respondent's office to report to him that B wanted an early refill of the Norco. B also called that day to see if her medication had been refilled and told respondent's staff person that she was out of the medication because she had the flu and was vomiting and took extra pills. Respondent refused to provide her this early refill and notified B. He noted that B needed to come to her next appointment in April for any changes to the medication regimen.

At her next appointment on April 3, 2014, B emphasized that she needed to restore her medicine. She mentioned that the instructions for taking the meds were

different from the instructions on the paper prescriptions she was given. Respondent did not document that he discussed with her compliance. That day respondent issued her prescriptions for 240 pills of Hydrocodone-Acetaminophen with three refills, 90 pills of MS Contin, and 90 pills of Oxycodone. In his note of this date respondent did not mention the UDT.

On May 1, 2014, B noted that she had an unplanned surgery on April 1, 2014, and was recovering from the bruising from the surgery. Respondent noted that B was attempting to resolve her financial issues and she asked him for "periodic ativan" for anxiety. Respondent wrote a prescription for 30 pills of Lorazepam 1 mg.[21] He did not advise her regarding the risks and of combining the benzodiazepine with opioids. Respondent also did not document in his note that he referred B to a therapist or psychiatrist to address her anxiety.[22]

Between this appointment and her appointment on August 14, 2014, respondent continued B on the prescriptions in the same amounts and dosages, including for Lorazepam, he previously issued. At her August 14, 2014, appointment B wanted another early refill because she was going to visit her sister in New Mexico. He stated, "she is taught about her use of Tylenol." It is unclear what he meant by this. He issued prescriptions for her for the Lorazepam, MS Contin and Oxycodone.

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[21] Lorazepam is a benzodiazepine and a Schedule IV controlled substance. Ativan is the brand name for Lorazepam.

[22] In his report of the physical exam he performed, which included an examination of her "Orientation/Mood/Affect", respondent found B's "Mood and affect appropriate." He did not record that she displayed signs of anxiety.

On this date, respondent refused to authorize a refill of the Hydrocodone-Acetaminophen because as he wrote in the request form "Pt ad 3 rf on rx from 6/24/14. Too early." This suggests that B was taking more of this medication than she should have been taking.

At her September 8, 2014, appointment respondent noted that B advised him that she was taking too much acetaminophen as follows: "her liver enzymes. She is needing to reduce her acetaminophen." He did not directly address B's comment in his note, the basis of her concerns about her "liver enzymes," and he did not order liver enzyme testing, refer her to her primary doctor to have such testing done, or advise her to talk to her primary doctor about the testing. He continued B on Hydrocodone-Acetaminophen 10/325 mg without refills and issued her prescriptions for the other meds he had prescribed in the same amounts and dosages he previously ordered.

13. The record includes B's medical chart through March 23, 2015. Complainant, in the second amended accusation, identifies respondent's prescriptions of meds and treatment of B through September 2014 as the cause for discipline. Respondent's notes regarding treatment of B after September 2014 are not summarized except to note these records do not contain a pain agreement and that respondent did not have B to submit to a UDT until February 23, 2015. The lab results were negative for Oxycodone Hydrochloride, and positive for Hydrocodone Acetaminophen and MS Contin. This was the first UDT that B took.

14. As documented in a CURES report published December 31, 2014, between December 27, 2013, and September 18, 2014, respondent wrote the following prescriptions for Hydrocodone-Acetaminophen 10/325 mg (Exhibit 13, AGO 9590-9593) and B filled prescriptions for this med during this time frame in the following amounts and on the following dates: 240 pills on December 27, 2013, 240 pills on

January 18, 2014, 240 pills on February 9, 2014, 96 pills on February 19, 2014, 50 pills on February 27, 2014, and 240 pills on March 4, 2014. After this she filled prescriptions for 240 pills of Norco 10/325 mg at two different pharmacies in the same months: on April 1, 2014, which she filled at Rite Aid pharmacy, and 240 pills on April 15, 2014, which she filled at CVS pharmacy.

After this B obtained 240 pills of Hydrocodone-Acetaminophen on May 1, 2014, from a Rite Aid Pharmacy, 240 pills on May 14, 2014, from a CVS Pharmacy, 240 pills on May 29, 2014, from a Rite Aid Pharmacy, 240 pills on June 11, 2014, from a CVS Pharmacy, 240 pills on June 26, 2014, from a Rite Aid Pharmacy, 240 pills on July 8, 2014 from a CVS Pharmacy, on July 23, 2014, 240 pills, from aa Rite Aid Pharmacy, on August 14, 2014, 240 pills from a CVS Pharmacy, on August 21, 2014, 240 pills on August 21, 2014, from a a Rite Aid Pharmacy, on September 11, 2014, 80 pills from a a CVS Pharmacy, and on September 18, 2014, 240 pills from a a Rite Aid Pharmacy.

Thus, according to CURES, B obtained during this time a total of 4,166 Hydrocodone-Acetaminophen 10/325 mg pills. To calculate the number of pills B was taking daily it is noted that there were 265 days between December 27, 2013, and September 18, 2014. Dividing the number of days by the number of pills B obtained during this time means that B obtained, on average, 15 pills of Hydrocodone-Acetaminophen 10/325 mg for use on a daily basis. If one subtracts the 240 pills she obtained on September 18, 2014, it is reasonable to conclude that B used 3,926 Hydrocodone-Acetaminophen 10/325 mg pills from December 27, 2013, to September 18, 2014. If one further subtracts the replacement pills she obtained in February 2014 (96 and 50 pills) due to the claimed loss of her meds at that time this leaves 3,780 pills she obtained. This means that from December 27, 2013, through September 18, 2014,

B took per day on average 14 Hydrocodone-Acetaminophen 10/325 mg pills.[23] This amount was in excess of the dosage of 1 to 2 pills every six hours which respondent instructed B that she may take daily.

The CURES report (Exhibit 13) also documents that B obtained controlled substance medications respondent was prescribing her in excess of 30-day supplies. During the 10 months respondent treated B in 2013, B filled 12 prescriptions for 90 pills of MS Contin 30 mg, 15 prescriptions of Norco 10/325 mg (10 prescriptions for 240 pills, four prescriptions for 180 pills and one for 30 pills) and 10 prescriptions of

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[23] As discussed below, complainant's expert, Dhiruj Kirpalani, M.D., testified that B was taking 13 pills daily during this time frame, and this amount exceeded the 4,000 mg of acetaminophen an individual can safely take per day. In contrast, respondent's expert, Greg Polston, M.D., as discussed below, testified that respondent issued prescriptions between December 2013 and September 8, 2014, for B to use daily in amounts which were less than 4,000 mg per day and, thus, B was safely taking Hydrocodone-Acetaminophen 10/325 mg during this time. (Exhibit II, referencing specific parts of Exhibits 10 and 11.) But, Dr. Polston did not consider the number of prescriptions for Hydrocodone-Acetaminophen 10/325 mg from respondent that B filled, and the amount of pills she obtained during this time, based on respondent's prescriptions and refills the December 31, 2014, CURES report documents. (Exhibit 13, AGO 9590-9593.) As noted, respondent instructed B to take 1 to 2 pills daily as needed up to four times a day, which amounted to eight pills a day of Hydrocodone-Acetaminophen 10/325 mg for 2,600 mg of acetaminophen; however, B was taking far in excess of this amount according to the CURES report.

Oxycodone. In 2014, B filled 13 prescriptions of 90 pills of MS Contin 30 mg, 20 prescriptions for Norco 10/325 (15 prescriptions for 240 pills, 3 for 180 pills, and 1 for 50 pills), and 13 prescriptions for Oxycodone 10 mg (10 prescriptions for 90 pills and 3 for 120 pills).

Despite the amount of opioid pain meds she was taking, B did not have a pain agreement. Respondent, in addition, did not run CURES reports other than at the time of her first visit, and he did not have B submit to UDTs after he obtained a CURES report for B at her initial visit on February 27, 2013.

PATIENT C

15. Patient C ("Patient C" or "C") initially saw respondent for chronic arm and shoulder pain management on August 8, 2008, when he was in his late 20s, and respondent treated with him through May 28, 2014. Patient C signed a pain agreement August 8, 2008, and this was the only pain agreement C signed. Before seeing respondent, C underwent two shoulder surgeries in 2003 and 2006. To manage C's pain, respondent prescribed him high dose opioids, including Oxycontin, Oxycodone, Dilaudid and MS Contin. Respondent also prescribed Soma, Ambien, Lorazepam, and a muscle relaxant.[24] During the period of time at issue here, respondent administered numerous joint injections to C's shoulder to help alleviate the pain. He also had C submit to UDTs. However, despite results that raised concerns regarding C's

[24] Soma, known by its generic name carisoprodol, is a Schedule IV controlled substance which is classified under Health and Safety Code section 11057, subdivision (d)(18), as meprobamate, a metabolite of Soma. Ambien, which is known by the brand name zolpidem, is also a Schedule IV controlled substance.

medication use, respondent did not document he discussed these results with C or explain his thinking about the results.

Respondent documented his treatment of C and the prescriptions he issued to C in his records. The following records describe respondent's prescribing practices for the time period complainant's expert, Dhiruj Kirpalani, M.D., discussed in his testimony:

At C's January 12, 2012, visit C wanted to "add back the hydromorphone for a back up." C said he noticed "seasonal problems that he is experiencing secondary to weather changes." Respondent encouraged C to maintain his medication program: He issued prescriptions to C, for a 30-day supply, for 360 pills of Oxycodone 30 mg, 90 pills of Oxycontin[25], 80 mg, 90 pills of Soma, 350 mg, 30 pills of Ambien 12.5 mg, 30 pills of Dilaudid, 8 mg, and 60 pills of Cymbalta, 60 mg. Respondent instructed C that he may take up to two Oxycodone pills up to six times a day as needed. Respondent recorded that he performed a physical examination. In his plan he wrote "UDT to address compliance and diversion. It is consistent." The basis of respondent's comment that C's UDT was consistent is not clear from the record.

C, at his next visit on February 8, 2012, reported that the medications had been working and was getting proper pain control. He stated he was getting anxiety attacks with his pain. He stated further that if the pain was controlled he did not experience the anxiety attacks. Respondent discussed with him methods to control his anxiety. Respondent added, "He needs to stay ahead of the pain. He is having more issues with the weather." Respondent documented, under the "Plan"

[25] Oxycontin is a Schedule II controlled substance. It is a long acting opioid.

section under a section captioned "Patient Education," "The importance of compliance with the agreed upon course of action was stressed and that noncompliance could lead to untoward health outcomes. Discussed information." It is not clear what "information" respondent discussed with C. Respondent continued C on the same medications in the same amounts and dosages.

At C's March 6, 2012, visit, respondent administered a UDT to C which came back negative for Dilaudid in a lab report from Millennium dated March 11, 2012. Considering C was prescribed Dilaudid this result raised the question whether C was diverting the medication, did not need to use it, or he had run out of Dilaudid because he was taking more Dilaudid than he should have been. Respondent did not document he discussed this result with C at his subsequent visit on April 3, 2012, and he continued to prescribe medications to C in the same amounts and in the same dosages he previously prescribed. Respondent did not document in the March 6, 2012, note any goals for C.

On March 21, 2012, C called respondent and stated he "is running out of medication." Respondent noted that C should have plenty of medications to make it to his next appointment and, per his pain treatment agreement, "it may not be possible to replace lost or stolen medication." This note raised the possibility that C was using more meds than he was being prescribed.

At C's April 3, 2012, visit, as noted, respondent did not discuss the inconsistent UDT and prescribed C's meds in the same amounts and dosages he previously prescribed.

On May 1, 2012, C reported that he had an issue with work and "was having a tough time going in the morning." He asked for a note that "reflects his difficulty

in getting going in the morning." Respondent commented that C was "having some tolerance issue," he noted also that C was having "some issues" with "his relationship in that when he is having more pain he just checks out." Respondent stated that he was reluctant to increase C's medications and he was hopeful there was a "nonmedication means for controlling his pain." He added that C continued to have significant pain with functional deficits with respect to his shoulders. Respondent maintained C on the same medications and a muscle relaxant, 30 pills of Tizanidine[26] 4 mg to be taken at bedtime as needed with three refills. Respondent's note from this date repopulated the same note under the caption "Patient Education." For a goal, respondent wanted C to increase his ability to self-manage pain and related problems.

At this visit, respondent again had C undergo a UDT. Again, C tested negative for Dilaudid according to the Millennium lab report dated May 3, 2012. As noted immediately above, this suggested that C may have been diverting the med, using more than he should have been or did not need to take it. Respondent, once again, did not discuss this result with C at his next visit on May 24, 2012, or for that matter at any time.

Oddly, at C's May 24, 2012, office visit with respondent, respondent wrote in his note, under "Plan," "UDT to address compliance and diversion. It is consistent." This is the same language previously used in prior notes and appears to be boilerplate language that respondent repopulated. At any rate, respondent did not explain in the note how the May 3, 2012, negative lab result for Dilaudid could be deemed a consistent result.

[26] Tizandine is a short-acting muscle relaxer.

According to this note, respondent continued C on the Oxycodone, Oxycontin, Dilaudid, and Soma. He added Wellbutrin and a Flector patch.[27] He had previously prescribed these meds to C in 2010.

Prior to C's next visit on June 21, 2012, respondent administered a joint injection to C on June 13, 2012. C reported at his June 21, 2012, visit that the last two weeks he was having a tough time and he left arm had gone "very numb." Respondent increased the quantity of Dilaudid he was prescribing C from 90 to 120 pills despite the two recent negative UDTS. He added once again the Tizanidine muscle relaxant and Naproxen Sodium.

Respondent administered another joint injection to C at his July 18, 2012, appointment and he issued prescriptions to C for Oxycodone, Oxycontin, Dilaudid, and Soma in the same amounts and in the same dosages previously ordered. There is, however, no corresponding note indicating that respondent conducted an exam of C this date or that documents C's level of pain.

Respondent administered a third joint injection to C on August 15, 2012, and he issued the following prescriptions for C that day: Oxycodone, Oxycontin, Dilaudid, and Soma in the same amounts and doses previously ordered. He added, however, 60 pills of Lorazepam 1 mg. He also added a Voltaren Transdermal Gel. There is, again, no corresponding note indicating that respondent conducted an exam of C this date or that C's level of pain was documented.

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[27] Wellbutrin, which has the generic name Bupropion, is a medication used to treat depression. It is a dangerous drug pursuant to Section 4022.

On this date, respondent had C undergo a UDT. The August 17, 2012, Millennium lab result was again negative for Dilaudid. This was the third straight urine screen that was negative for Dilaudid. Yet, respondent in subsequent notes did not document that he discussed this result with C.

C called respondent on August 30, 2012, and said that the pharmacist "shorted" him 30 Oxycodone pills. Respondent's office called the pharmacy and was told that the pharmacy did not short respondent's Oxycodone pills. Of concern in this note, C asked "to go on detox." He also wanted to see respondent on September 10 instead of September 12 due to transportation issues. The next day C called and said he thought he would be in withdrawal by the middle of next week. He asked if he could stop his medication for the three-day weekend to avoid missing work to ease the withdrawal symptoms.

Per respondent's note, "The patient is brought in and his program is redone." No other information was provided.

C saw respondent on September 5, 2012. Respondent stated he reviewed all of C's medications to check them for "conflict." He found "[n]o conflict." Respondent noted that C had responded "to intermittent injection" [*sic*]. His plan consisted of "UDT to address compliance and diversion. It is consistent." Respondent refilled C's medications and he issued prescriptions for Ambien and Cymbalta. He changed the prescription for Oxycodone from 30 mg to 15 mg in a quantity of 720 pills as opposed to the 360 pills that he was prescribing. He changed the Oxycontin to 40 mg from 80 mg and increased the quantity of the pills from 90 to 180. He did not issue a prescription for Dilaudid this date and he did not document in his September 5, 2012, that he was stopping this prescription.

On September 12, 2012, respondent administered the fourth joint injection to C. Respondent again had C submit a UDT and again respondent tested negative for Dilaudid. This was the fourth UDT in a row where C tested negative for Dilaudid. Respondent did not document that he discussed these results with C in any of his notes, what, if any action he took in response to the results, or his thoughts regarding the negative screens.

On October 3, 2012, respondent issued prescriptions to C for 120 pills of Dilaudid, 90 pills of Oxycontin, 360 pills of Oxycodone, and 60 pills of Lorazepam. There is no accompanying note for this date.

C had joint injections on October 31, 2012, and November 28, 2012. On October 31, 2012, respondent issued prescriptions for the same medications ordered on October 3, 2012, in the same amounts and dosages. On November 28, 2012, he issued paper prescriptions for 360 Oxycodone pulls, 90 Oxycontin pills, and 120 Dilaudid pills. There are no accompanying progress notes for these dates. On November 29, 2012, for some reason, respondent issued an electronic prescription for 60 Lorazepam pills, although he signed the prescription on December 19, 2012. There is, again, no accompanying progress note for this date. There is no explanation why this prescription was issued in a digital form while the prescriptions issued on November 28, 2012, were issued by paper prescriptions.

On December 19, 2012, respondent administered another joint injection to C. He issued prescriptions to C for Oxycodone, Oxycontin, and Dilaudid in the same amounts and dosages previously ordered this date. There is no accompanying progress note for this date. Respondent submitted to another UDT on December 19, 2012, which this time showed Dilaudid, as expected, in C's system.

On January 16, 2013, respondent issued prescriptions for C for 360 Oxycodone pulls, 90 Oxycontin pills, and 120 Dilaudid pills. On this date, he added 90 pills of Soma 300 mg, which he had ordered in past visits. There is no accompanying progress note for this visit and, as a result, respondent did not explain why he added the Soma.

At C's February 13, 2013, appointment with respondent, C asked "for a change in his quantity prescribing [*sic*]." Respondent noted that respondent was functioning better with the injections. He checked C's medications for conflict and found no conflict. Respondent identified the goal to increase C's ability to self-manage pain and related problems. Under the caption "Patient Education," respondent wrote: "Questions were encouraged to stated satisfaction from the patient. The importance of compliance with the agreed upon course of action was stressed and that noncompliance could lead to untoward health outcomes. Discussed information on activity and restrictions body mechanics, chronic pain, depression." On this date respondent issued prescriptions to C for 360 Oxycodone pills, 90 Oxycontin pills, and 120 Dilaudid pills.

C next saw respondent on March 13, 2013. At this visit, he had C submit to another UDT. According to the Millennium lab report dated March 15, 2013, C once again tested negative for Dilaudid. Also, hydrocodone was identified in his system. According to the lab report, the hydrocodone was not matched to any of C's prescriptions. The lab report noted further that hydrocodone "is also a minor metabolite of codeine." Despite this information respondent did not document he discussed these results with C. Respondent issued prescriptions for Oxycontin, Dilaudid, 360 pills of Oxycodone 15 mg and 360 pills of Oxycodone 30 mg. It is not

clear from the record why respondent was prescribing two different dosages of Oxycodone. There is no accompanying progress note for this date.

On April 10, 2013, C had another joint injection. Respondent issued prescriptions to C for 360 30 mg Oxycodone pills, 360 15 mg Oxycodone pills, 120 Dilaudid pills, and 90 pills of Oxycontin on this date. There is no accompanying progress note in C's records for this date.

At C's May 8, 2013, appointment with respondent, C stated that he was "trying to wean himself from his medication due to cost but he is having some issues." He reported he had been placed on disability. C told respondent he was down to one 80 mg Oxycontin. He said he was willing to use morphine, as he had used morphine in the past. Respondent stated, "Reduction, consolidation and weaning program is in process." On this date, respondent issued the following prescriptions to C: 90 pills of MS Contin 60 mg, 360 pills of Oxycodone, 30 mg.

On May 23, 2013, C called respondent's office and asked for prescriptions for Oxycontin, Oxycodone and Dilaudid because "he has insurance for now but will be cancelled in 6/1." Respondent did not document his response. On May 24, 2013, respondent issued to C a prescription for 120 pills of Dilaudid 8 mg. In response to a note from C's pharmacy dated May 25, 2013, respondent authorized three refills for Soma 350 mg on May 28, 2013.

C called respondent's office again on May 29, 2013, and advised respondent that his insurance was running out at the end of May and he would like to be seen at end of the month. Respondent noted C's request. On May 30, 2013, C reported that he was running low on funds and needed to rework his medications. C also reported he was having very little use of his left upper extremity. Respondent

stated that he reviewed options with C and will try to have him "rely on short acting generics." He said that C's functional level was about the same. Respondent's plan for C was identified as follows: "Medication reduction program in process." His goal for C was the same goal he previously identified. Under "Patient Education" he used the same language he previously used in this section. Respondent issued prescriptions for 360 pills of 15 mg Oxycodone and 90 MS Contin pills.

On June 12, 2013, C called respondent and stated that the Oxycodone 15 mg was not helping with his pain and he wanted "something stronger." Respondent did not document in his note his response, but he issued another prescription for 180 pills of 30 mg Oxycodone.

C saw respondent on June 27, 2013. At this visit C told respondent that he could not afford Oxycodone and he was not working. Respondent stated that C was stable but would like to get more relief. He reviewed his program and provided refills. His goal for C was the same. For his plan for C, respondent stated that the medication reduction plan was in place and respondent would try to come in for a shoulder injection if he could afford it. On this date, respondent issued prescriptions to C for 360 pills of 15 mg Oxycodone and 90 MS Contin pills.

C called respondent's office on July 24, 2013. He stated that his wife would be starting a new job on July 25, 2013, and they had only one car. As a result, he was not able to make his appointment. He asked respondent to write prescriptions for him for that month. Respondent issued prescriptions for 360 pills of 15 mg Oxycodone and 90 MS Contin pills that day.

On August 20, 2013, C saw respondent and reported that he was able to get only one half of his short acting medicine and was having continued financial issues. Respondent stated that he would try to balance his program to make it "more affordable." He documented the same goal for C and patient education he had previously documented. This date, respondent issued to C prescriptions for 180 pills of Oxycodone 30 mg for a 15-day supply and 90 pills of MS Contin for a 30-day supply. Previously, on August 18, 2013, C's pharmacy asked respondent to authorize refills of Soma for C. Respondent authorized one refill of Soma on August 19, 2013.

C called respondent's office on August 26, 2013, and asked whether "[g]iven 15-day supply of Oxycodone" he can pick up the remaining amount. Respondent did not notate his response, but he issued on this date a prescription for 180 pills of Oxycodone 30 mg.

C called respondent again on September 10, 2013, and stated he needed a prescription for Oxycodone because he had run out of his medication, he was not doing well and he took more than usual. He asked to be able to pick up the medication when he got paid. Per the note, respondent stated that he was unable to give medication early. Two days later, on September 12, 2013, respondent, at the pharmacy's request, authorized C to have two refills of Soma.

C then saw respondent on September 16, 2013. C told respondent he was using the TENS unit[28] respondent had recommended. He told respondent he was

[28] A transcutaneous electrical nerve stimulation ("TENS") unit is a battery-operated device that some people use to treat pain.

using distraction to control pain. Respondent documented that he reviewed C's medications and provided C with "appropriate" refill prescriptions with instructions. C reported he was still having trouble with sleep. Respondent documented that the medication reduction program was in progress and he was going to schedule C for a shoulder injection. He documented the same patient education he previously documented. He issued C prescriptions for 180 pills of Oxycodone 30 mg and 90 pills of Soma.

Two days later, on September 18, 2013, C called and stated he needed a prescription for MS Contin. He said he could not do without the medication and wanted to pick up the mediation. Respondent issued a prescription for 180 pills of Oxycodone 30 mg and 90 pills of MS Contin that date.

On October 9, 2013, C called to ask to pick up a prescription for a later date because he had to go to Ohio because his grandfather was ill. No action was documented. On this date, respondent issued prescriptions to C for 180 pills of Oxycodone, 90 pills of MS Contin, and 90 pills of Soma.

On October 21, 2013, C saw respondent and reported that he had to buy two seats on an airplane because his weight had increased to such an extent he needed the two seats. Respondent documented C was using his medications as prescribed, but he was having trouble filling them because of his finances. He documented the same plan, goals and patient education he previously documented. He issued prescriptions to C for 360 pills of Oxycodone 30 mg and 90 pills of MS Contin.

On November 6, 2013, the pharmacy called respondent's office and advised respondent that C wanted to refill his MS Contin prescription 6 days early. Respondent was recorded to say it was ok to do this.

16. During an approximate ten-month period when respondent was treating C, he wrote prescriptions for opioid meds in more than 30-day supplies according to a CURES report complainant obtained, which was received into evidence, (Exhibit 17, AGO 5559-5562) as follows:

17. In 2012, 14 prescriptions of 90 pills of OxyContin 80 mg. (Exhibit 17, AGO 5559-5562);

In 2012, 14 prescriptions of 360 pills of Oxycodone 30 mg. (Exhibit 17, AGO 5559-5562);

In 2012, 14 prescriptions of Hydromorphone 8 mg. (Eight prescriptions for 120 pills 5 for 90 pills and 1 for 30 pills) (Exhibit 17, AGO 5559-5562); and

In 2013, 20 prescriptions of short acting Oxycodone (15 mg or 30 mg tablets) (Exhibit 17, AGO 5559-5562);

18. In March, April, May, June, September, and October of 2013, C filled two prescriptions of short acting Oxycodone each of these months. According to the CURES report admitted into evidence, in March 2013 he filled prescriptions for 360 pills of Oxycodone on March 13 and 22, 2013, April 10 and 18, 2013, May 8 and 30, 2013, June 13 and 27, 2013, September 16 and 30, 2013, and October 12 and 26, 2013.

TESTIMONY OF COMPLAINANT'S EXPERT, DR. KIRPALANI, REGARDING PATIENTS A, B AND C

19. Complainant called Dhiruj Kirpalani, M.D., as an expert witness to address respondent's prescriptions of high dose opioids and other meds to Patients A, B and C.

Dr. Kirpalani has been board certified in Pain Medicine since 2009 and Physical Medicine & Rehabilitation since 2008. He obtained a Doctor of Medicine Degree from the Rosalind Franklin University of Medicine & Science (formerly named Finch University of the Health Sciences)/The Chicago Medical School. He completed an internship at St. Joseph's Hospital, a residency in Physical Medicine and Rehabilitation at Stanford University Medical Center and a fellowship in pain medicine also at Stanford University Medical Center. He has conducted research in the field of pain medicine and authored articles based on his research. Since 2008, he has worked at Kaiser Permanente in Santa Clara. At Kaiser, he practices pain management as part of a multidisciplinary team which includes psychologists and other clinicians. He is licensed to practice medicine in California.

To assess respondent's prescribing practices and treatment of these three patients, complainant asked Dr. Kirpalani to review medical records, CURES reports and other materials relating to respondent's care of them. Dr. Kirpalani reviewed these materials and prepared a report dated May 4, 2017, in which he identified specific departures from applicable standards of care relating to the prescription of pain meds. Dr. Kirpalani's testimony in this hearing was materially consistent with his report.

Dr. Kirpalani identified the applicable standards of care and the degrees of departures from standards of care in his review. In identifying the standards of care, Dr. Kirpalani referenced the Board's 2007 and 2014 *Guidelines for Prescribing*

Controlled Substances for Pain ("Guidelines," 2007 and Nov. 2014). As he put it, these Guidelines helped "inform" the basis of his opinions. Dr. Kirpalani acknowledged differences between the 2007 and 2014 Guidelines and that standards for prescribing pain medications have evolved between 2007 and 2014, which included the time respondent prescribed meds to Patients A, B and C. The notable differences between these Guidelines involve the use of Pain Agreements, UDTs and CURES to monitor patient compliance with a pain medication regimen.

20. In November 2011, the Centers for Disease Control and Prevention (CDC) declared prescription drug abuse to be a nationwide epidemic. (*Guidelines for Prescribing Controlled Substances*, Nov. 2014, p. 1.) After this, as Dr. Kirpalani stated, the standard of care "started to move," and the care and treatment of pain management patients changed. By this time, Dr. Kirpalani testified doctors within the pain management field knew that patients may abuse medications, and also, doctors were aware of research that showed the limited efficacy of extensive opioid use. As a specialist in the field of pain management, respondent seemed to recognize the standards changed before November 2014, as before November 2014, respondent monitored Patients A, B, and C, using pain agreements, UDTs and CURES reports, to varying degrees.

The 2014 Guidelines recommend using UDTs and CURES (Pain Guidelines, Nov. 2014, page 15). Additionally, in the 2014 Guidelines, pain management agreements (page 11) are recommended for patients expected to receive more than three months of opioids.

While the 2014 Guidelines recommend the use of UDTs, CURES and pain agreements, the 2007 Guidelines recommended a doctor to periodically review the course of pain treatment of the patient and any new information about the etiology of

the pain or the patient's state of health. In this regard, the 2007 Guidelines provided as follows:

> [C]ontinuation or modification of controlled substances for management therapy depends on the evaluation of progress toward treatment objectives. If the patient's progress is unsatisfactory, the physician and surgeon should assess the appropriateness of continued use of the current treatment plan and consider the use of other treatment modalities.

The 2007 Guidelines, further, recommended required that a doctor "provide ongoing and follow-up care as appropriate and necessary."

While the Board in its November 2014 Guidelines formally recommend the use of UDTs, CURES, and Pain Agreements for monitoring purposes, before this date respondent used these tools to monitor Patients A, B and C. This is consistent with changes in the standard of care that took place after 2012.

As a pain management specialist, respondent seemed to recognize the standards changed after 2012 and before the Board promulgated the November 2014 Guidelines as exemplified by the fact that respondent monitored Patients A, B, and C, by the use of pain agreements, UDTs and CURES reports, to varying degrees, before November 2014. Thus, by 2012, it is apparent that, as a standard of practice, pain management specialists had as tools to monitor their pain management patients' compliance with their medication regimens, pain agreements, CURES and UDTs.

DR. KIRPALANI'S ASSESSMENT OF RESPONDENT'S TREATMENT OF PATIENT A

21. Dr. Kirpalani identified four issues involving respondent's prescription of pain meds to Patient A: Monitoring while on controlled substances, acetaminophen toxicity, informed consent, and inconsistent urine screen results.

Regarding monitoring while on controlled substances, Dr. Kirpalani identified the standard of care as follows:

> If the patient is considered appropriate for opioid therapy, a monitoring plan should be implemented to ensure patient safety. Elements of the monitoring plan include periodic review of the treatment plan and progress towards goals (more frequently in high risk patients), random urine screens, and frequent review of PDMP [Prescription Drug Monitoring Program or "CURES"] report, 30 day refills and pill counting (when appropriate). Patients should be tapered off opioids if they engage in aberrant behaviors, have adverse side effects, or make no progress towards therapeutic goals.

Dr. Kirpalani stated that respondent committed an extreme departure from this standard of care because respondent did not adequately monitor A in a number of ways: He ignored respondent's repeated aberrant behaviors, which included frequent ER visits, her daughter taking her pain meds, she obtained opioids from other doctors, and she had numerous inconsistent urine screens. Dr. Kirpalani stated that even though the standard of care did not require respondent to have A undergo these screens until 2014, respondent elected to have A undergo these screens as part of his

monitoring of A and he was still responsible to monitor A in light of the results of the inconsistent screens. Yet, respondent continued to prescribe Patient A pain medications. Dr. Kirpalani commented that it was hard for him to imagine any doctor continuing the meds respondent prescribed A considering the severity of her aberrant behaviors.

Further, Dr. Kirpalani did not see from respondent's records that A was obtaining any functional improvements in her condition despite receiving large quantities of high-dose opioids. He noted that between 2011 to 2013, respondent prescribed opioid medications to Patient A, including morphine equivalent doses (MED) that exceeded 300 MEDs. Dr. Kirpalani explained that MEDs are used to equate different opioids into one standard value. MED calculations permit all opioids to be converted to an equivalent of one medication, for ease of comparison and risk evaluations. The CDC has cautioned that taking above 90 MEDs per day poses a high risk, but pain specialists are not limited in the amount of MEDs they may prescribe.[29]

The second issue Dr. Kirpalani identified relating to respondent's care of A was "acetaminophen toxicity." He identified the applicable standard of care here as follows: To avoid significant liver damage, the maximum recommended dose of acetaminophen is 4,000 mg per day. Dr. Kirpalani testified that respondent, for a two-year period from 2011 to 2013, was prescribing six pills of Lortab 7.5/500 mg and four

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[29] During the hearing respondent emphasized that there is no upper MED limit for pain management specialists to prescribe. The parties' experts agreed, however, that while there is no upper prescribing limit for opioids a pain, a management specialist still has a duty to exercise appropriate clinical judgment when prescribing the amount of opioids.

pills of Percocet 10/325 mg daily to A. This equaled 4,300 mg per day for this period. He noted in his report that from December 2011 to November 2012, the average amount of acetaminophen respondent was prescribing A was 5,000 mg per day.

Due to the length of time respondent was prescribing this amount of acetaminophen and the risk of liver damage to A that this amount of acetaminophen posed, Dr. Kirpalani found that this represented an extreme departure due to the length of time respondent was prescribing this amount of acetaminophen and the risk of liver damage to A that this amount of acetaminophen posed.

Dr. Kirpalani next identified the third issue he found as "informed consent." He articulated this standard of care as follows: "Risks and benefits of the use of controlled substances and other treatment modalities should be discussed with the patient."

Dr. Kirpalani testified that respondent had A sign pain agreements on June 26, 2008, July 18, 2011, and September 16, 2014. Although the standard of care did not require respondent to use these pain agreements, respondent had her sign them and, as Dr. Kirpalani noted, she repeatedly violated them and as part of his duty to monitor A respondent could not ignore these results. He, thus, was responsible to act on the results. Despite the agreements, C obtained pain meds from multiple providers and pharmacies and often reported her meds were lost or stolen. In his report Dr. Kirpalani faulted respondent for allowing A to obtain one emergency room (ER) visit per month for pain exacerbations.

Dr. Kirpalani concluded that considering the number of violations of A's pain agreements and the fact that respondent allowed her to go to the ER as part of her controlled substances agreement and he continued to prescribe high doses of opioids

to A despite her repeated violations of these agreements, respondent committed an extreme departure from the standard of care.

The fourth issue that Dr. Kirpalani identified related specifically to A's inconsistent urine screens. He identified the standard of care as follows:

> After controlled substance therapy is initiated, random urine screens should be performed periodically to ensure compliance with treatment. If urine drug tests are repeatedly inconsistent with medications prescribed, particularly if the medication is not detected in the urine, the medication(s) should be discontinued.

Dr. Kirpalani identified 14 times between 2011 and 2014 that urine screens that respondent had A undergo were inconsistent with medications he was prescribing her. Dr. Kirpalani noted specifically the November 11, 2014, urine screen result that showed A had no controlled substances in her system. Despite this result, in A's records respondent did not detail that he discussed with her these inconsistent results. Moreover, he continued to prescribe her high dose opioids.

Dr. Kirpalani characterized respondent's violations of this standard as an extreme departure due to the number of inconsistent results.

DR. KIRPALANI'S ASSESSMENT OF RESPONDENT'S TREATMENT OF PATIENT B

22. Dr. Kirpalani identified the following issues with respect to respondent's treatment of Patient B: Respondent's Screening of B for opioid therapy, informed consent, overprescribing pain medications, acetaminophen toxicity, and monitoring B while she was using controlled substances.

Dr. Kirpalani first identified the standard of care for screening patients for opioid therapy as follows:

> Proper patient assessment and selection is essential before initiating and continuing opioid therapy for chronic pain. Elements of this screening process include a thorough history and physical exam, appraisal of prior non-opioid treatments, assessment of psychological and addiction risk, baseline urine drug screening, and review of the PDMP report.

Dr. Kirpalani testified that respondent did not meet this standard of care when he assessed B at B's initial February 27, 2013 visit. Respondent did not assess B's prior non-opioid treatments for pain, assess B's psychological or addiction risk, and he did not order a urine drug screen. Dr. Kirpalani characterized the level of departure from this standard of care as simple.

With respect to the informed consent issue he identified, Dr. Kirpalani stated that the standard of care required respondent to discuss with B the risks and benefits of using controlled substances and respondent should have discussed other treatment modalities with her. Dr. Kirpalani also testified that respondent was required to have this discussion when B's medications changed and, in particular, when he added the benzodiazepine to B's treatment regimen. He commented that most doctors would have documented this discussion or have their patients sign pain agreements. Dr. Kirpalani found it notable that respondent did not have B sign a controlled substances agreement. No such agreement was in B's records.

Dr. Kirpalani opined that respondent departed from this standard of care because he did not document he discussed the risks and benefits of controlled substances. Regarding the degree of departure Dr. Kirpalani believed that this violation of the standard of care represented an extreme departure. He said that respondent, even if there was a pain agreement in place, should have discussed with B the risks and benefits of benzodiazepines when he added it to her treatment regimen.

Regarding the overprescribing of controlling substances to B issue, Dr. Kirpalani testified that the standard of care required respondent to provide B with 30-day supplies without refills of the controlled substances he was prescribing. Respondent departed from this standard of care multiple times and the departure was extreme in Dr. Kirpalani's opinion.

Dr. Kirpalani identified from the CURES report for 2013 to 2014 (Exhibit 13) that in the ten months respondent treated B in 2013, B filled 12 prescriptions for 90 pills of MS Contin 30 mg, and 15 prescriptions for Norco 10/325 mg (10 prescriptions for 240 pills, four prescriptions for 180 pills and one for 30 pills). For 2014, B filled 13 prescriptions of 90 pills of MS Contin 30 mg, 20 prescriptions for Norco 10/325 (15 prescriptions for 240 pills, 3 for 180 pills, and 1 for 50 pills), and 13 prescriptions for Oxycodone 10 mg (10 prescriptions for 90 pills and 3 for 120 pills).

Because B was able to fill these prescriptions in these amounts during the 2013 and 2014 time frame, B routinely obtained in excess of 30-day supplies of each of these controlled substances because respondent was seeing B in less than 30 day increments and also, was providing B with early refills of controlled substances. As noted, during this time frame, respondent did not obtain a CURES report to assess the amount of prescriptions B was obtaining.

Regarding the fourth issue Dr. Kirpalani identified, acetaminophen toxicity, the maximum recommended dose of acetaminophen should never exceed 4,000 mg per day. From December 27, 2013, through September 2014, B was taking well in excess of this amount. During this time, respondent prescribed 240 pills of Norco 10/325 mg (which included one prescription for 180 pills of Norco) 17 times. As a result, B appeared to be taking an average of 14 Hydrocodone-Acetaminophen 10/325 mg pills per day. Considering that each pill contains 325 mg of acetaminophen, B was exceeding the 4,000 mg maximum amount she should have taken. Had respondent run CURES reports for this time, respondent would have been able to see this. In an effort to highlight the extent to which respondent was overprescribing Norco to B, Dr. Kirpalani stated that between December 2013 and through May 2014 respondent wrote 16 prescriptions of Norco 10/325 mg for B. Respondent, in fact, wrote 13 prescriptions for Norco for B during this time, which included three three-time refills and a prescription for 50 Norco pills.

Dr. Kirpalani found the degree of departure here to be extreme.

Regarding the fifth issue, monitoring B while she was taking controlled substances, Dr. Kirpalani identified the standard of care as follows:

> If the patient is considered appropriate for opioid therapy, a monitoring plan should be outlined to ensure patient safety. Elements of this monitoring plan include periodic review of the treatment plan and progress towards goals (more frequently in high risk patients), random urine screens, and frequent review of PDMP report, 30 day refills and pill counting (when appropriate). Patients should be tapered off opioids if they engage in aberrant behaviors,

have adverse side effects, or make no progress towards therapeutic goals.

Dr. Kirpalani testified that respondent violated the standard of care in the following respects: Although he saw B on a regular basis to review her treatment plan, he did not identify specific treatment goals in his documentation. He only identified the treatment goal in general terms as follows: "Increase the patient's ability to self-manage pain and related problems. Maximize and maintain optimal physical activity and function. Reduce subjective pain intensity." He did not have B submit to a UDT until February 23, 2015, two years after respondent began prescribing controlled substances.

B engaged in concerning aberrant behaviors: she reported that her medications were lost and stolen, she needed early refills for travel, and she was filling prescriptions at more than one pharmacy in less than 30-day intervals. Dr. Kirpalani gave as an example respondent's failure to monitor that B filled 240 pills of Norco 10/325 mg on April 1, 2014, at Rite Aid Pharmacy and just two weeks later on April 15, 2014, she filled another prescription for 240 pills of Norco 10/325 mg at a CVS Pharmacy. He identified the same pattern of filling prescriptions for 240 pills of Norco 10/325 mg on May 1, 2014, May 14, 2014, May 29, 2014, June 11, 2014 and June 26, 2014. He found it concerning that respondent was not running CURES reports on B in 2013. Dr. Kirpalani also found it concerning that respondent did not ask B to bring in her medications for pill counting.

Dr. Kirpalani concluded that respondent's breach of the standard of care constituted an extreme departure because respondent continued to prescribe controlled substances to B despite lack of clear functional goals, lack of adequate monitoring, and B's aberrant behaviors.

DR. KIRPALANI'S ASSESSMENT OF RESPONDENT'S TREATMENT OF PATIENT C

23. Regarding Patient C, Dr. Kirpalani initially identified the following four issues, as charged in the second amended accusation: Screening, informed consent, overprescribing pain medications, and inconsistent urine screen results. However, at the start of the hearing, complainant withdrew the screening issue (Paragraph 57, subdivision (c), page 17). Dr. Kirpalani's summary of the three standards of care applicable to each of the remaining three issues is identified above.

Regarding the informed consent issue, Dr. Kirpalani concluded that respondent departed from this standard of care for these reasons: Respondent only required C to sign one pain management agreement in six years, at his initial visit on August 6, 2008, and C violated this agreement multiple times with frequent requests for early refills due to self-escalating medication use, losing his prescriptions, or reporting them as stolen. The fact that respondent continued to prescribe high dose opioids to C given his behavior, in Dr. Kirpalani's opinion, represented an extreme departure from the standard of care.

Regarding overprescribing pain medications to C, Dr. Kirpalani found that respondent repeatedly prescribed these medications to C in greater than 30-day supplies and, thus, violated this standard of care as detailed above as follows: In 2012, 14 prescriptions of 90 pills of OxyContin 80 mg. (Exhibit 17, AGO 5559-5562); in 2012, 14 prescriptions of 360 pills of Oxycodone 30 mg. (Exhibit 17, AGO 5559-5562);in 2012, 14 prescriptions of Hydromorphone 8 mg. (8 prescriptions for 120 pills 5 for 90 pills and 1 for 30 pills) (Exhibit 17, AGO 5559-5562); and in 2013, 20 prescriptions of short acting Oxycodone (15 mg. or 30 mg. tablets) Exhibit 17, AGO 5559-5562). Also as detailed above, in March, April, May, June, September, and October of 2013, C filled two prescriptions of short acting Oxycodone each of these months. According to

the CURES report, in March 2013 he filled prescriptions for 360 pills of Oxycodone on March 13 and 22, 2013, April 10 and 18, 2013, May 8 and 30, 2013, June 13 and 27, 2013, September 16 and 30, 2013, and October 12 and 26, 2013.

Dr. Kirpalani then concluded that these multiple instances where C obtained pain medications in greater than 30-day supplies represented an extreme departure from the standard of care.

Finally, regarding C's inconsistent UDTs, Dr. Kirpalani found that C departed from this standard of care because, despite inconsistent UDTs on numerous occasions, respondent did not document that he discussed these results with C and the fact that he continued to prescribe medications to C despite these results represented an extreme departure from the standard of care. With this noted, only those inconsistent UDTs after October 5, 2010, seven years before the filing of the initial accusation in this matter, are considered as a possible cause to impose discipline on this basis.

Summary of Respondent's Treatment and Care of Patients D and E and Dr. Verdolin's Testimony Regarding Patients D and E

PATIENT D

24. On June 21, 2010, Patient D ("Patient D" or "D"), a then 45-year old female patient, first saw respondent for chronic pain and headaches. D's health plan, in a letter dated May 14, 2010, authorized D to see respondent as a pain management specialist. At this initial visit Patient D brought progress notes from her primary care provider for the period from November 2, 2009, to February 15, 2010. These notes contain a number of her primary doctor's assessments of D's physical and mental health conditions relevant to the issues in this matter as follows: Per the February 10,

2010, progress note, D was assessed with: "Bronchitis" and "Asthma, exacerbation." In the January 28, 2010, progress note, she was assessed with 1) Chronic H/A [headaches] 2) Chronic neck pain 3) Anxiety. In her doctor's December 30, 2009, progress note, D was assessed with "Chronic pain" and "ADD vs. bipolar D/O vs/ anxiety." On December 2, 2009, she was assessed with "Chronic pain," "Neck pain," "Anxiety d/o vs ADD vs/ Bipolar d/o." Also, among the records Patient D provided respondent was a physical therapy plan of care document dated January 13, 2010.

At her first visit with respondent, Patient D reported taking medications for pain beginning in 1994. These meds included Fentanyl, Soma, Vicodin, and cortisone shots. Patient D reported she had an MRI of the cervical area in 2009, and prior treatment with acupressure and chiropractic. Respondent did not order any imaging studies, did not request the patient's prior MRI report from 2009, and he did not order a baseline urine drug screen at this visit.

As part of his assessment of D at this first visit, respondent performed an initial history and physical examination of Patient D. However, respondent did not include vital signs, a reported pain score, an appraisal of prior non-opioid treatments for chronic pain, or an assessment of psychological and/or addiction risk. He identified her "Orientation/Mood/Affect" as follows: "Oriented to person, place, time and general circumstances. Mood and affect appropriate." This same language appears in all of respondent's subsequent treatment notes. He did not identify that she suffered from anxiety. The patient's chart for this visit included a musculoskeletal exam. Respondent documented the exam as follows:

> Head/neck [posterior] shoulder girdle; no erythema, ecchymosis or edema. Generalized moderate tenderness over the neck and shoulder girdle, moderate tenderness

over the right occipital groove, moderate tenderness over the scapular area. Held head in a forward position. Full, painless range of motion of the neck. Normal stability. Normal strength and tone.

Spine, Ribs, Pelvis: No erythema, ecchymosis or edema. No tenderness of spine, ribs or S1 joints. No kyphosis, lordosis, or scoliosis. Full, painless range of motion of the thoracic and lumbar spine. Normal stability. Normal strength and tone.

This language for the musculoskeletal exam was the same for each of D's visits with respondent throughout the time respondent treated her.

Respondent assessed D with "Radiculopathy Cervical" and "Numbness Paresthesia of Skin."

Respondent's plan for D was as follows: 1) Agree with present medication program [¶] 2) Consider trigger point injections/occipital nerve injection on the right side with lidocaine and sarapin if approved [¶] 3) Consider PT to the cervical area pending approval [¶] 4) Consider but hold in reserve electrodiagnostic evaluation to address cervical radiculopathy.

For D's goals respondent identified the following: "Increase the patient's ability to self-manage and related problems. Maximize and maintain optimal physical activity and function. Return to productive activity at home, socially, and/or at work. Reduce subjective pain intensity."

At this initial visit Patient D signed a Pain Agreement. The terms of this Pain Agreement, in part, prohibited early refills, doctor shopping, the use of more than one pharmacy, indicated that D may be subjected to random pill counts where respondent may require her to bring in all opioid and adjunctive medicines in their original bottles for respondent to review. She was also advised that respondent may require her to submit to random urine drug testing, and that evidence of misuse may be grounds for termination. Misuse was defined as hoarding, dose escalation, obtaining medications from other providers, and loss of prescriptions. The Pain Agreement also defined addiction and withdrawal from pain medications. In the agreement, D authorized respondent to contact any health professional, family member, or pharmacy to obtain or provide information about her care. Patient D identified her husband as her emergency contact in her intake sheet with respondent and provided respondent with her husband's name and number.

Patient D signed no additional pain agreements throughout her care and treatment with respondent, and respondent had no additional documented discussions with the patient regarding opioid medications' risks, benefits, and alternatives.

Respondent identified that D had prescriptions for Norco 10/325 mg, Soma 350 mg, and Ativan 1 mg, among other medications.

D next saw respondent on July 28, 2010. D then said she was out of her medicine and needed to have her program "reworked today." She said that she had been using a Fentanyl patch. She told respondent she had a new job teaching criminal justice. Respondent reviewed D's medication program and went over "proper medication usage" with her. He stated that he would track and record her medication usage and he "will also try to manage her to her maximum functional level."

Respondent noted that he spent significant additional time with D going over the medication program with her to make sure she understood expectations of each type of medication.

He issued prescriptions for the following medications: 60 pills of Xanax with a three time refill supply, a Duragesic transdermal patch, 180 pills of Norco 10/325 mg with a three time refill, 90 pills of Soma 350 mg with a three time refill. It is not clear why he decided to issue D a prescription for Xanax at this visit.

Less than two weeks later, on August 10, 2010, D called respondent's office and stated that she was having problems with the fentanyl patch constantly falling off and, as a result, she was taking up to 10 Norco pills a day. She also advised respondent that she obtained a "blue pill" from someone to relieve her pain and she took it. In the note recording this call, respondent acknowledged D's report regarding her medication usage and stated that D needed to come in to have her medication program reset to get her back on track.

On August 18, 2010, D saw respondent. Respondent noted that D was having problems with the Duragesic patch and he confirmed with her pharmacy that she was given a certain type of patch. It is not clear from his note this date how he changed, or "reset" as he stated in the August 10, 2010, note, D's meds except that he issued prescriptions for 180 pills of Oxycodone 15 mg and the Duragesic patch.

On September 7, 2010, D's pharmacy contacted respondent to advise him that D was seeking early refills of Norco, Soma and Xanax. At the bottom of the pharmacy's fax, respondent documented that he authorized the early refills.

At D's September 14, 2010, visit with respondent, D reported that she had a headache. She reported that she continued to have significant pain problems in the

cervical and suboccipital area. He noted that she was a candidate for suboccipital injections. He stated that there were no significant changes to her medication program.

On this date he issued prescriptions for 90 pills of Soma with three refills and 120 pills of Oxycodone 30 mg. This represented an increase in dosage for the Oxycodone from 15 mg. He continued the Norco and Xanax prescriptions.

Patient D called respondent's office on October 5, 2010, and stated that she wanted a prescription of Oxycodone 30 mg to cover the time before her next appointment with respondent on October 14, 2010. Respondent issued a prescription of 30 pills of this medication.

At her October 14, 2010, appointment with respondent, D stated that she had a "situation in that she ran out of her oxy." She was taking 30 mg at the rate of four every four hours. Respondent documented he counseled her regarding appropriate medication usage. He reviewed all of her medications. He issued a new prescription for 180 pills of Oxycodone 30 mg to be taken once every four hours as needed. He also issued to her 90 pills of Soma with three refills, 240 pills of Norco 10/325 mg and 60 pills of Xanax with three refills.

Patient D reported at her November 9, 2010, appointment with respondent that she has been taking more medicine and she had a new symptom in her hands and fingers. Respondent added Oxycontin 40 mg as a "fill in" medication. He documented that he spent significant additional time going over her medication program and making a plan. In addition to adding Oxycontin to the plan, respondent added a Pennsaid Transdermal Solution. On this date he issued prescriptions for 60 pills of Oxycontin, 240 pills of Norco with 3 refills, 60 pills of Xanax 1 mg with three refills, and

90 pills of Soma with three refills. With respect to the Norco, Xanax and Soma prescriptions it appears that respondent lost track that he had issued prescriptions in these amounts with these refills on October 14, 2010. He also issued a prescription for 180 pills of Oxycodone.

Patient D called respondent on November 20, 2010, and stated that she was going to be out of her medications before her December 7, 2010, appointment. Respondent stated that he did not understand why she was out of her meds considering that he wrote prescriptions for Oxycodone and Oxycontin on November 9, 2010. He asked his staff to have her explain. Patient D stated that "she will cut her medication in half to make it last."

At her December 7, 2010, appointment, Patient D stated that she liked her medicine, but it needed to be reworked. Respondent discontinued the Oxycontin and issued a prescription for 240 pills of Oxycodone 30 mg. Otherwise, respondent kept the same medication regimen in place. He noted that he counseled D regarding proper medication usage.

On January 4, 2011, D reported that she had not been functioning well with Xanax; she stated that she liked Valium better. She told respondent that she was willing to go on Ativan. Respondent issued prescriptions this date for 90 pills of Ativan 1 mg with three refills, 240 pills of Oxycodone 30 mg, and a Duragesic patch.

D next saw respondent on February 1, 2011. She reported that she missed the Norco she had previously taken, but she was extremely pleased with her present medications. She also stated she needed a work note to go back to work on Friday. Respondent gave her a note that stated that D may return to work on February 4, 2011 "due to respiratory problems." It is unclear from his records what her respiratory

problem involved. It is noted that she was taking medications for asthma. At the same time, she stated that she had some uncertainty regarding her employment, and she "tries" to remain functional. Respondent issued prescriptions for 240 pills of 90 Oxycodone, 90 pills of Soma 350 mg with three refills, 240 pills of Norco with three refills, and 60 pills of Xanax with three refills.

D reported at her March 1, 2011, appointment that the work note he wrote for her worked. She stated that she was pleased with her present medications. She said he was getting a good result with the Ativan. D stated that she was trying to remain functional. He issued prescriptions for Fentanyl transdermal patch and 240 pills of Oxycodone 30 mg on this date.

At her March 22, 2011, appointment D stated that she was taking more medicine than expected, she was having difficulty staying with the medication program, and she was having a "cervical exacerbation." Respondent instructed D to not unilaterally change the way she took her medications. He issued prescriptions for Fentanyl transdermal patch and 240 pills of Oxycodone this date. Respondent recorded that D's mood and affect were appropriate.

On April 5, 2011, respondent wrote a prescription for D for physical therapy two times a week for four weeks. In a subsequent note from the physical therapy provider, dated May 31, 2011, respondent was advised that D did not make her initial appointment.

At D's April 21, 2011, visit with respondent, D stated that she needed Soma because it helped her sleep and she was having right shoulder pain.[30] Respondent stated that he would like to consolidate her medications in the future to simplify her program. He commented that D may need to go through a weaning and reduction program in order ultimately for the medications to work more effectively. Despite his comments, respondent maintained her on the same program. He issued prescriptions for 90 pills of Soma with three refills, 240 pills of Oxycodone 40 mg, 90 pills of Ativan 1 mg with three refills, and a Fentanyl Transdermal patch. Respondent again recorded that D's mood and affect were appropriate.

Five days later, on April 26, 2011, D called respondent's office and stated that "she needs to discontinue the Soma due to her taking so many of them." She said she would discuss this further with him at her next appointment. Respondent documented he "noted" her call.

On May 10, 2011, D called respondent and stated that she got pulled over for child endangerment for being under the influence of controlled medications. She said she needed respondent to write a letter for her, and she needed this letter by May 19, 2011, when she was scheduled to appear in court. The note also documented that she had called on April 26, 2011, and asked not to be prescribed Soma.

Before her next scheduled appointment, on May 12, 2011, D's pharmacy called respondent to advise him that D wanted an early refill for 60 pills of Alprazolam

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[30] Starting in 2012, Soma (known by its metabolite as meprobamate) was classified as a Schedule IV controlled substance and, as such, was identified in the CURES report admitted as evidence (Exhibit 2).

(Xanax) 1 mg. Respondent had last prescribed D Xanax on February 1, 2011, with three refills. Respondent authorized the refill. He did not document the reason he authorized this early refill at this time.

25. Four days after this call from her pharmacy, on May 16, 2011, D called respondent stating that she was in withdrawal and needed something to ease her frustration. She believed she was going to have a seizure and wanted Suboxone.[31] Respondent commented that her situation was to be addressed at her May 16, 2011, appointment, but she missed this appointment.

26. On May 18, 2011, D called and was "very upset stating that she has not heard" from respondent and she needed respondent to write a letter stating that he prescribed Norco to her. She repeated that she felt she was going through withdrawal and needed something to prescribed to her for this. Respondent stated he would handle her situation at her May 19, 2011, visit.

On May 18, 2011 respondent wrote a summary of his care of D since 2010 and that D asked that he no longer prescribe Soma to her on April 26, 2011. He then listed her medications.

27. On May 23, 2011, D's pharmacy notified respondent that D was seeking to refill Norco nine days early. Respondent did not authorize this early refill.

28. On July 7, 2011, D's pharmacy, which appears to be a different pharmacy than the pharmacy she had been going to, asked D to provide a new prescription for

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[31] Suboxone (buprenorphine and naloxone) is a Schedule II controlled substance under Health and Safety Code section 11055.

Ativan. Respondent issued a prescription for 30 pills of Ativan on July 8, 2011, without any refills. He noted next to the prescription that D needed a follow-up appointment. Despite his note that she needed a follow-up appointment with him, there is no documentation in the record between July 7, 2011, and October 26, 2011, that respondent attempted to have D come in for an appointment with him.

29. On July 8, 2011, D's pharmacy, the pharmacy she identified in her pain agreement, asked respondent to provide refill authorization for Hydrocodone/APAP 10/325, which respondent authorized on July 11, 2011.

30. On July 20, 2011, D sent respondent an authorization for release of information from Community Health Systems, Inc., which respondent signed.

31. The last progress note in D's chart is dated October 25, 2011, which documents that D called respondent to advise him that she lost her insurance and had been able to see him. She said she made her Norco last during the time and had one more refill of the medication and wanted an early refill. She stated that she left her prescription at her mother's home and she wanted respondent to call her pharmacy to authorize an early refill.

32. At this point, respondent pulled D's CURES report and found that she had obtained medications from two other doctors and, as a result, he advised D that he was not going to authorize the refill. D called him back "very upset." She said that the one doctor worked at a clinic and had given "her reduced quantities of medications as listed in the CURES report." Respondent then authorized the early refill of Norco and documented that he was going to send her a discharge letter.

33. The next document in D's chart, is the CURES report dated October 25, 2011, which respondent ran on D. This is the first and only time he ran a CURES report

regarding D's medication usage. This report documented that two other doctors had issued prescriptions for D for 90 pills of Hydrocodone-Bitartrate 10/325 mg and 90 pills of Alprazolam on July 20, 2011, August 17, 2011, September 9, 2011, September 20, 2011, and September 22, 2011. In the CURES report, there are handwritten notations that D obtained 240 pills of Norco on October 6, 2011, and Xanax on October 21, 2011. In addition, there are the following handwritten notations: "Dr. Ferreras 33 days 9/22 #120 33 days #360" and Dr. Chesler 10/6 #240-Billed Ins. Cleared. Original Date 7/11" and "Patient has ins. P/U Xanax 10 21 11 cleared."

34. The next day, October 26, 2011, respondent sent a letter to D by certified mail advising her that he was withdrawing from her care due to the change in her insurance coverage and her treatment with another doctor.

35. About five months later, on May 3, 2012, D was found dead in her home where she lived with her husband. The San Diego County Medical Examiner's investigative report dated May 10, 2012, noted that she had a history of years of prescription medication abuse. The Medical Examiner's report documented her husband's concerns about her prescription drug abuse over the eight years they were married. The Medical Examiner contacted D's primary care doctor, who was prescribing the medications identified in the CURES report respondent ran on October 25, 2012. This doctor reported that D had a history of chronic neck pain, anxiety, depression, possible bipolar disorder, and opiate dependency.

36. In a report signed August 16, 2012, Deputy Medical Examiner, Bethann Schaber, M.D., concluded that D died as a result of an acute mixed drug overdose due to the combined toxic effects of oxycodone, carisoprodol, diphenhydramine, and clonazepam. Dr. Schaber classified the manner of death as accidental.

37. Between on or about June 21, 2010, through on or about October 25, 2011, respondent provided care and treatment to Patient D that included issuing the following:

- 30-day supplies of the following prescriptions, including refills;
- Ten prescriptions of 60 pills of Alprazolam 1 mg.
- Six prescriptions of Lorazepam 1 mg. (one for 30 pills, one for 40 pills, and four for 90 pills);
- Ten prescriptions of Oxycodone 30 mg. (one for 30 pills, one for 40 pills, one for 120 pills, two for 180 pulls, one for 200 pills, four for 240 pills) and one prescription of 180 pills of Oxycodone 15 mg. #180;
- One prescription of 60 pills of Oxycontin 40 mg;
- Two prescriptions of Fentanyl 25 mcg: (one of #10 and one of#15), two prescriptions of Fentanyl 50 mcg. #15, and one prescription of Fentanyl 75 mcg. #15;
- Nineteen prescriptions of Norco 10/325 mg. (one for #50, one for #60, one for #80, two for #100, one for #l40, four for #l80, and nine for#240).
- Six prescriptions with three refills of 90 pills of Soma 350 mg.

Soma, specifically its metabolite meprobamate, which respondent prescribed to D, was identified in CURES as a Schedule IV substance starting in 2012, although it was classified as a Schedule IV controlled substance under Health and Safety Code section 11057 before 2012. Thus, the medication did not appear in the CURES report that respondent ran on D on October 26, 2011.

38. Between June 21, 2010, and April 21, 2011, D saw respondent for approximately 13 clinical visits. Throughout that time, including at clinical visits on March 22, 2011, and April 21, 2011, treatment goals documented by respondent were generic, rather than specific, clear functional patient goals, and the musculoskeletal examination notes for each visit were identical.

39. While under respondent's care, including at clinical visits on March 22, 2011, and April 21, 2011, no urine drug screens were performed on Patient D, no pill count was ever conducted or documented, and respondent never referred D for imaging studies, behavioral management, psychiatry, or addiction treatment.

40. While under respondent's care, Patient D displayed aberrant behaviors, including but not limited to, admitting to overusing her medications, repeatedly requesting early refills, and filling prescriptions at different pharmacies. Despite her repeated noncompliance with the Pain Agreement, respondent continued to prescribe D controlled substances including high-dose opioids with little documented discussion regarding her repeated instances of noncompliance, and limited changes to plan to address her noncompliance.

41. Between April 22, 2011, and October 25, 2011, Patient D did not present to respondent for treatment due to an apparent change in her insurance coverage. During that time, Patient D contacted respondent's office on multiple occasions to report that she was in withdrawal and needed medications.

PATIENT E

42. Patient E ("Patient E" or "E") was a 62-year old man who had been treating with respondent for chronic pain management from 2008 until his death on

February 12, 2012, from a combination of opioid, methadone[32], oxycodone, hydrocodone, alprazolam, citalopram and alcohol. E signed a pain agreement with respondent on June 30, 2008, which advised him of the risks of opioid use. Regarding the combination of alcohol and opioid medications the pain agreement stated the following; "The use of alcohol and opioid medications is contraindicated."

According to E's records, respondent assessed E with cervical pain with radiation, cervical radiculopathy, and paresthesia of the skin. He did not assess him with any other medical conditions. During the time he treated E, he prescribed to him high dose opioids, Norco and Percocet, Xanax, and Lexapro, Wellbutrin and Buspar for anxiety and depression.[33]

43. During the time respondent treated E, respondent was hospitalized on two occasions related to overdosing on medications in October 2009 and abuse of alcohol in December 2010. In October 2009 he was admitted with aspiration pneumonia with MSSA,[34] and confusion. On December 7, 2010, E was admitted involuntarily under Welfare and Institutions Code section 5150 after he was brought to the hospital because he was hallucinating and believing people were in his home while he wielded a loaded gun. The Palomar Hospital Admission Report described, under his

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[32] Methadone is a Schedule II controlled substance. It has the brand name Methadose.

[33] Lexapro, Wellbutrin and Buspar are medications used to treat depression.

[34] Methicillin-sensitive Staphylococcus aureus (MSSA) is a bacterial infection.

social history, that E "[d]rinks heavily." A summary of this hospitalization is provided below.

44. E's first recorded visit with respondent was December 23, 2008. Respondent stated that he was an "established" patient, meaning that there were records prior to this date that were not part of E's records admitted as evidence. E stated that he needed his medications refilled, he had been using methadone appropriately, and he had been experiencing more pain with the cold weather. Respondent noted that he had hospitalizations or ER visits. Respondent assessed E with cervical pain and radiculopathy and numbness paresthesia of the skin. He issued prescriptions this date for 600 pills of Methadone 10 mg, 240 pills of Hydrocodone-Acetaminophen 10/325 mg with three refills, 120 pills of Xanax 1 mg with 3 three refills, 120 pills of Wellbutrin 100 mg with three refills, 120 pills of Gabapentin 600 mg with three refills.[35]

In this note, respondent identified E's goals as follows: Increase the patient's ability to self-manage pain and related problems. Maximize and maintain optimal physical activity and function. Reduce subjective pain intensity. These goals remained the same throughout respondent's treatment of E.

Respondent continued E on the medications he prescribed E until September 17, 2009, when he added 90 pills of Percocet 10/325 mg.

On October 21, 2009, E's wife called respondent to advise him that respondent was found unresponsive on October 18, 2009, and taken to the hospital where he

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[35] Gabapentin, also known as Neurontin, is used to treat neuropathic pain. It is a dangerous drug pursuant to Section 4022.

remained unresponsive and was placed on a ventilator. Respondent advised her to keep him informed regarding how he was doing. E's hospital records were not part of respondent's record. According to the Medical Examiner's investigative narrative, which was admitted into evidence as an exhibit, E was taken to Palomar "for an overdose on his prescription medications" and he was on a respirator for five days before he was discharged. (Exhibits 28 and E, AGO 9043.)

E saw respondent with his wife on November 12, 2009. At this visit, E said he was getting his pills filled by his wife and his wife was now a "partner in the setting of his medications and maintaining his usage." Respondent noted that E was not moving that much and needed physical therapy. E asked about enrolling in a chronic pain management support group and "mentioned alcoholic anonymous as a support group as well." E's comment regarding attending Alcoholics Anonymous suggested that his hospitalization was due to his abuse of alcohol. Respondent documented that he spent a significant amount of time reworking his medication program and discontinued meds E was no longer using, namely Percocet, Hydrocodone-Acetaminophen, Methadose, Lipitor, and Chantix. Respondent issued new prescriptions for 120 pills of Norco, 180 pills of Methadone, and 45 pills of Xanax 1 mg.

Respondent had E submit to a urine screen this date to assure compliance with the program. Oddly, respondent did not have E undergo testing for alcohol. This was the one and only time respondent had E submit to a UDT during E's treatment with respondent. The results, dated November 16, 2009, were negative for Percocet, which given E was being prescribed this drug, was expected to be seen. The negative result was, accordingly, an inconsistent result. Notably, respondent did not document whether he talked to E about this result in his subsequent visit with him.

Between this visit and E's visit on December 14, 2010, after his second hospitalization, respondent continued E on Gabapentin, Lexapro, Methadone, Xanax, Norco and Percocet. On September 14, 2010, he noted that E was taking Buspirone, an anti-anxiety medication. During this time, E reported that he lost weight, which he wanted to do, and was approved for Social Security disability benefits.

As noted, on December 7, 2010, E was admitted involuntarily under Welfare and Institutions Code section 5150 after he was brought to the hospital because he was hallucinating believing people were in his home while he was wielding a loaded gun. The Palomar Hospital Admission Report described, under his social history, that E "[d]rinks heavily."

45. The admitting emergency room doctor provided the following assessment of E's admitting condition: "Alcohol withdrawal with hallucinations"; "Hallucinations secondary to alcohol withdrawal"; "Toxic encephalopathy secondary to alcohol withdrawal with hallucination presentation" and "History of chronic pulmonary disease." E was diagnosed with alcohol and opiate dependencies, psychosis, and chronic pain with cervical surgery. (Exhibit 12, AGO 9043-9044) According to the emergency department's behavioral health assessment, the social worker's DSM IV impression was "Major Depression" and "alcohol and opiate abuse." Respondent was assessed with global assessment of functioning scale score of 20, meaning his functional capacity was limited. The social worker in this assessment described him as a danger to himself and others. (Exhibit E, MCER-0041.)

E's wife reported at the hospital that respondent was providing pain management for E and E had been drinking 1.5 liters of vodka and "overusing his pain medication and methadone at home." (Exhibit E, MCER-0073.) She also stated that he relapsed six months before his admission. She said that respondent lost his balance

and became increasingly incoherent with disorganized speech and he had multiple bruises because of falls.

46. On December 7, 2010, E's wife called respondent's office to advise respondent that E was hallucinating and was admitted to the hospital. She said she wanted to speak with respondent because "there are things going on that you don't know about." Notably, respondent did not call E's wife back to discuss her concerns. Instead, he noted, "This issue is handled at his visit." There is no evidence in E's records that respondent contacted E's wife.

47. Respondent saw E on December 14, 2010, and counseled him about "abstinence of alcohol" and appropriate medication usage. He referred E back to his June 30, 2008, pain agreement. He characterized E's 5150 hold episode as follows: "He has had an episode when he was drinking and that caused him to be taken to ER." He told respondent that firearms were removed from his home. Respondent did not take any of E's vital signs, including his blood pressure. In fact, respondent never took E's vitals at any subsequent visits. Respondent, further, did not refer E to a psychiatrist or therapist, he did not discuss support groups with E, and he did not have E submit to a UDT. Respondent similarly did not refer E to a behavioral health specialist or have him submit to a UDT in E's subsequent visits. In this note respondent stated that he would communicate with E's wife regarding the episode. However, there is no record that respondent had such a discussion with E's wife or talked to her. He did not change the goals for E or his plan for E. Respondent refilled E's prescriptions as follows: 120 pills of Norco, 90 pills of Xanax, 180 pills of Methadone, 90 pills of Percocet and maintained him on the Lexapro, Gabapentin and Buspirone. Respondent did not authorize refills of the meds he issued prescriptions for this date. Respondent stated that he intended to obtain E's hospital records.

48. On January 11, 2011, respondent met E and respondent reported that E then went over his hospital records. E asked respondent for a letter about his condition and said he was getting a letter from his marriage counselor in order to get his "rights back for his firearms." The records respondent obtained from E's hospitalization are not in E's records. It is, thus, not possible to know what records E went over with respondent or the nature of their conversation regarding E's hospitalization. Respondent's note for this date is brief and notably contains no advisements regarding possible treatment for alcohol abuse or referral to a psychiatrist or therapist. Respondent did not document that he asked E about his alcohol use. He also did not have E submit to a UDT. Respondent's assessment and plan for E remained the same. He continued E on the same medications and issued prescriptions for 90 pills of Percocet, 120 Norco pills, 180 pills of Methadone, and 90 pills of Xanax. There is no record that respondent wrote a letter on E's behalf to allow him to have his firearms back.

49. On April 14, 2011, E's health plan sent respondent a letter with an alert regarding respondent's prescription of multiple opioids, Alprazolam, and Gabapentin to E. Respondent marked on a form the health plan asked respondent to complete that E "was compliant prior to receipt of this communication."

50. At E's April 26, 2011, visit with respondent, E reported that he had been using his medications correctly and his refills were on track. He stated that he wanted to restart Chantix to help him quit smoking. E told respondent he fired his primary care doctor but offered no explanation. On this date, respondent issued prescriptions for 120 pills of Wellbutrin 100 mg, 30 pills of Lexapro 20 mg, 180 pills of Methadone 10 mg, 90 pills of Percocet 10/325 mg, 90 pills of Xanax 1 mg, 120 pills of Norco 10/325 mg, and Chantix. The Lexapro and Wellbutrin were authorized for three refills. Again,

respondent did not take any of E's vitals, or inquire of his alcohol use, or discuss behavioral health treatment.

51. At E's next appointment on May 24, 2011, E reported that he was still looking for a primary care doctor. Respondent issued refills for Methadone, Norco, Percocet, Xanax and Chantix. At this and other appointments during this time, respondent did not take E's vitals, did not ask him about his alcohol use, and did not discuss with him behavioral health treatment. E told respondent that the police returned his firearms.

52. From May 2011 to November 8, 2011, respondent maintained E on the same medication regimen. At E's November 8, 2011, appointment E said that he did not need all of his meds and he had a "list." He wanted help losing weight, and he reported he was approved for a diagnostic ultrasound of his shoulder. Respondent did not ask respondent about alcohol use, did not take his vitals and did not discuss with him behavioral health treatment. He issued prescriptions for 90 pills of Buspirone 15 mg with three refills, 90 pills of Percocet, 180 pills of Methadone, 120 pills of Norco, 90 pills of Xanax.

53. At his December 6, 2011, appointment, respondent documented that E has been responsible with his medication use, he saw no conflict, he discussed with him the "expectations" regarding his mediation use and he reviewed his pain treatment agreement. Respondent educated E regarding appropriate shoulder exercises to minimize pain. Respondent again did not ask respondent about alcohol use, did not take his vitals and did not discuss behavioral health treatment with him. Respondent issued prescriptions for the medications in the same amounts and dosages he previously ordered.

54. E's last visit with respondent before his death was on January 31, 2012. At this visit E reported to respondent that "He is happy with his pain program and he is not needing any changes. He is stable and he has had no new needs today." Respondent did not ask respondent about alcohol use, did not take his vitals and did not discuss with him behavioral health treatment. He issued prescriptions for 90 pills of Buspirone 15 mg with three refills, 90 pills of Percocet 10/325 mg, 180 pills of Methadone 10 mg, 120 pills of Norco 10/325 mg, 90 pills of Xanax.

55. Less than two weeks later, on February 12, 2012, E's wife found him dead in their home. E's wife told responding paramedics she considered E to be an alcoholic and he was known to overdose or take too much of his medications with alcohol.

56. In a report signed April 20, 2012, Chief Deputy Medical Examiner, Jonathon R. Lucas, M.D., concluded E's cause of death was the "combined effects of alcohol, methadone, oxycodone, hydrocodone, alprazolam, bupropion, and citalopram." The manner of death was described as an accident. (Exhibit 28 AGO 9046.) Dr. Lucas noted the following:

> Although none of the medications were excessively elevated and the methadone concentration appeared consistent with the chronic dosing, the combined effects of the medications coupled with the alcohol would have had additive central nervous system and respiratory depressant effects.

With this noted, Dr. Lucas stated that E's "pill counts were consistent with some overuse of alprazolam. . ."

According to the toxicology report, E had 0.12 percent of alcohol by weight and volume, 0.62 mg/L of methadone volume in his blood and 7 mg in his gastric system, and was positive for opiates, benzodiazepines, and the other controlled substances respondent prescribed E.

57. As part of its investigation, a Health Quality Investigation Unit investigator asked respondent to respond in writing to four questions about his care and treatment of E. Respondent provided written responses to the four questions in a document HQIU received on February 15, 2018. Respondent stated in this document that he obtained a signed pain agreement from E and he referred E for UDTs on more than one occasion. However, contrary to that representation, according to the medical records, Respondent had only had E submit to a UDT on one occasion. Respondent submitted a pain agreement E signed in 2008 to HQIU in which E acknowledged that the use of alcohol and methadone were not compatible.

In response to HQIU's the question regarding whether respondent referred E for a mental health assessment at any time in 2010 to 2012, respondent said he did not. But, he said he "did participate" in "contributing to his care" "surrounding" E's admission to the behavioral unit at Palomar Hospital. In fact, there is no evidence in the record that respondent participated in E's psychiatric care at Palomar. Respondent did not document in E's chart that he ever talked to any clinicians at Palomar or exchanged information with these persons.

To support, apparently, his contention that he participated in E's mental health treatment, respondent wrote that he obtained and reviewed E's Social Security Disability "comprehensive psychiatric evaluation." Respondent was referring to a six-page report dated April 10, 2010, entitled "Complete Psychiatric Evaluation," signed by Romuldo R. Rodriguez, M.D, "a board eligible psychiatrist." E sent this report to

respondent on April 29, 2010, and it is part of respondent's records for E. (Exhibit 30, AGO 9377-9381.) Dr. Rodriguez evaluated E to determine only whether he qualified for Social Security Disability; he was not evaluating him for treatment purposes. The evaluation is not comprehensive or even complete. The only information Dr. Rodriguez obtained was from E, who described his family and medical history in broad strokes. E also told Dr. Rodriguez that he considered himself to be an alcoholic, but he had not drunk alcohol for 13 years, which was incorrect in light of his October 2009 hospitalization and E's statement to respondent he might attend AA. Dr. Rodriguez conducted a cursory, or mini, mental health examination of E without more formal psychiatric assessments or testing. Based on this evaluation, he found that E suffered from Major Depressive Disorder, in remission, and he concluded that E had minimal functional limitations or work restrictions due to this condition. He did not make any other assessments of E.

Testimony of Complainant's Expert, Michael Verdolin, M.D. Regarding Respondent's Treatment of Patients D and E

58 As noted earlier, complainant called Michael Verdolin, M.D., as an expert to address respondent's care, treatment and prescription of pain medications to Patients D and E. Dr. Verdolin is a board-certified anesthesiologist and pain management physician. He received his medical degree from the University of Miami School of Medicine in 1996. He completed an internship in internal medicine in 1997 at the National Naval Medical Center in Bethesda, Maryland, and a residency in Anesthesiology in 2000 at the National Naval Medical Center and Walter Reed Army Medical Center (Walter Reed) in Washington, D.C. Dr. Verdolin completed a fellowship in interventional pain management at Walter Reed in 2004. He is a Diplomate of the American Board of Anesthesiology. Since 2006, he has been an Assistant Professor of

Anesthesiology at the Uniformed University of the Health Sciences in Bethesda, Maryland. Since 2008, he has been a member of the clinical faculty in pain management teaching services at Scripps Mercy Hospital in San Diego and is the founder and president of a pain management clinic. Since 2014 he had been the Medical Director, Synovation Medical Group. He has authored or co-authored a number of peer-reviewed articles in the field of anesthesiology and has given presentations on topics in the field. Dr. Verdolin has served as an expert reviewer for the Board since 2007.

Dr. Verdolin reviewed the evidence of record in this matter and prepared a detailed report dated March 17, 2018, which was received into evidence.

Dr. Verdolin's Assessment of Respondent's Care and Treatment of Patient D

59. Regarding respondent's care and treatment of Patient D, Dr. Verdolin identified the following issues:

Did respondent follow the Board's 2007 prescribing practices guidelines that required that he perform a good faith physical examination of D, take steps to ensure against diversion of controlled substances, assess the benefits of the controlled substance respondent was prescribing D and adjust treatment according to risk and harm, provide D with informed consent regarding the risks and benefits of the controlled substances he was prescribing her, conduct periodic reviews, appropriately consult with D, and maintain accurate and adequate and accurate medical records?

When respondent learned that D was noncompliant with opioid therapy did respondent attempt to obtain any subspecialty consultation?

When D was found to be non-compliant with opioid therapy and the mutually binding pain management agreement did respondent attempt to have D submit to a UDT or undergo a pill count?

When presented with repeated departures from the mutual pain agreement did respondent consider and act on D's obvious misuse of prescribed meds and her addiction to these meds that might have saved her life?

Dr. Verdolin summarized the standards of care relevant to these questions as follows:

Respondent was required to conduct a good faith examination of a pain management patient at the outset of prescribing controlled substances. This good faith examination consists of vital signs including blood pressure, heart rate, temperature, and respiratory measurements. Informed consent for treatment with controlled substances must be obtained from the patient which delineates the risks and benefits of taking controlled substances. A pain agreement may be used to provide informed consent. Before prescribing opioids, there must be an identifiable, documented diagnosis causing chronic pain in the patient. Opioid therapy must not be considered an ongoing, ever escalating therapeutic plan. Rather, it should be part of a comprehensive treatment plan that includes referral to sub-specialists, including addiction specialists, psychiatrists, therapists, physical therapists and surgeons when appropriate.

Treatment objectives including specifically identifiable pain management goals must be clearly identified in the provider's plan. Periodic review by the provider of response to treatment must be documented in the treatment plan and appropriate adjustments made as appropriate. A clear plan of action by the physician must be

identifiable and the logic in the treatment objectives clearly delineated in the plan section. Response to plan objectives must be identified in the treatment plan and if the patient fails to respond adequately to the goals then it is incumbent on the provider to taper and stop the opioid prescriptions.

In addition to assessing the efficacy of the treatment (i.e., back to work, quality of life, goals being met) the prescriber must assess for possible diversion. This means urinalysis, review of CURES reports or other objective means. When urinalysis identifies illicit substances or possible diversion due to the lack of prescribed substances or their metabolites in the patient's system, a frank discussion must be had with the patient and the prescriber must thoroughly assess, and document, the patient for possible diversion. If this assessment indicates likely diversion, prescription of controlled substances must be stopped. Also, suspicion for use of illicit substances or misuse of controlled substances requires the prescribing doctor to refer the patient to an addiction specialist. It is also problematic to prescribe opioids to a known addict without the involvement of a specialist. Continued unexplained increases in dose requirements without concurrent improvement in quality of life should spur a referral to a pain management specialist to help guide treatment.

Unequivocal peer-reviewed studies demonstrate that the chronic use of opioids is associated with depression, opioid tolerance, dependence, addiction potential, decreased immune functioning, risk to a fetus, and significantly compromised endocrine functioning. These negative side effects must be discussed with the patient and addressed in the form of written informed consent identifying risks, benefits and alternatives. Additionally, there are relative contraindications to co-prescribing benzodiazepine medications and opioids concurrently given the risks of respiratory depression and death.

As the fifth vital sign, the level of pain should be entered as a numerical value also known as the visual analog scale. In the absence of any objectifiable scan to indicate the patient's pain, a patient's response to therapy is accepted as a standard. As such, at a minimum, when treating pain, its number should be recorded in the record. Additionally, focused system evaluation is indicated. However, copy/pasting of findings from one visit to another indicates that an examination may not have been performed, from the perspective of Medicare's chart auditing. To that end, verbatim copy/pasting of physical exam findings cannot meet the standard of care.

When a physician witnesses evidence of self-harm, or addiction, the prescribing physician has a duty to rescue, or at least offer intervention. This includes stopping or tapering medications, providing appropriate psychiatric referrals, and involving family members to the extent permitted by the patient.

60. Dr. Verdolin concluded that respondent departed from each of the standards of care he identified with respect to his care and treatment of D. In his analysis regarding these departures, based on the records he reviewed, and consistent with the prescribing guidelines in place at the time, Dr. Verdolin concluded that respondent did not document in D's records any objective findings to explain D's history of chronic pain. D was not reported to have a history of surgical intervention in her cervical spine and respondent did not identify any imaging studies in the record.

Dr. Verdolin found it notable that D's records indicate that D appears to have a history of substance misuse because she was seeing multiple doctors and she was obtaining multiple opioid medications which were prescribed with Soma, a muscle relaxant, and also a benzodiazepine, Ativan. Respondent did not document that D was considered for treatment with a psychiatrist for anxiety with respect to the Ativan prescription.

Dr. Verdolin further found it notable that D repeatedly violated the June 21, 2010, pain management agreement she signed, as recorded in 12 visits she had with respondent. Yet, despite these violations, respondent did not utilize a pill count or have D submit to a UDT. Here, Dr. Verdolin directly addressed whether respondent was required to have D submit to the urinalysis because her insurance would not pay for it. Dr. Verdolin did not accept respondent's explanation as a reason why he could not have utilized point of care, or "cup" testing. He noted in his report that the board and subspecialty pain management societies encouraged the use of urinalysis to monitor compliance. As discussed earlier in this decision, respondent appeared to accept the importance of UDTs in monitoring patients because, pre-2014 pain guidelines, he regularly had patients in this matter submit to UDTs. At any rate, Dr. Verdolin stressed that at the very least respondent could have required D to bring in her medications for a pill count.

Regarding respondent's record keeping, Dr. Verdolin found it concerning that respondent copied/pasted critical portions of D's exams into D's records. He cited the following identical note regarding D's physical exam that appeared in D's records as an example of respondent's practice:

> Head/neck [posterior] shoulder girdle; no erythema, ecchymosis or edema. Generalized moderate tenderness over the neck and shoulder girdle, moderate tenderness over the right occipital groove, moderate tenderness over the scapular area. Head held in a forward position. Full, painless range of motion of the neck. Normal stability. Normal strength and tone.

Dr. Verdolin commented that this note was maintained in D's records even when D complained of new symptoms in November 9, 2010. Despite this, respondent did not perform a directed neurological exam of D, did not order tests, even though he had considered ordering tests since June 21, 2010, he did not record vital signs or pain scales to follow whether D was in withdrawal.

Dr. Verdolin further noted that respondent copied/pasted the same plan from the start of D's treatment with him in later notes, and this plan was not implemented. There was no attempt to consider behavioral or interventional pain options. Respondent only once, in April 2011, a year after D's initial visit with him, identified that D went to physical therapy. The plan reads as follows:

> PLAN: 1) Agree with present medication program.
>
> 2)Consider trigger point injections/occipital nerve injection on the right side Lidocaine and sample if approved
>
> 3)Consider PT to the cervical area pending approval.
>
> 4) Consider but hold in reserve electrodiagnostic evaluation to address cervical radiculopathy.
>
> GOALS: Increase the patient's ability to self-manage pain and related problems, optimal physical activity and function. Return to productive activity at home, socially and/or at work. Reduce subjective pain intensity.

It appeared to Dr. Verdolin that respondent did not appreciate the degree of D's medication addiction and/or her misuse of the meds he was prescribing her. Dr. Verdolin stated that since 2011 CURES has been available online to doctors as a useful

tool to see if D was doctor shopping. In essence, respondent did not follow the pain agreement in place. His responses to violations of the agreement were to increase the doses and formulations. As an example of this, Dr. Verdolin testified that, without seeing D, respondent issued her a prescription for Alprazolam on May 12, 2012, after he had issued a prescription for 90 pills of Ativan on April 21, 2011. He issued this prescription for Alprazolam two days after she was stopped by law enforcement on May 10, 2011, for child endangerment due to the side effects of medications she was taking. Dr. Verdolin testified that there was no reason for respondent to give D both Alprazolam and Ativan. At this point, respondent should have intervened due to D's misuse of meds and because she was addicted to opioids per the definition of addiction as defined by the pain management agreement she signed on June 21, 2010. In this agreement, D acknowledged the nature of addiction to opioid medications and dependence upon these meds. D agreed to allow respondent to contact family members and provide information about her care to others, including pharmacies, or to obtain information if he felt it was necessary.

61. Regarding the degrees of departures he found, Dr. Verdolin concluded that respondent committed an extreme departure from the standard of care regarding the first issue he identified because he continued to prescribe medications to D despite her repeated aberrant behavior, possible addiction and her repeated failure to follow the pain agreement she signed with respondent. In reaching this conclusion, Dr. Verdolin considered that respondent failed to perform a perform a good faith physical examination of D, take steps to ensure against diversion of controlled substances, assess the benefits of the controlled substance respondent was prescribing D and adjust treatment according to risk and harm, obtain D's informed consent regarding the risks and benefits of the controlled substances he was prescribing her, conduct

periodic reviews, appropriately consult with D, and maintain accurate and adequate medical records.

Dr. Verdolin concluded that respondent committed an extreme departure from the standard of care when he failed to have D undergo a UDT or conduct a pill count after she repeatedly failed to comply with the pain agreement. Although he identified the level of departure as extreme in his report, respondent is charged with a simple departure in the amended accusation regarding this conduct. As such, his opinion is only considered in terms of assessing respondent's conduct as a simple departure to the extent a departure from the standard of care is found.

Dr. Verdolin further concluded that respondent committed a simple departure from the standard of care when he failed to consider D for a psychiatric consultation. Respondent's expert, Dr. Polston, agreed with Dr. Verdolin on this point.

Dr. Verdolin's Assessment of Respondent's Care and Treatment of Patient E

62 Regarding respondent's care and treatment of Patient E, Dr. Verdolin identified the following issues:

Were the 2007 prescribing guidelines as promulgated by the Medical Board of California for controlled substances followed including: good faith physical examination, prevention of diversion, assessment of benefit and adjust treatment according to risk and harm, informed consent of the patient, periodic review, appropriate consultations, and adequate record keeping?

When the patient was found to have an alcoholic decompensation was there any attempt to modify therapy or obtain subspecialist consultation?

Were the standards of care regarding co-administration of multiple negatively interacting medications with Methadone, which have the absolute potential to cause sudden cardiac death, ever taken into consideration or addressed with the patient?

Dr. Verdolin articulated the same standards of care he identified regarding his evaluation of Patient D with respect to the first two issues. With respect to the third issue Dr. Verdolin identified the standard of care as follows:

Potential fatal interactions between methadone and multiple drug classes have been known for decades. There are three major interactions to be concerned with: 1) interaction with cytochrome P450.[36] Any drug that interferes with the basic liver metabolic function has the potential to prolong the respiratory depressant effects of methadone; 2) interaction and prolongation of the QT interval[37]; co-administration of methadone with several drugs, including Selective Serotonin Reuptake Inhibitors (SSRIs), place the patient at risk for sudden cardiac risk and as a result, since 2003 and formalized by 2009, the recommendation for an electrocardiogram (EKG) prior to and/or continuing during methadone treatment has been made, such that complete and total avoidance of SSRIs (like Lexapro) is a guideline recommendation; 3) interaction and potentiation of respiratory depressant effects with co-administration of benzodiazepines (like Xanax) and abuse of alcohol must be avoided with methadone. The guidelines state: "Before starting methadone, take a patient history for syncope, seizures and cardiac conditions. Take a family history of cardiac conduction defects or sudden death. Withhold methadone if a strong history is present. Perform a physical

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[36] Dr. Verdolin did not define this medical term.

[37] Dr. Verdolin also did not define this medical term.

and look for cardiac arrhythmia, severe atherosclerosis, or abnormal blood pressure. Withhold methadone if cardiovascular disease is clearly evident. Before starting methadone, determine if a patient is taking any of these agents which may interfere with CP450 activity, either stop these agents or withhold methadone: a) antidepressants (TCAs, SSRIs) b) antibiotics."

63. Based on the records he reviewed Dr. Verdolin formed the opinion that respondent committed a significant and extreme departure by prescribing medications to E in violation of the board's 2007 guidelines. He reached this conclusion because E had a history of alcohol abuse, with a relapse, and E's wife contacted respondent with significant concerns about E's behavior. Yet, despite such concerns and E's history, respondent did not refer E for psychiatric treatment.[38] Dr. Verdolin testified that after E's second hospitalization respondent should have tapered E's Methadone.

64. Dr. Verdolin explained in his report that respondent did not complete at any time a systematic history of E including follow through on potential cardiac disease. Respondent did not record vital signs during E's office visits, and he did not identify numerical ratings for E's pain. Respondent recorded multiple times that the "patient is happy with his pain program." As Dr. Verdolin put it in response to a cross-

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[38] Respondent's only reference to psychiatric treatment for E is found in a document from April 6, 2009, captioned "Primary Treating Physician's Progress Report." The purpose of this document is not clear except it appears to be related to some kind of civil action. Respondent documented the following in this note: "[E] is asking about a substitute for Wellbutrin and buspar. He is directed to a psychiatrist if he is to change his psych meds. He can get angry when he does not have good pain control."

examination question, respondent recorded the same physical exam results at every one of E's visits and gave E his medications. Respondent administered two co-acting opioids (Norco and Percocet) at the same time while he prescribed Xanax without psychiatric evaluation or reasoning. Respondent also administered to E three anti-depressants/anti-anxiety medications (Lexapro, Wellbutrin and Buspar) without psychiatric consultation or supervision. Respondent never referred E for follow-up imaging and procedural options such as injections. Despite a major deviation from the plan, which included an involuntary psychiatric hold and confiscation of E's firearms in December 2010, respondent did not change prescribing habits or obtain a subspecialty consultation. Respondent did not have E provide a pill count.

65. Dr. Verdolin stressed that the one and only time when E was required to submit to a UDT, the results were inconsistent because Percocet was not found in his system when it should have been. Oddly, on this one UDT that was administered to E, respondent did not have E tested for alcohol metabolites. In response to a question posed to him during cross-examination, Dr. Verdolin stated that it appeared that respondent was not looking for indications of alcohol abuse; considering E's history it was important that respondent look for such indications. In this context he also noted that taking E's vital signs was important.

66. Regarding the second issue, failing to refer E for a subspecialist psychiatric or behavioral health consultation, Dr. Verdolin found that respondent departed from this standard of care and this departure was extreme. In reaching this conclusion Dr. Verdolin found the following facts important: E was reported to have firearms, at the hospital E reported that he was drinking a liter and half of vodka, and E's wife reported to respondent that he was hallucinating.

Notwithstanding evidence that E had an ongoing alcohol abuse problem, respondent did not alter his treatment plan for E or suggest that E obtain treatment for detoxification.

Dr. Verdolin questioned the accuracy of respondent's written statement to the board's medical consultant that he "participated" in E's psychiatric treatment while E was at Palomar. (Exhibit 30.) Dr. Verdolin found no documentation in E's records that respondent participated in E's psychiatric treatment. Dr. Verdolin commented on respondent's written response to the board's medical consultant in which he acknowledged that he reviewed E's "full psychiatric report." Dr. Verdolin noted that the psychiatric report respondent was referring to was a Social Security Disability psychiatric report relating to E's application for Social Security Disability. According to this report, E stated he was not an "active" drinker, but he admitted he was an alcoholic. Regardless whether this was true, Dr. Verdolin believed that this information required respondent to have E formally evaluated for addiction, given other information in E's records and E's behavior.

67. With respect to the third issue he identified, prescribing certain medications with Methadone, Dr. Verdolin found that respondent departed from the standard of care he identified above, and this departure was extreme. Dr. Verdolin also stated that respondent displayed a lack of knowledge in prescribing Methadone to E without adequately assessing him.

Dr. Verdolin gave the following reasons for his conclusions on this issue: By 2007 it was well known to pain management specialists that methadone can cause sudden cardiac death, and this was of particular concern for patients with pre-existing cardiac arrhythmias or elevated blood pressure. Since at least 2008, there have been recommendations to provide a screening EKG and continue to do so periodically

during treatment. Respondent did not take E's vital signs, including E's blood pressure, and he did not order an EKG for E. In addition, he prescribed Xanax and Lexapro to E, both of which have contraindication warnings, while he prescribed Methadone to E. Respondent, further, did not document he discussed the risks and benefits for these particular medications with E. Also, as noted above, respondent did not document he referred E for any subspecialty psychiatric consultation.

In addition, respondent did not document in E's records that he considered that E, a known alcoholic, was using alcohol, the ultimate interacting chemical. Dr. Verdolin found it notable that E was hospitalized with respiratory depression while he was respondent's patient. Yet, based on the record, respondent did not consider the special circumstances regarding Methadone. Dr. Verdolin also found it notable that respondent's health plan, Anthem Blue Cross, sent warning letters to respondent regarding side effects and accepted standards of care. But it appeared to Dr. Verdolin that respondent merely checked the boxes on the forms and did not modify the prescriptions to E accordingly.

On cross-examination, Dr. Verdolin acknowledged that E reported he was seeing a marriage counselor and after his second hospitalization he was referred to an after-care program. These considerations did not change Dr. Verdolin's opinions.

Respondent's Testimony

68. Respondent obtained his medical degree from the University of Minnesota and has been practicing in the area of rehabilitation and pain management medicine since 1989. In 1989 Palomar Hospital recruited him to set up a rehabilitation program at that facility, and he set up his own practice in 1991. He has held staff privileges at Palomar for 30 years without restriction. Respondent has been board

certified in rehabilitation medicine since 1990, with subspecialties in neuromuscular, electrodiagnostic and pain medicine. Respondent passed the pain management boards in 2003. Respondent's testimony was supplemented by a declaration he signed dated May 22, 2018.

Over the years his practice evolved where he now treats patients with intractable pain where they need a "safe spot" to obtain pain management medications. Respondent regards himself as this safe spot. Respondent obtained board certification in his area for this reason. Respondent's practice grew from 20 patients to 200 patients seen on a weekly basis. He had to hire more people due to the "collapse of community in pain management." It is understood that respondent meant by his comment here that fewer doctors specialize now in pain management.

Respondent emphasized that the goal of pain management is the functionality of the pain management patient. He said that due to the opioid crisis he has had to be more vigilant in prescribing pain meds to patients to achieve this functionality. He noted that the Guidelines have changed since 2000. Now, due to these changes, he has to respect the "chemical boundaries," the risk versus the benefits of pain management. He discusses these risks versus benefits with patients at the first visit and he assesses realistic goals for the patients to improve their functionality. Respondent described this as a balance like an artistic balance, "more art than science," where he customizes the treatment for patients. Respondent analogized treatment of a pain management patient to treating "smoking" with efforts to titrate and or reduce the activity. Respondent emphasized that the most important factor to him is the patient doctor trust relationship. He listens to patients and makes unique connections to these patients. In this regard, he sees patients monthly to maintain this unique connection.

Respondent said that he has treated tens of thousands of patients and has discharged just a few for violations of their pain agreements. He is reluctant to terminate the patient doctor relationship and he keeps trying to observe and guide patients who are not compliant. Respondent believes his supervision of the patients is safer that the supervision provided by a family doctor. As he put it, he is concerned that another doctor would be less vigilant than he is in terms of supervising a pain management patient. Respondent expressed concern that pain patients may seek their pain relief elsewhere.

Respondent said that he does not use a pain scale. A pain scale would be like turning poetry into math. He looks at function, which he described as a rough approximation. He gave as examples a patient who said he or she walked his or her dog or attended church. Such descriptions mean more to him than a numerical pain evaluation. With this said, respondent stated that he now uses a numerical pain scale but he again stressed that it is more meaningful to identify functionality.

69. Respondent discussed his care and treatment of the five patients at issue in the second amended accusation.

Regarding Patient A, he first saw this patient in 2004. He described her as one of his most challenging patients, a "big challenge" as he described her treatment, but he said, despite the challenges he faced treating her, he would not give up on her and was intent on closely following her. He noted that A had cervical injury and fusion and other pain complaints. He was also concerned because she had a cancer diagnosis while under his care. Respondent said that the protocol for a patient with cancer changes where the doctor can use different medications. However, A's records do not document that A was diagnosed with cancer.

Respondent examined A's records and detailed his discussions with A, his rationale for continuing to prescribe pain medications to her, and his advisements to her to remain compliant with her pain agreements and to take pain medications only as prescribed. Respondent said he regularly discussed with her proper use of pain medicine, issued paper prescriptions to her, and limited the prescriptions to 30-day supplies. He told her that she needed to use just one pharmacy. He "severely counseled" her after she reported that her medication was stolen. He did not prescribe more medications to her after she reported her meds were stolen from her safe. Respondent said he set limits "all the time" and did not increase her Valium as one example. He took steps to limit her ability to obtain refills, and he did not refill her medications. Respondent said he started a medication tapering program, but he also noted that tapering A's medications was a "challenge" and "difficult." In response to a question on cross-examination, he said she was a "complicated patient," but it was his professional responsibility to not abandon her. Respondent did not, however, explain why A was a complicated, challenging and difficult patient. He said he discussed with her a consolidation program, but he said that this required her "buy in" and he has found that forced reductions are not successful. Respondent also said in this regard that as a general matter, patients are terrified when their meds are reduced because they fear their pain will return. He also noted that patients get angry when they do not get their medications. He said in general he advises patients to skip a dose. But respondent did not document in A's records that he advised A to skip a dose. Respondent noted he discussed with A possible dismissal from his treatment.

Regarding A's ER visits, respondent said that her visits to the ER were warranted and within the pain management agreements he required her to sign. Respondent stressed that he talked with ER doctors where she went for pain treatment.

Respondent also talked about his efforts to have her seek non-opioid therapies. Respondent said he tried to incorporate as many different modalities, including electrical stimulation, as possible to try to reduce her medications. He noted that she was seeing an acupuncturist. In his March 3, 2015, notes he recorded that respondent was seeing a psychiatrist.

Regarding the UDTs respondent had A submit to, respondent cited one occasion, on March 4, 2014, where he talked to her about UDT "test results."[39] Between 2010 and 2014, by his count he had A submit to 13 screens in an effort to monitor her compliance. He discounted the value of UDTs and noted that in 2010 it was not the standard of care to administer UDTs. He noted that the testing at the time was unreliable, and a "cup test" at the cost of six dollars could have false positive results. Respondent recognized that lab confirmation was more helpful. In 2010 to 2012, cup tests were available, but he used them only for laboratory confirmation. He stated he was not able to pay the cost of the confirmatory lab tests himself due to the cost, which can be up to $1,100.

At the same time, respondent noted that he sought to have Sharp Community Medical Group (SCMG) endorse and pay for UDTs before screens were required as

[39] According to this note, when respondent "challenged" her with her UDT test result, A told him that "she has been using her medication less often." This calls into question respondent's testimony that it was a challenge to have her reduce or taper her pain medications since A, by her own account, was apparently willing to take less pain meds.

matter of the standard of care. At the time, SCMG was not authorizing UDTs because SCMG did not believe they were medically necessary.

70. With respect to Patient B, respondent described her as a complex pain management patient due to the six caesareans she had and the abdominal and vaginal issues she was experiencing as a result.

Respondent addressed the lack of a pain management agreement. He was puzzled it was not in the file, and he noted that he referenced it in the January 2014 record where he indicated he "reviewed" the pain agreement with B.

Respondent disputed the contention that he prescribed B meds in greater than 30-day supplies as alleged in paragraph G (page 15) of the second amended accusation. He said he never wrote prescriptions for greater than 30-day supplies during a 10-month period in 2013, and was puzzled by the allegation. This period of time represents the start of B's treatment with respondent in February 2013 through December 2014. In only one sense respondent was correct: he did not prescribe pain meds to B in greater than 30-day supplies. But, he is fundamentally incorrect because B's appointments during this time with respondent were more frequent than 30 days apart, and as a result, B obtained greater than 30-day supplies of pain meds based on the timing of respondent's prescriptions and refills of these prescriptions. As detailed above, during this 10-month period, respondent issued 15 prescriptions for Hydrocodone-Acetaminophen 10/325, 12 prescriptions for MS Contin, and 10 prescriptions for Oxycodone. (Exhibit 13, AGO 9588-9590.) This means that respondent was giving B access to greater than 30-day supplies of meds during this 10-month time frame. A review of CURES at this time would have shown this.

In response to questions posed to him on cross-examination, respondent denied that he lost track of the 30-day supplies of pain prescriptions he issued to B. He blamed the pharmacy for "stacking up" B's pain meds. In response to another question posed to him on cross-examination, respondent acknowledged that he could have written prescriptions that stated when the fill dates were due.

Respondent also disputed the allegation that he violated the standard of care by prescribing B pain meds containing acetaminophen in doses greater than 4,000 mg per day. He specifically disagreed with the claim in the second amended accusation at sub-paragraph "H" at page 15 which alleges that between December 2013 through September 2014 respondent wrote prescriptions for meds containing acetaminophen with daily dosages of 4.6 grams (4,600 mg). He said that in fact during this time he was prescribing daily dosages of 2.6 grams. He added that in general he was providing B with a prescription for meds containing 325 mg of acetaminophen to be taken 6 times a day. This would amount to 1,950 mg of acetaminophen per day.

Also as discussed above, respondent's calculation here is incorrect because, according to CURES, B was able to *obtain* during this time *at least* 3,780 Hydrocodone-Acetaminophen 10/325 mg pills based on his prescriptions to her between December 2013 and September 2014. From December 27, 2013, through September 18, 2014, B took on average 14 Hydrocodone-Acetaminophen 10/325 mg pills per day, even taking into account meds that she claimed she had lost, by dividing the 3,780 pills B obtained during this time by the 265 days between December 2013 and September 2014. This amount is well in excess of the 4,000 mg limit of acetaminophen Dr. Kirpalani identified as safe to use.

With this noted, respondent questioned the 4,000 mg Dr. Kirpalani identified as the amount of acetaminophen a person can take safely daily. Respondent said that the

CDC reported in 2016 that 90 MED is the daily limit, which is 18 Hydrocodone-Acetaminophen 5/300 mg pills that may be prescribed safely. This may mean that 5,400 mg of acetaminophen (300 mg of acetaminophen multiplied by 18) is the safe daily amount an individual can take, according to respondent.

Respondent also disputed the allegation at paragraph I of the second amended accusation (page 16) that he did not document or discuss with B her aberrant behaviors. He cited two instances when he documented he discussed her behavior: he went over her CURES report with her to note he was tracking her medication use, and he documented the importance of safeguarding her medications.

71. With respect to Patient C, respondent stressed the nature of C's pain condition due to the amputation of his arm and reconstructive surgery he had.

Respondent stated that after August 2008, when C signed a pain management agreement, he discussed numerous times with C the risks and benefits of opioid use. As a "template" of these discussions regarding the risks of opioid use, respondent referenced his April 3, 2012, note, where he documented the following: "The importance of compliance with the agreed upon course of action was stressed and that noncompliance could lead to untoward health outcomes." He further cited instances in C's record where he noted he "counseled" C. However, respondent testified that he did not specifically identify "risks" as the subject of his discussions with C. He also stated he counseled C about his pain management agreement and advised C not to change his meds without authorization.

Respondent also disputed the contentions at paragraphs K and L of the second amended accusation. Paragraphs K and L (page 16) allege that in 2012 and 2013, respondent frequently prescribed C extra controlled substances and/or two short

acting Oxycodone prescriptions in the same months in March, April, May, June, September and October 2013 and during and approximate 10-month time frame he wrote prescriptions for more than a 30-day supply, "including extra prescriptions and refills." He said, with respect to the allegation in paragraph K, that he had a purpose for writing the prescriptions he wrote. Respondent added that his practice was not to prescribe greater than 30-day supplies of meds with certain exceptions. With respect to the allegation at paragraph K, respondent explained that he may have written the prescriptions for Dilaudid, a short acting medicine, as a bridge. He said that there were times mid-month that the medications needed to be adjusted due to the strength of the medications C obtained from the pharmacy. It is not clear from his testimony here what he means.

72. With respect to Patient D, respondent disagreed with the allegations in the amended accusation that he inappropriately prescribed pain meds to her despite her aberrant behavior, possible addiction to pain meds, and her non-compliance with her pain agreement. Respondent believed he appropriately prescribed pain meds to D and he emphasized that he referred her to physical therapy, reduced her meds and did not approve early refills. When he learned she was treating with another doctor he terminated the doctor patient relationship and wrote a letter to her in this regard.

Respondent explained that D was another "complicated" patient, but she showed no outward signs of addiction. Her mood and affect were appropriate, and she arrived on time for her appointments. He did not believe referral to a psychiatrist was needed. Because of his "battle" with the SCMG medical group regarding paying for the confirmatory labs, respondent did not have her submit to UDTs. However, based on D's records, there was nothing to indicate he asked SCMG to authorize UDTs for D. He did not do a "pill count" because he did not believe pills counts were valid or useful.

He explained he held this view because he did not want patients carrying around their meds, and patients can get meds from other persons. Respondent expressed concern that having patients bring their meds to the office would create "chain of custody" issues. Despite his belief that pills counts were not useful, respondent acknowledged that the pain agreement D signed allowed him to require D to bring all of her opioid and "adjunctive" medications in their original bottles upon his request.

With regard to his record keeping of D's care, respondent admitted his record keeping was "lacking," he did not document D's headaches specifically, the electronic records repopulated records from prior visits, and the plans and goals for D should have been better.

In response to questions on cross-examination, respondent acknowledged that he was concerned D was addicted to the pain meds he was prescribing, but despite this concern he authorized refills). In hindsight, respondent said he should have referred her to a psychiatrist. He noted that this was not the standard of care at the time. Later in his testimony, on cross-examination, he said he was perhaps "overcompassionate" in his decision making to authorize refills despite his concerns about D.

73. Regarding his care and treatment of Patient E, respondent stated that he "really had a connection" with E, and as an indication of this connection, respondent noted that E frequently brought his young son to his appointments with him because E wanted to be a good example to his son.

Respondent testified that E displayed no "outward signs" of alcohol abuse, was stable, wanted to work, and E reported that he was improving and experiencing less pain. He noted that the last time he saw E before his death, there were no issues

regarding his alertness or slurring of his speech. If E displayed such behaviors, respondent stated he would have recorded them. Respondent emphasized that E was "stable" on the program.

Respondent admitted that he did not refer E to an addiction specialist, he did not take E's vital signs, after E's second hospitalization for alcohol abuse he did not document any discussion with him inquiring of his alcohol use, and he never requested that E undergo an EKG. In hindsight, respondent said that he probably should have more aggressively involved himself with E's whole family, and in retrospect, he wished he had more meetings with E's wife to ensure he was taking his meds appropriately. In response to a question on cross-examination regarding whether he referred E to AA, he said it was his "understanding" that E was in AA, though he did not document that E was attending AA. He said he found a pain support group for E to attend and he "made some recommendations," though it was unclear what these recommendations were. Respondent testified that he told E that he should see a psychiatrist. However, he did not document that he referred E to a psychiatrist in E's medical records.

Respondent admitted his treatment of E fell below the standard of care and there are a number of things he would now do differently with respect to his treatment of E. He said that having E submit to UDTs would have been "reasonable," and taking E's vital signs would have allowed him to assess whether E was "hiding" his alcohol use. He also stated he would have had more detailed discussions with E regarding how E was taking his meds, like having him to recite "I know this is for. . ." and the times during the day E was taking his meds. Respondent commented that with patients in general if they are taking their meds correctly "they're going to come up with their schedule and say it straight away."

74. Since his treatment of the patients identified in this matter, respondent testified that he has made changes to his practice. He is now more vigilant and his record keeping has improved. He records the MEDs in every prescription and tries to limit MEDs to 90. He has a new more robust electronic medical recordkeeping (EMR) system that allows him to get UDTs paid for and is "more active" with CURES. He runs CURES reports monthly for his patients. Respondent now takes vital signs of each of his patients and purchased machines that take blood pressure, respiration and pulse readings, and a machine to record a patient's weight. He now records each patient's weight, blood pressure, and respiratory rates.

Respondent took and completed the University of California Physician Assessment and Clinical Education (PACE) program's medical record keeping course on January 13, 2017, and prescription practices course on April 26, 2017. Respondent said he found the PACE program beneficial and has employed a number of things he learned into his practice. To show how he has materially changed how he documents patient care, respondent submitted a template of a patient record which he created which contains areas to document a patient's vital signs, including blood pressure, pain level, history, and medications. (Exhibit KK.) It also contains templates for advising patients regarding the risks and benefits of prescribed medications. Respondent now regularly checks CURES reports for each patient. Respondent also provided other documents to show how he has changed his practice, including a detailed summary of improvements he has made (Exhibit LL), a Non-Opioid Pain Management Checklist (Exhibit MM), an Opioid Contract Violation Notice (Exhibit NN), a Brief Pain Inventory (Exhibit OO), an improved Pain Agreement (Exhibit PP), New Patient Medical History Checklist (Exhibit QQ), an Opioid Informed Consent document (Exhibit RR), and a document advising patients of opioid withdrawal symptoms (Exhibit SS).

Testimony of Respondent's Expert Gregory Polston, M.D.

75. Dr. Polston graduated from the University of Wisconsin Medical School in 1989 and completed an anesthesia residency at the Naval Medical Center in 1998 and a Pain Fellowship in 2001. Dr. Polston is currently a Clinical Professor of Anesthesia at UCSD Medical Center and the Clinical Director in Pain Medicine at the Veterans Administration San Diego Medical Center. He is a Diplomate of the American Board of Anesthesiology with an added qualification in pain management. Dr. Polston is a Fellow, Interventional Pain Physician, and he has sat on numerous professional committees. Dr. Polston is also the author of book chapters, articles and abstracts in the field of pain management. He has served and testified as a board expert.

Based on his review of each of the five patient records, and other relevant records, Dr. Polston initially found, as he stated in his report dated November 3, 2018, that respondent did not depart from any applicable standards of care with respect to the treatment of these five patients, Dr. Polston testified that respondent committed three simple departures from the standards of care, as detailed below. Aside from this testimony in these areas, his testimony is for the most part consistent with the conclusions in his report.

76. Regarding respondent's treatment of Patient A, Dr. Polston found the following:

With respect to the issue of respondent's monitoring of Patient A, Dr. Polston found it significant that A had a diagnosis of "bone cancer" and her headaches were related to a pituitary tumor, and as a result respondent appropriately monitored Patient A. Dr. Polston reasoned, as he detailed in his report, the cancer diagnosis made A's care more challenging, multiple specialists were treating her pain including a

neurosurgeon and a psychiatrist, and also because the Guidelines did not apply to A as a cancer patient.

Dr. Polston, however, conceded during his testimony that respondent did not confirm that A was diagnosed with cancer, respondent did not consult with any of A's doctors to ascertain whether she had cancer, and he should have done so. Further, A's record does not support the conclusion that A had cancer and was treated for cancer. In addition, a pathology report dated October 5, 2005, found that A had a "probably benign enchondroma," which Dr. Polston conceded was not a cancer diagnosis. (Exhibit 33.)

Dr. Polston, moreover, conceded that he did not know the specialties of any of other doctors who were prescribing opioids to A, as documented in CURES reports. Thus, his conclusion that A was seeing specialists appeared to be in error.

Saliently, when asked on cross-examination whether, in light of A's "significant aberrant behaviors" and the unsubstantiated cancer diagnosis, respondent complied with the standards of care applicable in November of 2014, Dr. Polston responded that respondent displayed "lack of knowledge" because he continued to prescribe controlled substances in the same amounts. When asked on redirect whether this represented a simple or extreme departure from the standard of care, Dr. Polston repeated that respondent's conduct represented a lack of knowledge.[40]

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[40] Dr. Polston here found that respondent's lack of knowledge constituted incompetency in the practice of medicine. Complainant alleged respondent was incompetent under the Ninth Cause for Discipline, but only with respect to Patient E.

Regarding respondent's prescription of over 4,000 mg of acetaminophen daily to A, Dr. Polston testified that respondent was not prescribing Patient A combination products for her to take in greater than 30-day supplies. In his report he explained that Dr. Kirpalani did not take into account the medications that A "reported" to have been lost or stolen, and the "daily doses that Dr. Kirpalani used in his report were higher than the *actual doses that the patient was taking.*" (Emphasis added.) Dr. Polston added that the Food and Drug Administration (FDA) did not limit the amount of acetaminophen in combination products until 2014. He did not, however, disagree that the standard of care requires a doctor to attempt to limit the amount of acetaminophen to 4,000 mg daily. Dr. Polston, further, offered, as a basis for his conclusion that respondent did not depart from the standard of care, that there was "not evidence that [A] had liver issues." He concluded that respondent did not depart from the standard of care in prescribing acetaminophen to A.

Concerning the third issue, respondent's informed consent of the risks and benefits and alternatives of the medications he was prescribing A, Dr. Polston concluded, based on the pain agreements A signed, and the record of his discussions with A, that he did not depart from the standard of care. In his report analyzing this issue, Dr. Polston emphasized that A had cancer and "this fact" is why respondent did not abandon A. He concluded that respondent did not depart from the standard of care on the informed consent issue. It is noted that even with this respondent continued A on the same medication regimen.

Complainant did not move to amend the second amended accusation to conform this evidence regarding respondent's treatment of Patient A to the pleading.

Concerning A's inconsistent urine screen results, Dr. Polston identified the standard of care as involving respondent's "interpretation" of the results and not, as Dr. Kirpalani identified the issue, as involving respondent's documentation of the results in A's notes and his continued prescription of the meds despite inconsistent results. Dr. Polston noted that respondent reviewed and notated A's lab report results and he "appropriately used the results in his clinical decision making," as he wrote in his report. His view here cannot be credited. Dr. Polston did not explain how respondent documented in A's notes he used the inconsistent results in his prescribing practices. Only once, on November 11, 2014, respondent did acknowledge an inconsistent result, which he described as "unacceptable" and advised Patient A of the possibility of "being discharged." Respondent said in this note that he counseled A about this result. Dr. Polston also questioned the validity of UDTs due to variations in patient metabolism rates.

Dr. Polston also discussed A's visits to the ER and addressed Dr. Kirpalani's concerns about it. He stressed that respondent had A sign a modified pain agreement in an effort to limit or control her ER visits and throughout this time respondent was monitoring A and appropriately counseling her.

77. With respect to Patient B, Dr. Polston reached the following conclusions:

Concerning respondent failure to adequately screened B at the first visit, Dr. Polston disagreed with Dr. Kirpalani that respondent departed from the standard of care. Dr. Polston stated that respondent reviewed B's Kaiser medical records, obtained a CURES report at her first visit, and reviewed records that showed that she was not a smoker and had "no history of alcohol." Dr. Polston also noted in his report that respondent commented on her psychological status and function in the physical exam he conducted.

Concerning the informed consent issue, Dr. Polston found that respondent appropriately advised B of the risks and benefits of taking the meds he was prescribing. For his conclusion on this point, Dr. Polston stated that respondent documented the importance of compliance with the program numerous times and on one occasion he advised B that noncompliance could lead to an "untoward" health outcome. Dr. Polston stated further that respondent met the 2007 Guidelines in place because these Guidelines did not require written consent.

With respect to the third issue, overprescribing of medications because B was able to obtain meds in greater than 30-day supplies during a ten-month period, Dr. Polston initially concluded, as he wrote in his report, that respondent did not depart from the standard of care because the individual prescriptions respondent wrote were not for more than 30-day supplies. However, Dr. Polston changed his view, somewhat, in his hearing testimony. He acknowledged that respondent wrote at least 14 Norco prescriptions for B during a ten-month period, including refills. (Exhibit 13.) He suggested however that B's pharmacist shared responsibility for the supply of Norco B was able to obtain.

With respect to the fourth issue Dr. Kirpalani identified, acetaminophen toxicity, Dr. Polston stated that respondent did not depart from the standard of care. He gave the following reasons for his conclusion: respondent was following B closely, B did not take all of the meds she was prescribed, respondent warned B on August 14, 2014, about taking too much acetaminophen where he recorded that "she is taught about her use of Tylenol," and the FDA did not require manufacturers to reduce the acetaminophen in combination products until 2014. Dr. Polston added that "generally" it was "easy" to go above the 4,000 mg threshold. He further commented that he was

not sure why liver enzymes go up, but he agreed that higher Tylenol levels worsen "the situation."

Regarding the fifth issue, respondent's monitoring of B, Dr. Polston disagreed with Dr. Kirpalani that respondent departed from the standard of care because respondent did not conduct periodic reviews, did not obtain regular CURES reports, did not have B submit to UDTs, did not document B's progress towards identified goals, and did not have B bring in her medications for respondent to conduct "pill counts." As the basis of his conclusion on this issue, Dr. Polston stated that UDTs were not required until the 2014 Guidelines. Later in his testimony, he conceded that the 2014 Guidelines did not represent a fixed start date where standards in the Guidelines became applicable because the pain management standards of care were evolving in light of the opioid prescription crisis before 2014. At the same time, Dr. Polston again questioned the value of UDTs because of the frequency of false positives. He stated that doctors were not required to use CURES until October 2018. Dr. Polston further testified that respondent adequately reviewed the medication program with B, he reviewed the results of the CURES report with her on one occasion, and documented he discussed with her the proper use of medications and safeguarding her medicines. He stated that the allegation at Paragraph I of the second amended accusation was not accurate because the record identified many examples where respondent reviewed B's medications and sought to reduce her dosages.

78. With respect to respondent's care of Patient C, Dr. Polston reached the following conclusions:

Concerning the first issue, as summarized in Paragraph J (page 16)[41] of the second amended accusation, Dr. Kirpalani's conclusion that respondent violated the standard of care because he only had C sign one pain agreement on August 8, 2008, and he had no additional discussions with him about the risks and benefits of opioid medications, Dr. Polston stated that respondent did not depart from the standard of care and in fact exceeded the standard of care because respondent was not required to have C sign a pain agreement at the time. As he put it in his testimony, the August 6, 2008 pain agreement C signed was a living document that advised C of the risks and benefits of opioid therapy and respondent was not required to have C sign two pain agreements. In addition, Dr. Polston stated that respondent met this standard when respondent went over the pain agreement with C on July 6, 2009, and also discussed the dosing schedule at this visit, and respondent "clearly discussed" "concerns" he had with C when they occurred during his treatment of C. Dr. Polston added that respondent stayed within the "Guidelines" framework by his advisements to C, specifically, his agreements' terms that allowed respondent the discretion to replace,

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[41] At the start of the hearing complainant withdrew the allegation at paragraph 57, subdivision (c), which alleged that respondent committed negligence when he allegedly failed to adequately screen C on August 8, 2008. Dr. Kirpalani characterized and numbered his summary of his analysis and conclusion on this issue as "Medical Issue #1: Screening." The informed consent issue is classified as "Medical Issue #2: Informed Consent" in his report and the remaining two issues are classified in sequence accordingly. It is noted here that the fourth issue Dr. Kirpalani identified in his report captioned "Medical Issue #4: Inconsistent urine drug test results" was not alleged in the second amended accusation.

taper or modify C's meds if they were reported as lost or stolen and the possibility of termination if C engaged in aberrant behaviors.

With respect to the third issue Dr. Polston addressed as identified by Dr. Kirpalani, respondent's over-prescription of pain meds to C, Dr. Polston found respondent did not deviate from the standard of care in terms prescribing C pain meds in greater than 30-day supplies. He reached this conclusion because, although C obtained more prescriptions during a 12-month period, Dr. Polston believed this was due to C's increased pain and the 30-day supplies he was receiving did not cover C's pain. Dr. Polston also found it important to note in assessing whether respondent departed from the standard of care that in May 2013 respondent increased C's Oxycodone dose but discontinued the OxyContin. As a result, C received a lower dose of the same medication.

79. With respect to Patient D, Dr. Polston reached the following conclusions:

Dr. Polston first found, consistent with the 2007 Guidelines, it was appropriate to treat D with pain medications even if she was addicted to the medications. Termination of the patient is not the first option he noted; it is the last option. In terms of his treatment and monitoring of D, Dr. Polston commented that respondent, by having D sign a pain agreement, exceeded the standard of care in place at the time. In addition, respondent documented her aberrant behavior and counseled her about it, though respondent did not expressly document that he counseled D regarding the risks and benefits of the medications. Dr. Polston stated that based on his interpretation of D's records it was clear to him that respondent counseled D in this regard. In support of this reading, he cited the October 14, 2010, note in which respondent recorded that he spent "[s]ignficant additional time" "going over the

expectations of her medications" and he "extensively counseled her "to keep to the medication program without fail."

Dr. Polston further opined that respondent was not required to have D undergo UDTs because this was not the standard at the time. Respondent was also not required to conduct a pill count of D's medications because in his view a pill count would not have shown anything because D said she ran out of medications.

Dr. Polston agreed with Dr. Verdolin in one respect concerning respondent's continued prescription of medications to D. Dr. Polston acknowledged in his testimony that respondent departed from the standard of care when he prescribed on May 12, 2011, an early refill of 60 pills of Alprazolam to D without seeing her. Dr. Polston testified respondent should have seen her before he issued this prescription. He stated that he believed the level of departure was simple and not extreme because respondent did not display a "wanton disregard of care" of D because he was at least in "some type of dialogue" with her and he documented his clinical reasoning. According to D's records, Dr. Polston's understanding here is not correct. In the May 12, 2011, note respondent did not explain his clinical reasoning for prescribing the Alprazolam and respondent was not in a dialogue with D around the time he issued the prescription. Dr. Polston added for his conclusion that the departure was simple and not extreme because respondent reviewed CURES. Dr. Polston's understanding here is also incorrect. Respondent did not review D's CURES profile on May 12, 2012. He ran a CURES report over five months later on D on October 25, 2012, the day he discharged her from his care.

With regard to other issues Dr. Verdolin identified, Dr. Polston also agreed with Dr. Verdolin that respondent committed a simple departure from the standard of care

when he failed to refer D to some sort of behavioral health professional in light of her aberrant behaviors.

80. With regards to Patient E, Dr. Polston reached the following conclusions:

Regarding the first issue, as Dr. Verdolin enumerated it, respondent's failure to follow the 2007 Guidelines, Dr. Polston found no departure from the standard of care. He concluded, based on his review of the record, that respondent performed physical exams, had clear "indications," as Dr. Polston wrote in his report, for the use of controlled substances and appropriately reviewed E's plan, respondent was aware of his history of alcohol abuse, and during his care and treatment of E, E presented appropriately without any signs he was using or abusing alcohol. Dr. Polston noted that respondent documented E was "stable" on the program, and as an indication of his functioning level, E was trying to give up smoking. Dr. Polston also found it significant that respondent referred E to physical therapy and provided E's primary doctor with his notes to ensure coordination of care. Although he did not use a numeric scale to assess E's pain, according to Dr. Polston, respondent adequately assessed E's pain level because he asked E qualitative questions about his pain and function. Based on his interpretation of E's record, Dr. Polston stated that respondent discussed the risks and benefits of using controlled substances on a regular basis. Dr. Polston further stated that respondent's records were adequate and accurate.

Notwithstanding this, Dr. Polston testified that it was "wrong" that respondent did not take E's vital signs. At the same time, he said that talking to E was sufficient if there was any concern. He noted that E was able to speak in full sentences and able to walk into exam room. It is noted, here, that respondent did not document that E spoke in complete sentences or that he walked into the exam room without any difficulty.

Dr. Polston emphasized in his testimony that respondent "enlisted" E's wife to participate in his care. His wife went with E to his November 12, 2009, visit with respondent shortly after his October 2009 hospitalization. At this visit E mentioned that he was considering attending AA and a support group to manage pain. It is noted that respondent did not document after this visit whether E in fact attended AA or any support group. Aside from this visit, respondent did not document he had any additional discussions with E's wife.[42]

Regarding the second issue, respondent's failure to refer E to a behavioral health specialist, Dr. Polston found no departure from the standard of care. He reached this conclusion because respondent followed E's hospital care, E's wife was "actively" involved in his care and E was "back in AA," as Dr. Polston wrote in his report, and E had not been drinking for 13 years. In his hearing testimony he added that he assumed E was in an aftercare psychiatric program after his release from the hospital. Dr. Polston's understandings here are not supported by the record. First, as noted, it cannot be found that E's wife was "actively" involved in E's care. Except for attending one office visit with E, respondent did not document that she was involved in E's pain management care. Second, E never reported he was in AA; he said he was considering AA and respondent never asked him whether he was in AA or any group therapy. Additionally, the record does not indicate that respondent was involved, or participated, in E's behavioral health care during his hospital admission or afterwards,

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[42] At the hearing, Dr. Polston emphasized several times E's wife's inclusion in respondent's treatment of E. But E's wife was involved with E's care on a limited basis, and as a factor in and of itself, her involvement has limited value in assessing the quality of respondent's care and treatment of E.

and E's records do not include records from his Palomar hospital admission. In fact, according to E's Palomar Hospital records, E mentioned respondent in the context of his discharge plan, and he was going to continue to see him for pain management. (Exhibit E, MCER 0073.) The Palomar hospital record does not indicate whether E in fact participated in an aftercare behavioral health program. Finally, contrary to Dr. Polston's understanding, E was not abstinent from alcohol for 13 years. E's wife reported that he had been drinking before he was involuntarily admitted on the 5150 hold in December 2010.

Regarding the third issue Dr. Verdolin identified, respondent's co-administration of methadone with other medications, failure to have E submit to an EKG or take his blood pressure, and failure to inquire regarding E's use of alcohol, Dr. Polston did not find that respondent departed from the standard of care or displayed a lack of knowledge. He found the following factors significant to his conclusion: the methadone dose E was taking was below the 100 mg level threshold level the 2009 methadone guidelines provided and was, thus, a safe threshold level for E to take even with the other medications he was taking, and there was no indication that E had any significant cardiac events. In his report, Dr. Polston noted that the Medical Examiner found that E did not have significant cardiac disease. He also noted that the Medical Examiner found that E appeared to have been taking Methadone in prescribed dosages.

In response to questions on cross-examination, Dr. Polston acknowledged that respondent did not document whether E was drinking. He, however, suggested that respondent documented he discussed E's alcohol use with E in his January 11, 2011, note when he went over respondent's Palomar hospitalization, though respondent did

not expressly state that he discussed E's alcohol use with him. Respondent advised E of the importance of abstinence from alcohol and using his medications as prescribed.

Evaluation of Expert Testimony and Evidence

81. In resolving the conflicts in the expert testimony in this matter, Drs. Kirpalani's and Verdolin's opinions are weighed against Dr. Polston's opinions. In making this assessment, consideration has been given to the qualifications and credibility of the experts, the reasons for their opinions, and the factual bases of their opinions. California courts have repeatedly underscored that an expert's opinion is only as good as the facts and reasons upon which that opinion is based. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 924.)

With certain exceptions discussed below, the testimony of Drs. Kirpalani and Verdolin are accepted over's Dr. Polston' testimony. Their testimony was more persuasive than Dr. Polston's testimony, and the factual bases for their opinions were more consistent with the record as a whole.

In conducting this evaluation only evidence within the seven-year statute of limitations has been considered. For Patients A, B and C this time period is on or after October 5, 2010. For Patients D and E this is time period is on after March 21, 2011. References to dates before these dates are only considered as background.

FIRST CAUSE FOR DISCIPLINE REGARDING PATIENT A

82. The second amended accusation identifies five areas where respondent is alleged to have committed gross negligence in his care and treatment of A, under Paragraph 54, subparagraphs A through E.

Subparagraph A alleges that between 2011 and 2014 respondent continued to prescribe high dose opioids while Patient A reported lack of analgesia and continued chronic pain, and decreased function, and she displayed aberrant behaviors. Respondent's conduct in continuing to prescribe high dose opioids in Dr. Kirpalani's opinion amounted to a failure to adequately monitor A. Dr. Polston relied for his conclusion that respondent did not depart from the standard of care here, as he wrote in his report, on the belief that A had bone cancer and respondent was thus not bound to follow the Guidelines in prescribing high dose opioids to a cancer patient. However, it is clear that respondent was not treating A with high dose opioids because he believed she had cancer. Respondent did not confirm with any doctor that A had cancer, and/or she was treating for cancer, and respondent never recorded in A's records that he assessed A as having cancer and being in treatment for this condition. Thus, Dr. Polston's opinion here is not credited. In contrast, Dr. Kirpalani's opinion is well-supported by the facts in the record. Respondent continued to prescribe A with high dose opioids despite the fact that she continued to experience chronic pain, the medications were not effective in treating her pain, and she displayed aberrant behaviors.

Subparagraphs B and C allege that between December 2011 to early 2013 respondent prescribed medications with acetaminophen containing doses of acetaminophen greater than the 4,000 mg amount that a person can safely take daily. Dr. Kirpalani found that this amount of acetaminophen placed A at risk of liver damage, and it exceeded the 4,000 mg daily threshold dose. Dr. Polston asserted that respondent did not issue prescriptions to A of medications containing acetaminophen that exceeded the 4,000 mg threshold. But Dr. Polston failed to consider that A was able to *obtain* medications with acetaminophen that exceeded the 4,000 mg threshold

based on his prescriptions between December 2011 and November 2012. Dr. Kirpalani's opinion here is fully credited.

Subparagraphs D and E allege that respondent committed gross negligence because he "continued" to prescribe Patient A controlled medications despite A's repeated violations of the pain agreement. Dr. Kirpalani stated that respondent departed from the standard of care because he prescribed these meds to her despite her repeated ER visits and inconsistent urine screens. Dr. Polston disagreed with the conclusion that respondent failed to appropriately monitor A and he agreed with respondent's decision to continue treating A. As Dr. Polston put it, discharge of a pain management patient is a last option. Further, respondent was aware of A's ER visits, and respondent took reasonable steps to monitor A. Notably, he modified the pain agreement to allow A to visit the ER once a month to deal with breakthrough pain, documented that he was taking steps to have A comply with the pain agreement, monitored her and counseled her regarding compliance. Respondent's testimony that he did not want to give up on the patient was credible. For these reasons, accordingly, Dr. Polston's opinion here is credited over Kirpalani's opinion. respondent acted reasonably in continuing to prescribe A controlled medications in light of her violations of the pain agreement and inconsistent urine screens.

FIRST CAUSE FOR DISCIPLINE REGARDING PATIENT B

83. Subparagraph F of the second amended accusation alleges that respondent committed gross negligence because he failed to discuss the risks and benefits of the use of controlled substances and/or enter into a pain agreement with B. Dr. Kirpalani found that respondent's conduct here constituted an extreme departure from the standard of care. Dr. Polston believed that respondent adequately documented that he discussed the risks and benefits of her use of controlled

substances. His opinion here is not credited over Dr. Kirpalani's opinion for this reason: Dr. Polston's reading of respondent's documentation was more an exercise of advocacy than a dispassionate review. He read respondent's November 13, 2013, note that "non-compliance could lead to untoward health outcomes" as meeting the informed consent standard. However, "Untoward health outcomes" due to "noncompliance" can mean a lot of things. Similarly, he found that respondent's documentation regarding B's need for compliance with the program, which he documented elsewhere in B's records, met the informed consent standard. Also contrary to Dr. Polston's interpretation, the language "noncompliance with the program" does not lead to the conclusion that respondent advised B of the risks and benefits of the medications he was prescribing her. Regarding the lack of a pain agreement, respondent stated that he believed there was a pain agreement in place that was not included in B's records. He noted that B's records indicate that he reviewed the pain agreement with her on January 7, 2014. However, his belief that B signed a pain agreement does not prove that B in fact signed pain agreement.

Subparagraph G alleges that during a 10-month period in 2013 respondent frequently prescribed to B more than 30-day supplies of controlled substances. Dr. Kirpalani testified this departure was extreme. His opinion on this issue was well supported factually in the record. (Exhibit 13.) In defense of respondent on this point, Dr. Polston asserted that respondent was not issuing B individual prescriptions in greater than 30-day supplies, but he conceded that B in was able to obtain prescriptions in greater than 30-day supplies.

Subparagraph H alleges that between December 2013 and September 2014 respondent wrote prescriptions for medications containing daily average acetaminophen doses of 4,600 mg. Dr. Kirpalani concluded that respondent's

departure was extreme. Dr. Polston did not materially dispute Dr. Kirpalani's testimony in this regard, and Dr. Kirpalani's opinion is fully credited. In his assessment of this issue, Dr. Polston stated that respondent was closely following B, he counseled her regarding Tylenol usage, and the FDA did not require manufacturers limit the amount of acetaminophen until 2014. However, Dr. Polston did not dispute that the safe daily dose of acetaminophen was 4,000 mg.

Subparagraph I alleges that respondent continued to prescribe controlled substances to B despite her aberrant behavior with "no discussion and/or documentation of discussions" with B about these behaviors. These behaviors included multiple requests for early refills and prescriptions at different pharmacies in less than 30-day intervals. Dr. Kirpalani framed the issue differently than the summary at subparagraph I. He characterized respondent's violation as a failure to adequately monitor B because respondent did not conduct periodic reviews, did not obtain regular CURES reports, did not have B submit to UDTs until February 23, 2015, did not document B's progress towards identified goals, and did not have B bring in her medications for respondent to conduct "pill counts."

Dr. Polston disagreed with Dr. Kirpalani's conclusion based on respondent's documentation in B's record. He stated that respondent reviewed the results of the CURES report with her on one occasion, and recorded he discussed the proper use of medications and safeguarding her medicines with her. He stated respondent reviewed B's medications and sought to reduce her dosages many times. He also asserted that the Guidelines did not require UDTs until November 2014, though he recognized that the standards were evolving before that date. At any rate, he questioned the value of UDTs to monitor compliance.

Dr. Polston's opinion here is credited over Dr. Kirpalani's for these reasons. First, Dr. Polston's testimony that respondent discussed with B her compliance with her medication program is supported in B's records, which document that respondent reviewed her "compliance" with the program, reviewed her program, and discussed with her safeguarding her medications. It is reasonable to find that respondent had these discussions with B because he was concerned about her aberrant behavior, contrary to the allegation in the subparagraph. Second, and more fundamentally, and again contrary to the allegation at subparagraph I, Dr. Kirpalani did not conclude that respondent violated the standard of care *because* he did not have "discussions" with her about her aberrant behavior, but because respondent did not adequately monitor her use of controlled medications. Thus, Dr. Kirpalani's opinion did not support the allegation at subparagraph I and, as such, is not a basis to find that respondent departed from any applicable standard of care.

FIRST CAUSE FOR DISCIPLINE REGARDING PATIENT C

84. Subparagraph J alleges that after C signed a pain agreement on August 6, 2008, C signed no additional pain agreements and respondent had no additional discussions with C regarding the risks and benefits of opioid meds. Dr. Kirpalani found that this conduct was an extreme departure from the standard of care. Dr. Polston disagreed with Dr. Kirpalani's opinion. He stated that respondent was not required to have two pain agreements and the August 6, 2008, pain agreement detailed the risks and benefits of opioid therapy in clause 14 and respondent counseled C to use medications as prescribed. He described the pain agreement C signed as a "living" document. As an example of this, on October 27, 2010, respondent counseled C about his medication use and in doing so referred C to his pain management agreement.

Dr. Polston's testimony on this issue is accepted over Dr. Kirpalani's opinion for these reasons: The standard of care Dr. Kirpalani identified does not identify the duration of any pain agreement and/or the frequency with which a pain management doctor must advise a patient of the risks of taking opioids after the patient signs a pain agreement. Also, the August 6, 2008, pain agreement that C signed contained specific advisements regarding the risks and benefits of opioid use.

Subparagraphs K and L allege that respondent frequently prescribed extra controlled substances to C and/or prescribed short acting Oxycodone prescriptions twice a month in March, April May, June, September and October 2013 and wrote prescriptions in greater than 30-day supplies. Dr. Kirpalani found that this conduct violated the standard of care and was an extreme departure. Dr. Polston stated that he did not believe respondent violated the standard of care because a pain management doctor may write additional prescriptions if medical necessity requires him or her to do so and respondent did not write individual prescriptions in supplies greater than 30 days.

Dr. Kirpalani's opinion is accepted over Dr. Polston's opinion on this issue. The record details that repeatedly respondent violated the standard of care by prescribing controlled high dose opioids to C in greater than 30-day supplies as follows: In 2012, 14 prescriptions of 90 pills of OxyContin 80 mg; in 2012, 14 prescriptions of 360 pills of Oxycodone 30 mg; in 2012, 14 prescriptions of Hydromorphone 8 mg (8 prescriptions for 120 pills 5 for 90 pills and 1 for 30 pills); and in 2013, 20 prescriptions of short acting Oxycodone (15 mg. or 30 mg. tablets). Also, in March, April, May, June, September, and October of 2013, C was able to fill two prescriptions of short acting Oxycodone each of these months based on respondent's prescriptions. According to the CURES report, in March 2013 C filled prescriptions for 360 pills of

Oxycodone on March 13 and 22, 2013, April 10 and 18, 2013, May 8 and 30, 2013, June 13 and 27, 2013, September 16 and 30, 2013, and October 12 and 26, 2013. In C's records, respondent did not adequately document why he believed C required this amount of opioid medications.

FIRST CAUSE FOR DISCIPLINE REGARDING PATIENT D

85. Subparagraph M alleges that between March 20, 2011, and October 25, 2011, respondent continued to prescribe to Patient D despite her repeated aberrant behaviors, possible addiction and noncompliance with her pain agreement. Dr. Verdolin concluded that respondent's conduct violated the standard of care and was an extreme departure from this standard. In reaching this conclusion, Dr. Verdolin found that respondent failed to perform a good faith physical examination of D, take steps to ensure against diversion of controlled substances, assess the benefits of the controlled substances respondent was prescribing her, adjust treatment according to risk and harm, obtain D's informed consent regarding the risks and benefits of the controlled substances he was prescribing her, conduct periodic reviews, appropriately consult with D, and maintain accurate and adequate medical records. Except with regards to one prescription respondent wrote, Dr. Polston disagreed with Dr. Verdolin's conclusions. He stated, based on his reading of the record, respondent counseled D appropriately and cited one note where he spent "significant" time counseling her regarding her medication usage. Dr. Polston also did not agree that respondent was required to have D submit to UDTs or have a "pill count" done.

With this noted, Dr. Polston agreed that respondent departed from the standard of care when he issued a prescription for Alprazolam on May 12, 2011, without seeing D and without documenting the reason he issued the prescription. Dr.

Polston believed however that the departure was not extreme but was a simple departure from the standard of care.

Dr. Verdolin's testimony is credited over Dr. Polston's on this issue. In contrast to Dr. Polston's testimony, Dr. Verdolin's opinion was well-supported in the record, including respondent's testimony, and was clear on this issue. In sum, the record documents that respondent did not adequately monitor his treatment and care of D. Such monitoring may have included use of UDTs, limited "cup" screens at his office, or the effort to obtain pills counts given D's notable aberrant behaviors and the possibility that she suffered from a substance abuse disorder.[43] He further failed to document the reasons he was prescribing her controlled medications. Notably, respondent did not document why he prescribed 60 pills of Xanax (Alprazolam) to D on July 28, 2010, and why he issued a prescription for this medication on May 12, 2011, soon after he provided her with a prescription for 60 pills of Ativan with three refills on April 21, 2011. Respondent did not document that he advised D of the risks and benefits of using these benzodiazepines in combination with the opioids and Soma he was prescribing her.

Dr. Polston's opinion that respondent's prescription of Alprazolam on May 12, 2011, represented a simple departure from the standard of care is given less weight

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[43] Dr. Polston testified that he did not believe that D suffered from a substance abuse disorder under the factors in the Diagnostic and Statistical Manual of Mental Disorders ("DSM") IV and/or V. This is an academic point because respondent never documented he considered whether she had a substance abuse disorder. At any rate, Dr. Polston admitted that respondent departed from the standard of care by not referring D to a behavioral health specialist as alleged in Paragraph 57, subdivision (D).

than Dr. Verdolin's opinion for these reasons: D reported that she was stopped and possibly arrested for being under the influence of medications and child endangerment and soon after she reported this, on April 21, 2011, respondent provided her with a prescription for 60 pills of Alprazolam with three refills. Considering the risks posed by the quantity of benzodiazepines she was taking in combination with the opioids and Soma medication she was taking the departure is properly classified as an "extreme departure." (See *Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052, for discussion regarding "extreme departure" and "want of care.")

FIRST CAUSE FOR DISCIPLINE REGARDING PATIENT E

86. Subparagraph N alleges that between February 12, 2009, and January 31, 2012, respondent continued to prescribe E controlled medications without taking a systematic and thorough history including vitals, without periodically reviewing and documenting efficacy of treatment, without regularly assessing for possible diversion, and without discussing the risks, benefits, and alternatives of pharmacological treatment.[44]

Dr. Verdolin testified that respondent's conduct in this regard represented an extreme departure from the standard of care. He described respondent's problematic conduct as follows: despite E having a history of alcohol abuse with two hospitalizations related to abuse of alcohol and substance abuse respondent did not

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[44] Only the period of time within the seven-year statute of limitations is considered for evaluating whether respondent committed any violations of the Medical Practice Act.

complete a systematic history of E that included an assessment or referral for potential cardiac disease. Respondent also did not record vital signs, including E's blood pressure, weight and respiratory rates, during E's office visits with respondent and he did not identify numerical ratings for E's pain. Respondent recorded that E was "happy" with his pain program, and respondent recorded the same physical exam results at every one of E's visits and simply gave E his medications. Further, respondent administered two co-acting opioids, Norco and Percocet, at the same time while he prescribed Xanax without a psychiatric evaluation or any reasoning. Respondent also administered to E three anti-depressants/anti-anxiety medications (Lexapro, Wellbutrin and Buspar) again without psychiatric consultation or supervision. In addition, respondent only had E undergo one UDT, which oddly did not include a request to screen for alcohol, and he did not require him to provide a pill count.

Dr. Polston found no departure from the standard of care. However, he admitted that it was "wrong" for respondent not to have taken E's vital signs. At the same time, Dr. Polston found that because respondent talked to E, and E was able to speak in complete sentences and was able to walk into the exam room, concerns of about E's alcohol use were adequately addressed.

Dr. Verdolin's opinion here is given greater weight than Dr. Polston's opinion. Dr. Verdolin's testimony was based on facts in the record while Dr. Polston's testimony is fairly termed more as advocacy than dispassionate analysis. His advocacy is apparent in his discussion regarding respondent's failure to take E's vital signs where he admitted it was wrong for E not to take E's vital signs, but because E, apparently, was able to talk in full sentences and walked into the exam room respondent was somehow able to assess his condition. But the medical records do not support Dr.

Polston's assumptions because respondent did not note E's abilities to speak and walk in the records.

Subparagraph O alleges that between February 12, 2009, and January 31, 2012, despite two hospitalizations, respondent failed to refer E for behavioral management, psychiatry, or addiction treatment, and continued to prescribe to E.

Dr. Verdolin testified that respondent violated the standard of care and he considered the level of departure as extreme. Dr. Verdolin found the following facts significant in his assessment: E was reported to have firearms, at the hospital he reported that he was drinking a liter and half of vodka, and E's wife reported to respondent that he was hallucinating.

Dr. Polston testified that respondent did not violate the standard of care. In reaching this conclusion he considered these factors significant: respondent followed E's Palomar hospital care, E's wife was "actively" involved in his care and E was "back in AA," as Dr. Polston stated in his report. He noted that E had not been drinking for 13 years. Dr. Polston also assumed E was in an aftercare psychiatric program after his release from the hospital.

Dr. Verdolin's testimony here is accepted over Dr. Polston's because his opinion is well-supported in the record and Dr. Polston's is not. Contrary to Dr. Polston's understandings regarding factors he found important in his assessment of this issue, respondent's wife was not documented to have been actively involved in E's care with respondent, respondent did not participate in E's care at Palomar, and also, E was not in AA or receiving behavioral health aftercare.

Subparagraph P alleges that between February 12, 2009, and January 31, 2012, respondent regularly prescribed Methadone to a known alcoholic, in addition to

multiple other contraindicated medications known for causing sudden death, and never ordered an EKG or took E's vital signs. Here, only respondent's conduct within the seven-year period under the statute of limitations is considered.

In reaching this conclusion, Dr. Verdolin stated that by 2007 pain management specialists knew that methadone can cause sudden cardiac death, and this was of particular concern for patients with pre-existing cardiac arrhythmias or elevated blood pressure. Since at least 2008, a screening EKG and periodic EKGs were recommended during treatment. Respondent did not take E's blood pressure, or any of E's vital signs, and he did not order an EKG for E. In addition, he prescribed to E Xanax and Lexapro, both of which have contraindication warnings, while he prescribed Methadone to E. Respondent, further, did not document that he discussed with E the risks and benefits for these medications. In addition, respondent did not document in E's records that he considered whether E, a known alcoholic, was using alcohol, the "ultimate" interacting chemical. Dr. Verdolin found it notable that E was hospitalized with respiratory depression while he was respondent's patient. He assessed the level of departure as extreme and also as a lack of knowledge.

Dr. Polston concluded that respondent did not violate the standard of care because he was prescribing E a safe dosage of Methadone and E displayed no signs of cardiac disease. He further concluded that E did not display a lack of knowledge by prescribing Methadone to E, as Dr. Verdolin asserted.

Dr. Verdolin's opinion on this issue is found more persuasive than Dr. Polston's for these reasons. Dr. Verdolin's opinion is fully supported in the record and Dr. Polston appeared to discount E's problematic alcohol and substance abuse history. This history is as follows: After a prescription drug overdose in October 2009, E was on a ventilator for five days and in December 2010, he was hospitalized due to his abuse

of alcohol and, possibly, his abuse of opiates, as his wife believed. After this second hospitalization, respondent did not document that he asked E about his alcohol use, took his blood pressure, or ordered an EKG, and did not have him submit to a UDT to test for alcohol or possible abuse of his medications. He did not return E's wife call to him on December 7, 2010, after she left a message that she wanted him to know certain things about her husband. In his testimony, Dr. Polston appeared to believe the risk of sudden cardiac death posed by E's Methadone prescription was limited, if nonexistent, because the prescribed dose was below 100 mg daily threshold. Nonetheless, it is reasonable to conclude that there was a risk in E's Methadone usage in combination with the other medications respondent prescribed E and the possibility that E may abuse alcohol, which given his history was real possibility. The fact that E died from a combination of the effects of "alcohol, methadone, oxycodone, hydrocodone, alprazolam, bupropion, and citalopram" (Exhibit 28 AGO 9046) is proof of this risk.[45]

By his testimony, Dr. Polston appeared to ignore an important purpose of respondent's care of E: In exercising his clinical judgment he had a duty to address *risk*, by taking E's vitals, asking him specifically about his alcohol use, and requiring him to submit to UDTs. These tools were available to respondent as a pain

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[45] E was not taking the medications in dosages respondent prescribed E. The Medical Examiner noted the following in his autopsy report: E's "pills counts were consistent with some overuse of alprazolam. . ." This is mentioned because it highlights the inherent risk to E in the medications respondent was prescribing him in combination with his use of alcohol.

management specialist to assess the risk to E posed by the opioid meds and benzodiazepines respondent was prescribing E.

SECOND CAUSE FOR DISCIPLINE (REPEATED NEGLIGENT ACTS) REGARDING PATIENTS A, B, C AND D[46]

87. Paragraph 55 alleges that respondent committed repeated negligent acts in his care of "Patients A, B. C, and D". Paragraph 56 incorporates the gross negligence allegations at paragraph 54, subparagraphs A through P. To the extent, as found immediately above that respondent is found to have committed extreme departures from applicable standards of care he is also found to have committed repeated negligent acts regarding his care and treatment of Patients A, B, C and D. This cause for discipline also alleges more specific allegations regarding Patients B and D. Paragraph 57, subdivision (b), that respondent departed from standard of care on February 27, 2013, when he performed an initial history and physical examination of Patient B that lacked an appraisal of prior non-opioid treatments for chronic pain, and/or assessment of psychological and/or addiction risk and a baseline urine drug screen. Dr. Kirpalani concluded that respondent conduct represented a simple departure from the standard of care. Dr. Polston disagreed and concluded that respondent adequately assessed Patient B because he reviewed B's Kaiser records and in his physical examination of B he commented on B's psychological status. Dr. Kirpalani's opinion here is accepted over Dr. Polston's. Respondent did not document that he inquired of B's prior non-opioid treatment and did not conduct an assessment

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[46] The Second Amended Accusation states that respondent committed repeated negligent acts regarding Patients A.,B, C and D but not E although Paragraph 55 incorporates allegations of gross negligence in respondent's treatment of Patient E.

of B's addiction risk. His psychological assessment of B was limited, and his documentation was boilerplate language. Respondent did not require B to submit to a UDT.

Paragraph 57, subdivision (d), alleges that respondent departed from the standard of care because between March 22, 2011, and October 25, 2011, respondent failed to consider a referral for a psychiatry consultation for addiction despite the fact that D displayed aberrant behaviors, possible addiction, and non-compliance with her pain agreement.[47] Dr. Verdolin determined that respondent committed a simple departure from the standard of care and Dr. Polston agreed that respondent's failure to refer D to "some form of behavioral health" was a departure from the standard of care considering D might have been addicted to her medications was "appropriate."

Paragraph 57, subdivision (e), alleges that between March 22, 2011, and October 25, 2011, respondent failed to obtain a urine drug screen on Patient D and failed to conduct a pill count despite the fact that D displayed aberrant behaviors, possible addiction, and noncompliance with her pain agreement. As he wrote in his report, Dr. Verdolin concluded that respondent committed an extreme departure from the standard of care for failing to take these steps but, as noted earlier, respondent is only charged with a simple departure in the amended accusation regarding this conduct. Thus, his opinion is considered only as a simple departure from the standard of care for purposes of this decision. At any rate, Dr. Polston disputed Dr. Verdolin's opinion because at the time UDTs were not required by the standard of care and, in D's case, a pill count would have had limited value because D said she had run out of her medications.

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[47] Complainant withdrew Paragraph 57, subdivision (c).

Dr. Verdolin's testimony is found more persuasive than Dr. Polston's. As discussed, beginning in 2011 the standard of care for pain management doctors was evolving due to the opioid prescription crisis. Respondent appeared to recognize this because he utilized UDTs during this time notably with respect to other patients. Moreover, D's documented behaviors raised serious concerns about her health and welfare due to abuse of pain medications. Even if respondent acted within the standard of care when he decided not to discharge her as a patient or significantly taper or wean her off the meds he was prescribing, respondent still had a duty to evaluate D's opioid medication usage and, towards this end, UDTs, even a limited "cup screen," and/or pill counts were tools to help him gain some understanding regarding whether D was using the meds he was prescribing her as he had instructed.

THIRD CAUSE FOR DISCIPLINE REGARDING EXCESSIVE PRESCRIBING TO PATIENTS A, B AND C

88. The Third Cause for Discipline alleges that respondent repeatedly excessively prescribed controlled medications to Patients A, B and C. As found above, respondent repeatedly excessively prescribed controlled medications to Patients A, B and C.

With respect to patient A, between December 2011 to early 2013 respondent prescribed medications containing doses of acetaminophen greater than the 4,000 mg amount that a person can safely take daily. With respect to patient B, during a 10-month period in 2013 respondent frequently prescribed to B more than 30-day supplies of controlled substances and violated the standard of care and between December 2013 and September 2014 wrote prescriptions for medications with daily average acetaminophen doses of 4,600 mg, which was greater than greater than the 4,000 mg amount that a person can safely take daily. With respect to Patient C,

frequently prescribed extra controlled substances to C and prescribed short acting Oxycodone prescriptions twice a month in March, April May, June, September and October 2013 and wrote prescriptions in greater than 30-day supplies in violation of the standard of care.

FOURTH CAUSE FOR DISCIPLINE REGARDING PRESCRIBING DANGEROUS DRUGS WITHOUT AN APPROPRIATE PRIOR EXAMINATION REGARDING PATIENTS B AND C

89. The Fourth Cause for Discipline alleges that respondent prescribed dangerous drugs to Patients B and C without requiring B and C to present for adequate and/or appropriate prior examinations. As found above, respondent failed to conduct an adequate and/or appropriate exam of B on February 27, 2013, when he performed an initial history and physical examination of Patient B that lacked an appraisal of prior non-opioid treatments for chronic pain. Complainant withdrew the allegation that respondent failed to conduct an adequate screening exam of C on August 8, 2008. The allegation regarding Patient C in the Fourth Cause of Discipline is therefore dismissed.

FIFTH CAUSE FOR DISCIPLINE REGARDING FAILURE TO MAINTAIN ACCURATE AND ADEQUATE RECORDS REGARDING ALL FIVE PATIENTS

90. The Fifth Cause for Discipline alleges that respondent failed to maintain accurate and adequate medical records in his care and treatment of Patients A through E. Based on the evidence of record respondent failed to maintain accurate and adequate records for these patients in the following instances:

Between 2010 and 2014, Patient A provided urine drug test results that were inconsistent with the medications respondent prescribed to her. Except for one instance on November 11, 2014, respondent failed to document he discussed with A these inconsistent results.

Regarding Patient B, on February 27, 2013, respondent did not document he assessed B's prior non-opioid treatments for pain, assess her psychological or addiction risk, and he did not order a urine drug screen. Also, regarding Patient B, he did not document he discussed the risks and benefits of controlled substances with her and he did not identify specific treatment goals in her records.

Regarding Patient C, despite inconsistent UDTs on numerous occasions, respondent did not document that he discussed these results with C.

Regarding Patient D, respondent did not document on May 12, 2011, the reason he authorized a refill of Xanax to her.

Regarding Patient D, at each of her visits with him respondent copied/pasted the same physical exam finding portions of D's exams into D's records.

On July 7, 2011, D's pharmacy asked D to provide a new prescription for Ativan. After he issued her a prescription he notated next to the prescription that D needed a follow-up appointment. Despite his note, there is no documentation in the record between July 7, 2011, and October 26, 2011, that respondent attempted to have D come in for an appointment with him.

Regarding Patient E, after January 11, 2011, when he advised E not to use alcohol and after his second hospitalization, respondent did not document between March 21, 2011, and January 2012 that he considered whether E was using alcohol or

that he was treating for alcohol abuse. He also did not document that he considered the special circumstances regarding his prescription of Methadone to this patient, per Dr. Verdolin's testimony.

SIXTH CAUSE FOR DISCIPLINE REGARDING VIOLATIONS OF STATE OR FEDERAL LAWS

91. The Sixth Cause for Discipline alleges that respondent violated federal and/or state laws and or regulations by prescribing dangerous drugs and/or controlled substances with respect to the patients in this matter. Based on the above findings, respondent violated applicable sections of the Medical Practices Act in his prescribing of dangerous drugs and controlled substances to Patients A, B, C, D and E.

SEVENTH CAUSE FOR DISCIPLINE REGARDING UNPROFESSIONAL CONDUCT

92. The Seventh Cause for Discipline alleges that respondent engaged in unprofessional conduct as alleged in the other Causes for Discipline. Based on the findings made above, respondent's conduct constituted unprofessional conduct.

EIGHTH CAUSE FOR DISCIPLINE REGARDING VIOLATIONS OF THE MEDICAL PRACTICE ACT

93. The Eighth Cause for Discipline alleges that respondent violated or attempted to violate directly or indirectly the Medical Practices Act. Based on the findings made above, respondent violated applicable sections of the Medical Practices Act.

NINTH CAUSE FOR DISCIPLINE REGARDING INCOMPETENCY REGARDING HIS CARE AND TREATMENT OF PATIENT E

94. The Ninth Cause for Discipline alleges that respondent demonstrated incompetence in his care and treatment of Patient E by prescribing Methadone to a known alcoholic in addition to multiple other contraindicated medications known for causing sudden death without ordering an EKG or taking E's vital signs. As found above, Dr. Verdolin's opinion was more persuasive than Dr. Polston's testimony on this issue and is fully credited.

Dr. Shurman's Testimony Regarding the Evolving Standards of Care Governing Pain Management

95. Respondent called Joseph Shurman, M.D., to testify regarding the evolving standards of care involving pain management since the 1980s and how pain management has changed. Dr. Shurman is a licensed physician who specializes in the management of chronic pain. He is board certified in Anesthesia and Pain Management. Dr. Shurman received his medical degree from Temple University in 1967. He served his internship at Chestnut Hill Hospital and completed his residency specializing in anesthesia at Massachusetts General Hospital.

As Dr. Shurman put it, pain management is now a field with land mines and pain management doctors face a perfect storm where they are in the middle of "this thing," meaning the public debate concerning the prescription of opioids. As a result, a pain management doctor is "damned if he stops meds" or if he continues to prescribe them. For decades, pain management doctors were able to prescribe without limits and now, in his view, we are back to a point of the under-treatment of pain. He based his testimony onvarious documents, studies and guidelines which detail how the

practice of pain management and prescription of opioids have evolved since the late 1980s. (Exhibit JJ, subparts 1 to 5, 7, 10, 12, 19, 20, 26, 28, 29, 30.)

Character Evidence

96. A number of individuals testified on respondent's behalf as character witnesses and submitted letters on his behalf.

Dan Calac, M.D., is a licensed physician who is Chief Medical Officer for Indian Health Council in San Diego County. He has referred the majority of complex pain management patients to respondent and has reviewed patient charts for those patients and found them to be complete, "very detailed" with appropriate testing. He regards respondent as an asset to the community. Dr. Calac did not review the second amended accusation, but he said respondent explained the charges to him.

Bill McCarberg, M.D., is a retired family physician who worked for Kaiser for 30 years and completed extensive training in pain management and palliative care. He referred patients to respondent because he trusted respondent's expertise. He believes that respondent is a competent pain management doctor, he had confidence in him as a pain doctor, and he had no reservations about referring patients, including family members, to him. Dr. McCarberg also testified that he talked to patients about respondent and they told him he provided excellent services. Dr. McCarberg testified that he had not read anything about this matter.

Nemia Joy Rucker is a long-term pain management patient of respondent. She said that respondent has helped her manage her intractable pain condition with both pain medications and injections. She described respondent as compassionate and caring. Ms. Ruger stated that respondent now takes her vital signs but was not sure whether he did this earlier in her treatment with him. Ms. Ruger does not know

anything about the allegations against respondent involving the five patients at issue in this matter.

Greg Bohart, M.D., is a retired orthopedic doctor who stopped practicing in 2014 and sees respondent as a pain management patient. Dr. Bohart retired in part due to orthopedic problems he had, and he treated with respondent for pain related to those issues. Dr. Bohart described the treatment he received from respondent as excellent. He said that respondent was very thorough. Dr. Bohart does not know anything about the allegations against respondent in this matter.

In addition to the testimony of these persons, respondent submitted declarations from Marcelo Rivera, M.D., Belinda Dure-Smith, M.D., and respondent's patients John Merten, Leslie Seifert, Alfred Romero, and Scott Maylen. The statements of these persons were admitted as administrative hearsay and supplement and explain respondent's credible testimony that he is dedicated to providing quality care to his pain management patients.

Drs. Rivera and Dure-Smith wrote in their declarations that they have referred patients to respondent and have never been concerned about the quality of care respondent provided their patients.

Respondent's patients described respondent as caring and thorough and they would like to continue to receive care from him.

The Parties' Arguments Regarding the Degree of Discipline

97. The parties did not dispute that respondent's license is subject to some form of discipline. Complainant asks that respondent's license be subject to a minimum of five years of probation, with the following terms and conditions: an

educational course, a prescribing course, a record keeping course, an ethics course, a practice monitor, solo practice prohibition, and all standard terms and conditions of probation. Complainant does not seek a more severe level of discipline because respondent has been practicing medicine for a long period of time without any prior disciplinary history and he has made necessary changes to his practice.

Respondent asks that his license be subject to a reprimand as a result of the repeated negligent acts respondent's expert Dr. Polston testified he committed. In closing argument, respondent noted that he has practiced for a long time without incident and has been a dedicated and recognized pain management specialist in the community and placing him on probation would impact his ability to practice in this field.

LEGAL CONCLUSIONS

Purpose of Physician Discipline

1. The purpose of the Medical Practice Act (Chapter I, Division 2, of the Business and Professions Code) is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.)

The purpose of administrative discipline is not to punish, but to protect the public by eliminating those practitioners who are dishonest, immoral, disreputable or incompetent. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.)

Standard of Proof

2. The standard of proof in an administrative action seeking to suspend or revoke a physician's certificate is clear and convincing evidence. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

Applicable Statutes Regarding Causes to Impose Discipline

3. Section 2227, subdivision (a), states:

> 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) 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 the discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

4. Section 2234 provides in part:

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

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

(b) Gross negligence.

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

[¶] . . . [¶]

(d) Incompetence. . . .

5. Section 2266 provides:

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

6. Section 2242, subdivision (a), "[p]rescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct."

7. Section 4022 defines a dangerous drug as:

> . . . any drug or device unsafe for self-use in humans or animals, and includes the following:
>
> (a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.
>
> (b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a ____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.
>
> (c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

8. Section 725, subdivision (a), provides, in part, "Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment . . . as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon . . . ."

9. Section 2266 provides that failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

10. Section 2238 provides: "A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

Decisional Authority Regarding Standard of Care

11. The standard of care requires the exercise of a reasonable degree of skill, knowledge, and care that is ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care involving the acts of a physician must be established by expert testimony. (*Elcome v. Chin* (2003) 110 Cal.App.4th 310, 317.) It is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal.App.4th 234, 280.)

Courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052.) Simple negligence is merely a departure from the standard of care. Incompetence has been defined as "an absence of qualification, ability or fitness to perform a prescribed duty or function." (*Id.* at 1054).

Decisional Authority Regarding Incompetency

12. Incompetence has been defined as a "general lack of present ability to perform a given duty." (See, *Pollak v. Kinder* (1978) 85 Cal.App.3d 833, 837-838, where the court distinguished negligence from incompetence when it stated, "[A] licensee may be competent or capable of performing a given duty but negligent in performing that duty.") In *James v. Bd. of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1109, the court held: "Incompetence generally is defined as a lack of knowledge or ability in the discharge of professional obligations."

Case Law Regarding Unprofessional Conduct

13. In *Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575, the appellate court noted that "unprofessional conduct" as that term was used in Business and Professions Code section 2361 (now section 2234), included certain enumerated conduct. (*Id.* at p. 575.) The court further stated (*Ibid.*):

> This does not mean, however, that an overly broad connotation is to be given the term "unprofessional conduct;" it must relate to conduct which indicates an unfitness to practice medicine. [Citations.] Unprofessional conduct is that conduct which breaches the rules or ethical code of a profession, or conduct which is unbecoming a member in good standing of a profession. [Citation.]

Public Letter of Reprimand

14. Section 2233 provides as follows:

> The board may, by stipulation or settlement with the affected physician and surgeon, issue a public letter of reprimand after it has conducted an investigation or inspection as provided in this article, rather than filing or prosecuting a formal accusation. The public letter of reprimand may, at the discretion of the board, include a requirement for specified training or education. The affected physician and surgeon shall indicate agreement or nonagreement in writing within 30 days of formal notification by the board of its intention to issue the letter. The board, at its option, may extend the response time. Use of a public reprimand shall be limited to minor violations and shall be issued under guidelines established by regulations of the board.

Disposition Regarding Case for Discipline

CAUSE EXISTS UNDER THE FIRST CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR CONDUCT CONSTITUTING GROSS NEGLIGENCE

15. Complainant proved by clear and convincing evidence that respondent committed gross negligence in violation of Section 2234, subdivision (b), as asserted in paragraph 54, subparagraphs A through C with respect to respondent's treatment and care of Patient A based on the findings in this decision. Complainant did not prove the allegations in subparagraphs D and E of paragraph 54 as found earlier in this decision.

Complainant proved by clear and convincing evidence that respondent committed gross negligence as asserted in subparagraphs F, G, and H of paragraph 54. Complainant did not prove the allegation in subparagraph I of paragraph 54.

Complainant proved by clear and convincing evidence established that respondent committed gross negligence as asserted in subparagraphs J, K and L of paragraph 54 with respect to his care and treatment of Patient C as found earlier in this decision.

Complainant proved by clear and convincing evidence that respondent committed gross negligence as asserted in subparagraph M of paragraph 54 with respect to his care and treatment of Patient D as found earlier in this decision.

Complainant proved by clear and convincing evidence that respondent committed gross negligence as asserted in subparagraphs N, O and P of paragraph 54 with respect to his care and treatment of Patient E as found earlier in this decision.

CAUSE EXISTS UNDER THE SECOND CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR CONDUCT CONSTITUTING REPEATED NEGLIGENT ACTS

16. Complainant proved by clear and convincing evidence that respondent committed repeated negligent acts, as asserted in paragraph 57, subdivisions (a), regarding his care and treatment of Patients A, B, C, and D, (b), regarding his care and treatment of Patient B, and subdivisions (d) and (e) of this same paragraph with regards to his care and treatment of Patient D, in violation of Section 2234, subdivision (c), as found above.

CAUSE EXISTS UNDER THE THIRD CAUSE FOR DISCIPLINE TO IMPOSE DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR EXCESSIVE PRESCRIBING OF DRUGS TO PATIENTS A, B AND C

17. Complainant proved by clear and convincing evidence that respondent excessively prescribed drugs to Patients A, B and C in violation of Section 725, subdivision (a), based on the above findings.

CAUSE EXISTS TO IMPOSE DISCIPLINE UNDER THE FOURTH CAUSE FOR DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR PRESCRIBING OF DANGEROUS DRUGS WITHOUT AN APPROPRIATE PRIOR EXAMINATION

18. Complainant proved by clear and convincing evidence that respondent violated Section 2042 when he prescribed drugs to Patients B without conducting an adequate and/or appropriate prior examination of Patient B on February 27, 2013. Complainant withdrew the allegation that respondent failed to conduct an adequate screening exam of C on August 8, 2008, and the allegation regarding Patient C here is dismissed.

CAUSE EXISTS TO IMPOSE DISCIPLINE UNDER THE FIFTH CAUSE FOR DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR FAILURE TO MAINTAIN COMPLETE AND ACCURATE MEDICAL RECORDS

19. Complainant proved by clear and convincing evidence that respondent failed to maintain accurate and adequate records in his care and treatment of Patients A, B, C, D and E as found above in violation of Section 2266.

CAUSE EXISTS TO IMPOSE DISCIPLINE UNDER THE SIXTH CAUSE FOR DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR VIOLATING FEDERAL AND STATE LAWS REGULATING DANGEROUS DRUGS AND CONTROLLED SUBSTANCES

20. Complainant proved by clear and convincing evidence that respondent violated sections of the Medical Practice Act in his prescribing of dangerous drugs and controlled substances to Patients A, B, C, D and E in violation of Section 2238.

CAUSE EXISTS TO IMPOSE DISCIPLINE UNDER THE SEVENTH CAUSE FOR DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR UNPROFESSIONAL CONDUCT

21. Complainant proved by clear and convincing evidence that respondent engaged in general unprofessional conduct in violation of Section 2234, subdivision (a), based on the above findings.

CAUSE EXISTS TO IMPOSE DISCIPLINE UNDER THE EIGHTH CAUSE FOR DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR VIOLATING OR ATTEMPTING TO VIOLATE PROVISIONS OF THE MEDICAL PRACTICE ACT

22. Complainant proved by clear and convincing evidence that respondent violated sections of the Medical Practice Act in violation of Section 2234, subdivision (a).

CAUSE EXISTS TO IMPOSE DISCIPLINE UNDER THE NINTH CAUSE FOR DISCIPLINE AGAINST RESPONDENT'S LICENSE FOR INCOMPETENCE

23. Complainant proved by clear and convincing evidence that respondent demonstrated incompetence in his care and treatment of Patient E in violation of Section 2234, subdivision (d), when he prescribed Methadone to a known alcoholic in addition to multiple other contraindicated medications known for causing sudden death without ordering an EKG or taking E's vital signs.

The Board's Disciplinary Guidelines and Evaluation Regarding the Degree of Discipline

23. With causes of discipline having been found, the determination now must to assess the degree of discipline and the terms and conditions to impose. In this regard, the Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th Edition, 2016) states:

> The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake Board-ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

24. For each of the violations established relating to respondent's treatment of Patients A, B, C, D and E, the Board's disciplinary guidelines provide the following recommended terms and conditions:

- For gross negligence, repeated negligent acts, and/or incompetence under Business and Professions Code section 2234, subdivisions (b), (c), and (d), or failure to maintain adequate records under Business and Professions Code section 2266, revocation, stayed, and five years' probation, with conditions including an education course, prescribing practices course, medical record keeping course, professionalism program (ethics course), clinical competence assessment program, monitoring, solo practice prohibition, and prohibited practices.

- For excessive prescribing under Business and Professions Code section 725 or prescribing without an appropriate prior examination under Business and Professions Code section 2242, revocation, stayed, and five years' probation, with conditions including a 60-day suspension, a Drug Enforcement Administration (DEA) controlled substances restriction, maintenance of controlled substance records, education course, prescribing practices course, medical record keeping course, professionalism course, clinical competence course, and monitoring.

Disciplinary Considerations and Disposition Regarding the Degree of Discipline

25. As noted, the purpose of an administrative proceeding seeking the revocation or suspension of a professional license is not to punish the individual, the purpose is to protect the public from dishonest, immoral, disreputable or incompetent

practitioners. (*Fahmy,* supra, 38 Cal.App.4th at p. 817.) Rehabilitation is a state of mind and the law looks with favor upon rewarding with the opportunity to serve one who has achieved "reformation and regeneration." (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041, 1058.) The determination whether respondent's license should be revoked or suspended includes an evaluation of the rehabilitation and mitigation factors.

26. After considering the Board's guidelines, the evidence of rehabilitation and mitigation and the evidence of record as a whole, it is determined that a three-year period of probation with specific terms and conditions will ensure public protection. These terms and conditions include a practice monitor, the successful completion of a clinical competency training program, and record and prescribing practices and additional educational courses. Considering the substantive efforts respondent has taken to correct his practices, departures from the disciplinary guidelines are warranted as follows: it is not necessary to ensure public protection, considering the steps respondent has taken to correct his office practices, that respondent be barred from prescribing scheduled drugs. It is also not necessary that respondent be prohibited from practicing as a solo practitioner and the period of probation is reduced to three years from five years as the guidelines recommend.

The determination regarding the level of discipline and denial of respondent's request for a reprimand is made for these reasons: Respondent's departures from the standards of care with respect to the five patients in this matter represent a systemic failure to accurately and adequately chart the condition of each patient and in certain instances adequately monitor the medications he was prescribing them and they were taking. As a result, Patients A, B, and C were able to obtain large doses of opioids and other controlled medications. At times, respondent lost track of the medications he was prescribing them. Further, despite their concerning and aberrant behavior,

respondent did not utilize CURES though it was available to him or consistently required patients to submit to UDTs, and even where UDT lab results were obtained, he ignored inconsistent results that showed patients were diverting medications, not using medications as prescribed, or that they did not need the medications.

His care and treatment of Patients D and E represented a similar pattern of inadequate charting, inadequate monitoring, and a failure to critically inquire and/or follow-up. Patients D and E's documented aberrant behaviors heightened respondent's need to adequately chart, monitor and critically assess his prescriptions to them because their health and safety were at risk. With respect to Patient D, her May 10, 2011, call to respondent and his response to it stand out as illustrative of the problem his care of her represented. On this date Patient D reported to respondent that a police officer pulled her over for being under the influence of medication and for child endangerment, and she asked him to write letter for her court appearance. By any measure this was a red flag that should have raised concerns for D's health and welfare (and possibly her child's), but respondent did not document he had such concerns. Instead, two days later, on May 12, 2011, without recording the reason he did this, respondent authorized an early refill of Alprazolam. He authorized this early refill less than two weeks after he wrote D a prescription for 90 pills of Ativan, another benzodiazepine, with three refills.

With respect to Patient E, despite an involuntary "5150" hospitalization in December 2010 for alcohol abuse, between March 21, 2011, and January 2012, respondent did not ask E about his use of alcohol, whether he was in follow-up behavioral care for this condition, whether he was attending AA, or any other group therapy. Respondent also did not document he advised E that he should see a behavioral health specialist or psychiatrist. Respondent further did not take E's blood

pressure, which is notable, as respondent acknowledged, because taking his vital signs may have allowed him to assess whether E was using alcohol. Respondent also did not have E submit to a UDT or cup test, and he did not ever have E undergo an EKG even though he was prescribing Methadone to E and it appeared, based on E's first hospitalization, that E suffered a respiratory issue requiring that he be placed on a ventilator. At each visit during this timeframe, respondent recorded E's condition based on how E presented to him at these visits and he appeared to accept E's superficial presentation to him. As Dr. Verdolin stated, it seemed respondent did not want to know about E's alcohol use. At the least, he should have critically assessed E in light of his recent history. Respondent did not return E's wife's call to him despite her message to him after E's December 2010 hospitalization there were things she wanted respondent to know. Further, respondent did not obtain E's Palomar Hospital records. Among these records, a social worker documented she suspected in a behavioral health assessment that E was abusing both alcohol and opiates. E's June 2008 pain agreement advised E that the use of opioids and alcohol are contraindicated.

Here, it is noted D and E were challenging patients whose needs for pain medications were not in dispute and respondent took steps to engage both patients and was attentive to them. D did not make appointments respondent had scheduled for her and after reviewing her CURES report, he appropriately discharged her as a patient. Respondent documented that E was trying to improve his lifestyle by trying to quit smoking and he may well have appeared healthy at his visits with respondent between March 21, 2011, and January 2012. Respondent, also, specifically advised E not to use alcohol and stressed this point to him at E's December 14, 2010 appointment.

But, as commented on earlier in this decision, the evaluation of respondent's treatment of all of these patients needs to be looked at in terms of the risks to these patients and respondent's efforts to size up and manage these risks using the tools available to him. By November 2011, when the CDC declared prescription drug abuse to be a nationwide epidemic, respondent as a pain specialist was on notice that he needed to use the tools available to him, whether UDTs, cup screens, pill counts, and/or CURES, *and* he also needed to critically assess patients and what they told him. Respondent was slow to respond to this change in the opioid pain medication management landscape and did not consistently use the tools available to him. Even when he did use these tools and was put on notice of potential problems, he did not take actions to protect his patients from their risky aberrant behaviors. In explaining his care and treatment of these patients, respondent testified that he was perhaps "overcompassionate" in his care and treatment of these patients, and he allowed his compassion, it appears, to override his critical judgment. This is most notable with regards to Patients A and E. At one point, on October 23, 2012, he documented he wanted to give A "hope" and he ignored indications that A's meds were being diverted to her daughter. With regards to E, he emphasized in his hearing testimony that he had a special connection with E and, as some indication of this connection, E bought his young son with him at his appointments. Respondent appeared to have ignored the possibility that E could have been abusing alcohol.

27. Respondent testified credibly he has learned from his mistakes, has benefited from prescription drug and record keeping courses he completed in 2017, and he has taken steps to ensure he does not make the same mistakes again.[48]

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[48] Respondent admitted that he made mistakes with regards to his care and treatment of Patients D and E. He did not specifically take responsibility for his

Respondent has backed up his testimony with concrete steps. He has improved his record keeping through his new EMR system, and now takes vital signs, and checks CURES regularly. He supported his testimony with materials he now uses in his practice to better monitor and manage opioid pain patients. As additional factors against a more severe level of discipline, respondent is well-regarded in the community by his patients and colleagues and has practiced in the field of pain management since 1993 without discipline. Accordingly, as noted, departures from the Board's recommended terms and conditions are appropriate: instead of a five-year period of probation, a three-year period of probation will ensure public protection. In addition, in light of his substantive and substantiated efforts to correct his practice, respondent is not barred from prescribing certain scheduled drugs. Respondent also is not required to take an ethics course as the guidelines recommend. His conduct did not involve material breaches of his ethical duties to the five patients. Regarding respondent's request for a public reprimand, respondent's request is denied for this reason: Even considering the factors in his favor, given the nature of the departures found, a reprimand is not appropriate. Use of a public reprimand is limited to "minor violations" of the Medical Practice Act under Section 2233. Even if only the departures that respondent's expert, Dr. Polston, found are considered, respondent's violations of the Medical Practice Act were not minor.

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conduct relating to Patients A, B and C, but it is found that respondent held a good faith belief that his care and treatment of these patients was appropriate and his failure to admit he made mistakes in his care of treatment of Patients A, B and C is not considered as a factor in the imposition of the degree of discipline. (See *Hall v. Committee of State Bar Examiners* (1979) 25 Cal.3d 730, 743-745.)

ORDER

Certificate No. A 43963 issued to respondent Brian Howard Chesler, M.D., is revoked. However, the revocation is stayed, and respondent is placed on probation for three years upon the following terms and conditions.

1. Education Course

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

2. Prescribing Practices Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment.

Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

3. Medical Record Keeping Course

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

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

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

4. Clinical Competence Assessment Program

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

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

Respondent shall pay all expenses associated with the clinical competence assessment program.

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

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

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

5. Monitoring - Practice

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

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

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

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

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

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

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the Board or its designee, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

6. Notification

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

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

7. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

8. Obey All Laws

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

9. Quarterly Declarations

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

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

10. General Probation Requirements

COMPLIANCE WITH PROBATION UNIT

Respondent shall comply with the Board's probation unit.

ADDRESS CHANGES

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

PLACE OF PRACTICE

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

LICENSE RENEWAL

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

TRAVEL OR RESIDENCE OUTSIDE CALIFORNIA

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

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

11. Interview with the Board or its Designee

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

12. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United

States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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

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

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

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

13. Completion of Probation

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

14. Violation of Probation

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

15. License Surrender

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

16. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an

annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

DATE: September 27, 2019

DocuSigned by:
Abraham Levy
C84194237D2243C...

ABRAHAM M. LEVY
Administrative Law Judge
Office of Administrative Hearings

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Attorneys for Complainant

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

In the Matter of the Second Amended Accusation Against: **Bradley Howard Chesler, M.D.** **1955 Citracado Pkwy Unit 203** **Escondido, CA 92029-4110** **Physician's and Surgeon's Certificate No. A 43963,** Respondent.	Case No. 800-2014-008851 OAH No. 2018010827 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about August 31, 1987, the Medical Board issued Physician's and Surgeon's Certificate No. A 43963 to Bradley Howard Chesler, M.D. (Respondent). Physician's and Surgeon's Certificate No. A 43963 was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2019, unless renewed.

JURISDICTION

3. This Second Amended Accusation, which supersedes the First Amended Accusation filed on March 21, 2018, is brought before the Board, 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 provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states, in pertinent part:

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

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

"(b) Gross negligence.

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

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

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

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care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"..."

6. Section 2238 of the Code states:

"A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

7. Section 725 of the Code states, in pertinent part:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon...

"...

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

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

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

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

"..."

9. Section 4021 of the Code states:

"'Controlled substance' means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code."

10. Section 4022 of the Code states in pertinent part:

"'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only,' or words of similar import.

"...

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

"..."

11. Section 2266 of the Code states:

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

12. Unprofessional conduct under section 2234 is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

13. Respondent has subjected his Physician's and Surgeon's Certificate No. A 43963 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he was grossly negligent in his care and treatment of Patients A, B, C, D, and E[1] as more particularly alleged hereinafter:

14. The following drugs, alleged to have been prescribed below, are dangerous drugs and substances listed in the Controlled Substances Act:

(a) Oxycodone is a Schedule II controlled substance.

[1] To protect the privacy of all patients involved, patient names have not been included in this pleading. Respondent is aware of the identity of the patients referred to herein.

(b) Short Acting Oxycodone is a Schedule II controlled substance.

(c) Percocet (Oxycodone) is a Schedule II controlled substance.

(d) Lortab (Hydrocodone) is a Schedule II controlled substance.

(e) Valium (Diazepam) is a Schedule IV controlled substance.

(f) OxyContin is a Schedule II controlled substance.

(g) Norco (Hydrocodone) is a Schedule II controlled substance.

(h) Vicodin (Hydrocodone) is a Schedule II controlled substance

(i) Fentanyl is a Schedule II controlled substance.

(j) MS Contin is a Schedule II controlled substance.

(k) Soma (Carisoprodol) is a Schedule IV controlled substance as of January 11, 2012.

(l) Hydromorphone is a Schedule II controlled substance.

(m) Dilaudid (Hydromorphone) is a Schedule II controlled substance.

(n) Lorazepam (Ativan) is a Schedule IV controlled substance.

(o) Alprazolam (Xanax) is a Schedule IV controlled substance.

(p) Methadone is a Schedule II controlled substance.

Patient A:

15. On or about February 7, 2005,[2] Patient A, a female patient, presented to Respondent with chronic neck pain following a motor vehicle accident, with a C5-C6 anterior cervical discectomy and a fusion. In or about 2005, Patient A underwent a right upper extremity surgery to remove a tumor, and in or about 2007, she underwent surgery to remove hardware in her right arm due to ongoing pain.

16. Under Respondent's care, Patient A's pain was treated with multiple types of controlled substances, including OxyContin, Norco 10/325, Vicodin 5/500, Valium, Dilaudid, Fentanyl patch, and Percocet.

17. On or about June 26, 2008, July 18, 2011, and September 16, 2014, Patient A signed patient agreement forms (Pain Agreements) for Respondent. The terms of the July 18, 2011, Pain

[2] 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.

Agreement provided, in part, that Patient A would present to only one Emergency Room visit per month for pain exacerbations, and would obtain medications only from the agreed-upon pharmacy.

18. In and about the years 2011 to 2013, Respondent prescribed opioid medications to Patient A, including morphine equivalent doses[3] (MED) that exceeded 300 MEDs. During that time Patient A's actions included the following:

(a) Patient A reported a lack of adequate analgesia, continued chronic pain, and decreased function;

(b) Patient A presented to multiple emergency departments for pain relief;

(c) Patient A made requests for early refills of medications, and reported medications lost or stolen; and

(d) Patient A obtained medication refills from ten prescribers at seven pharmacies.

19. In or about the time periods from 2010 to 2014, Patient A provided urine drug test results that were inconsistent with the medications Respondent prescribed to her. Throughout that time frame, on approximately 14 occasions, Patient A's urine test results were inconsistent with the medications prescribed, including on or about November 11, 2014, when Patient A's urine drug test detected no controlled substances in her system. Throughout that time frame, Respondent failed to document and/or adequately document any detailed discussion with Patient A regarding these inconsistencies, and continued to prescribe controlled substances to her.

20. From in or about December 2011, to in or about November 2012, Respondent wrote approximately fifty-six prescriptions for medications containing acetaminophen for Patient A, prescribing approximately:

- Fifteen prescriptions of 120 tablets of Percocet;
- Fourteen prescriptions of 180 tablets of Lortab;
- Fourteen prescriptions of 90 tablets of Dilaudid; and
- Thirteen prescriptions of Valium.

[3] Morphine equivalent doses (MED) are used to equate different opioids into one standard value, based on morphine and its potency, referred to as MED. MED calculations permit all opioids to be converted to an equivalent of one medication, for ease of comparison and risk evaluations.

21. In or about the time period from 2011 to 2013, Respondent prescribed to Patient A, a daily combination of medications that contained acetaminophen: six (6) Lortab 7.5/500 tablets and four (4) Percocet 10/325 tablets, thereby prescribing an approximate average of 4300 milligrams (mg.) of acetaminophen per day.

22. In the twelve-month timeframe from in or about December 2011 to November 2012, Respondent prescribed to Patient A, an average of 5000 mg. of acetaminophen per day.

Patient B:

23. On or about February 27, 2013, Patient B, a female patient, first presented to Respondent for chronic abdominal and pelvic pain, and generalized pain. Patient B had a history of six cesarean section deliveries, and abdominal reconstruction with mesh. On that date, Respondent performed an initial history and physical examination of Patient B, however, the history lacked an appraisal of prior non-opioid treatments for chronic pain, and an assessment of psychological and/or addiction risk. No baseline urine drug screen was performed. A 12 month Controlled Substance Utilization Review and Evaluation System (CURES) report was reviewed. When Patient B first presented, she was taking MS Contin 30 mg., three times per day (*tid*). Respondent added Norco 10/325 and Oxycodone 10 mg. to her chronic pain medication regime.

24. On or about February 27, 2013, and thereafter, Respondent failed to document a discussion of the risks and benefits of the use of controlled substances with Patient B, and did not enter into a written Pain Agreement with Patient B at any time.

25. During an approximate ten-month period that Respondent provided care and treatment to Patient B, he wrote the following prescriptions for more than a 30-day supply, including extra prescriptions and refills:

- (2013) twelve prescriptions of MS Contin 30 mg. #90;
- (2013) fifteen prescriptions of Norco 10/325 (10 for #240; 4 for #180 and 1 for #30);
- (2014) thirteen prescriptions of MS Contin 30 mg. #90;
- (2014) twenty prescriptions of Norco 10/325 (15 for #240; 3 for #180; and 1 for #96); and
- (2014) thirteen prescriptions of Oxycodone 10 mg. (10 for #90; 3 for #120).

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26. In or about the time period from December 2013, through on or about September 2014, Respondent wrote seventeen prescriptions for medications containing acetaminophen for Patient B prescribing approximately:

- Sixteen prescriptions of Norco 10/325 #240; and
- One prescription of Norco 10/325 #180[4].

27. While caring for Patient B, Respondent saw her on an approximate monthly basis, mainly consisting of medication management. Treatment goals documented by Respondent were generic, rather than specific, clear functional patient goals. From on or about February 27, 2013, until on or about February 23, 2015, no urine drug screen was performed.

28. While under Respondent's care, Patient B displayed aberrant behaviors, including multiple requests for early refills, filling similar prescriptions at different pharmacies at less than 30-day intervals, during which time Respondent continued to prescribe for Patient B, with no documentation that she was asked to bring in medication for pill counting when there were inconsistencies in her refill pattern:

- On or about April 1, 2014, Patient B refilled her prescription for #240 Norco 10/325;
- On or about April 15, 2014, Patient B refilled her prescription for #240 Norco 10/325;
- On or about May 1, 2014, Patient B refilled her prescription for #240 Norco 10/325;
- On or about May 14, 2014, Patient B refilled her prescription for #240 Norco 10/325;
- On or about May 29, 2014, Patient B refilled her prescription for #240 Norco 10/325;
- On or about June 11, 2014, Patient B refilled her prescription for #240 Norco 10/325; and,
- On or about June 26, 2014, Patient B refilled her prescription for #240 Norco 10/325.

Patient C:

29. On or about August 8, 2008, Patient C, a male patient, first presented to Respondent for chronic left shoulder and arm pain. Patient C had a history of two shoulder surgeries in 2003 and 2006, reporting increasing pain around 2007. Respondent performed an ultrasound showing supraspinatus impingement and subscapularis shortening. Patient C's pain was managed with

[4] In or about September of 2014, Patient B reported to Respondent that her liver enzymes were elevated, after which Respondent reduced her Norco refill amount to 180 tablets.

multiple controlled substances including Soma, Norco, OxyContin, and short acting Oxycodone, MS Contin and Hydromorphone. On that date, Respondent performed an initial history and physical examination of Patient C, however, that history lacked an appraisal of prior non-opioid treatments for chronic pain, an assessment of psychological and/or addiction risk. No baseline urine drug screen was ordered.

30. On or about August 8, 2008, Patient C signed a Pain Agreement, and Respondent discussed the risks and benefits of the use of opioid medications. Patient C signed no additional agreements, and Respondent had no additional discussions and/or documented no additional discussions of opioid medications' risks and benefits, although during that time, Patient C violated the Pain Agreement multiple times with frequent requests for early refills, or by reporting the medications were lost or stolen.

31. During an approximate ten-month period that Respondent provided care and treatment to Patient C, he wrote the following prescriptions for more than a 30-day supply, including extra prescriptions and refills:

- (2012) 14 prescriptions of OxyContin 80 mg. #90;
- (2012) 14 prescriptions of Oxycodone 30 mg. #360;
- (2012) 14 prescriptions of Hydromorphone 8 mg. (8 of #120, 6 of #90); and
- (2013) 20 prescriptions of short acting Oxycodone (15 mg. or 30 mg. tablets);

32. In or about March, April, May, June, September, and October of 2013, Patient C filled two prescriptions of short acting Oxycodone in the same month.

33. While caring for Patient C, after November 2009, urine drug tests were performed multiple times per year, however, in nine instances between in or about March 2010 to in or about June 2013, Patient C's urine test results were inconsistent with his prescribed medication, specifically, Hydromorphone was not detected in the urine. However, Respondent continued to prescribe Dilaudid to Patient C. Respondent did not engage in and/or document any discussion of inconsistent urine test results with Patient C on subsequent office visits, and continued to prescribe controlled substances to Patient C.

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Patient D:

34. On or about June 21, 2010, Patient D, a then 45-year old female patient, first presented to Respondent for chronic pain and headaches. Patient D reported taking medication for pain beginning in 1994, which included but was not limited to Fentanyl, Soma, Vicodin, and cortisone shots, but no baseline urine drug screen was ordered at this visit. Patient D had a history of an MRI of the cervical area in 2009, and prior treatment with acupressure and chiropractic. Respondent did not order any imaging studies, and did not request the patient's prior MRI report from 2009 at that or any visit thereafter. On that date, Respondent performed an initial history and physical examination of Patient D that did not include vital signs, a reported pain score, an appraisal of prior non-opioid treatments for chronic pain, or an assessment of psychological and/or addiction risk. The patient's chart for this visit included a musculoskeletal exam that noted:

> "Head/Neck (posterior), shoulder girdle: No erythema, ecchymosis or edema. Generalized moderate tenderness over the neck and shoulder girdle, moderate tenderness over the right occipital grove, moderate tenderness over the right scapular area. Head held in forward position. Full, painless range of motion of the neck. Normal stability. Normal strength and tone."

35. On or about June 21, 2010, Patient D signed a Pain Agreement. The terms of this Pain Agreement, in part, specifically prohibited early refills, doctor shopping, the use of more than one pharmacy, indicated that the patient may be subjected to random pill counts and random urine drug screening, and that evidence of misuse may be grounds for termination. Patient D signed no additional Pain Agreements throughout her care and treatment with Respondent, and Respondent had no additional documented discussions with the patient regarding opioid medications' risks, benefits, and alternatives.

36. Between on or about June 21, 2010, through on or about October 25, 2011, Respondent provided care and treatment to Patient D that included writing the following prescriptions for a 30-day supply, including refills:

- Ten prescriptions of Alprazolam 1 mg. #60;
- Six prescriptions of Lorazepam 1 mg. (1 of #30, 1 of #40, and 4 of #90);

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- Ten prescriptions of Oxycodone 30 mg. (1 of #30, 1 of #40, 1 of #120, 2 of #180, 1 of #200, 4 of #240) and one prescription of Oxycodone 15 mg. #180;
- One prescription of Oxycontin 40 mg. #60;
- Two prescriptions of Fentanyl 25 mcg. (1 of #10 and 1 of #15), two prescriptions of Fentanyl 50 mcg. #15, and one prescription of Fentantyl 75 mcg. #15;
- Nineteen prescriptions of Norco 10/325 mg. (1 for #50, 1 for #60, 1 for #80, 2 for #100, 1 for #140, 4 for #180, and 9 for #240).

37. Between on or about June 21, 2010, through on or about April 21, 2011, Patient D saw Respondent on approximately 13 clinical visits. Throughout that time, including at clinical visits on or about March 22, 2011, and on or about April 21, 2011, treatment goals documented by Respondent were generic, rather than specific, clear functional patient goals, and the musculoskeletal examination notes for each visit were identical.

38. While under Respondent's care, including at clinical visits on or about March 22, 2011, and on or about April 21, 2011, no urine drug screen was performed on Patient D, no pill count was ever conducted or documented, and Respondent never referred the patient for imaging studies, behavioral management, psychiatry, or addiction treatment.

39. While under Respondent's care, Patient D displayed aberrant behaviors, including but not limited to, admitting to overusing her medication, repeatedly requesting early refills, and filling prescriptions at different pharmacies. Despite her repeated noncompliance with the Pain Agreement, Respondent continued to prescribe controlled substances for Patient D with little documented discussion regarding her repeated instances of noncompliance, and no change in plan to address her noncompliance.

40. Between on or about April 22, 2011, through on or about October 25, 2011, Patient D did not present to Respondent for treatment due to an apparent change in her insurance coverage. During that time, Patient D contacted Respondent's office on multiple occasions to report that she was in withdrawal and needed medications.

41. On or about October 25, 2011, Respondent authorized an early refill of Norco for Patient D. On that same date, Respondent formally discharged the patient from his care.

Patient E:

42. On or about February 12, 2009, Patient E, a then 59-year old established male patient and recovering alcoholic, presented to Respondent for recurring treatment for chronic neck pain following a work-injury and two surgeries. On that date, Respondent completed a physical exam of the patient, which was documented as:

> CONSTITUTIONAL: General Appearance: White male, well nourished body habitus, appears stated age, appropriately groomed.
>
> MUSCULOSKELETAL & SKIN EXAMS: Head/Neck (Posterior), Shoulder Girdle: There are scars consistent with previous surgeries listed in HPI/PMH. Moderate tenderness in the midline. Head and neck in neutral position. Unable to test range of motion with cervical spine fusion, in severe pain. Normal stability. Normal strength and tone. Spine/Ribs/Pelvis: No erythema, ecchymosis, or edema. No tenderness of spine, ribs or SI joints. No kyphosis, lordosis, or scoliosis. Full, painless range of motion of the thoracic and lumbar spine. Normal stability. Normal strength and tone.
>
> GAIT/STATIONS: Gait intact. Station, posture normal. Romberg negative. Does not use mobility aids.

Respondent's stated diagnosis for the patient was "723.3 – PAIN CERVICAL WITH RADIATION, 723.4 – RADICULOPATHY CERVICAL, 782.0 – NUMBNESS PARESTHESIA OF SKIN." The stated treatment plan goals for the patient were, "Increase the patient's ability to self-manage pain and related problems. Maximize and maintain optimal activity and function. Reduce subjective pain intensity." At the conclusion of the visit, Respondent refilled the patient's medications, including Methadose (Methadone) 10 mg #600, Xanax 1 mg #120 (with 3 refills), Hydrocodone-acetaminophen (Norco) 10-325 mg #240 (with 3 refills), Gabapentin[5] 600 mg #120 (with three refills), and Wellbutrin[6] 100 mg #120 (with 3 refills).

43. Between on or about February 12, 2009, through on or about January 31, 2012, Respondent provided care and treatment to Patient E that included writing the following prescriptions for a 30-day supply, including refills:

- Thirty-four prescriptions of Norco 10-325 mg. (12 of #240, 22 of #120);

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[5] Gabapentin is a nerve pain medication and anticonvulsant. It is a dangerous drug pursuant to Business and Professions Code section 4022.

[6] Wellbutrin, name brand for Bupropion, is a smoking cessation aid and antidepressant. It is a dangerous drug pursuant to Business and Professions Code section 4022.

- Thirty-seven prescriptions of Xanax 1 mg. (12 of #120, 21 of #90, 4 of #45);
- Twenty-seven prescriptions of Percocet 10-325 mg. #90;
- Thirty-five prescriptions of Methadone 10 mg. (5 of #600, of 30 of #180);
- Twenty-four prescriptions of Buspirone[7] 15 mg. #90;
- Thirty-two prescriptions of Lexapro 20 mg. #30;
- Twenty-eight prescriptions of Wellbutrin #100 mg; and
- Forty-four prescriptions of Gabapentin 600 mg (40 for #120, 4 for #45).

44. Between on or about February 12, 2009, through on or about January 31, 2012, Patient E saw Respondent on monthly basis on approximately 38 clinical visits, mainly consisting of medication management. Throughout that time, the patient's physical examination findings were relatively identical and never included any vital signs, heart rate, temperature and respirations, or pain scale. Throughout that time, Respondent's stated diagnosis and treatment goals for each visit were identical.

45. Between on or about February 12, 2009, through on or about January 31, 2012, Respondent did not enter into a written Pain Agreement with Patient E, or renew an established Pain Agreement with Patient E during that time period.

46. On or about April 6, 2009, Patient E was seen by Respondent. During that visit, the patient asked Respondent for a substitute for Wellbutrin and Buspirone, but was directed by Respondent to see a psychiatrist for any change in his psychiatric medications.

47. On or about October 18, 2009, Patient E was found unresponsive by his wife and was subsequently hospitalized for aspiration pneumonia with MSSA, confusion, COPD, and hyperlipidemia.

48. On or about November 12, 2009, after having been discharged from the hospital, Patient E returned to see Respondent. During this visit, Respondent counseled the patient about using his medications properly, but refilled his medications. Respondent ordered a urinalysis be taken from the patient to "assure compliance and to prevent diversion." Respondent did not

[7] Buspirone is an anxiolytic medication used to treat anxiety. It is a dangerous drug pursuant to Business and Professions Code section 4022.

request testing for alcohol, and the test results were inconsistent with the medications prescribed. This single urine test is the only test ordered by Respondent for Patient E between in or about February 12, 2009, through on or about January 31, 2012.

49. On or about December 7, 2010, Patient E was taken to the hospital after he was hallucinating and wielding a gun. At the hospital, Patient E displayed symptoms of alcohol withdrawal. Patient E admitted he had relapsed after 13 years of sobriety 6 months earlier, and had been drinking large amounts of vodka and abusing his pain medications.

50. On or about December 14, 2010, after having been discharged from the hospital, Patient E returned to see Respondent. During this visit, Respondent counseled the patient about using his medications properly and abstaining from alcohol, but made no changes in his treatment plan, and refilled all of his medications.

51. On or about December 17, 2010, Respondent received a "Member Health Note" from Patient E's insurance company stating that medical research indicates that chronic use of Alprazolam (Xanax) may lead to tolerance and dependency, that chronic use of opioid analgesics may lead to tolerance and dependency, and that the use of Gabapentin increases the risk of suicidal thoughts and behaviors.

52. Between on or about February 12, 2009, through on or about January 31, 2012, despite two hospitalizations, Respondent never referred the patient for imaging studies, EKG, behavioral management, psychiatry, or addiction treatment, but continued to prescribe high doses of various medications. Throughout that time, the patient's chart makes no mention of a specific discussion regarding the risks, benefits, or alternatives of pharmacological treatment, or an assessment of the efficacy of treatment.

53. On or about February 12, 2012, Patient E was found dead at his home as a result of the combined effects of multiple substances including alcohol, Methadone, Oxycodone (Percocet), Hydrocodone (Norco), Alprazolam (Xanax), and Bupropion.

54. Respondent committed the following acts of gross negligence in his care and treatment of Patients A, B, C, D, and E:

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Patient A:

A. In and about 2011 to 2013, Respondent continued to prescribe a high dose regime of controlled substances to Patient A, including doses that exceeded 300 MEDs, while she reported a lack of adequate analgesia and/or continued chronic pain, and/or decreased function, and/or displayed aberrant behaviors;

B. From in or about December 2011, to in or about November 2012, Respondent prescribed medications containing acetaminophen for Patient A, containing approximately 5000 mg. per day of acetaminophen;

C. From in or about December 2011, to in or about early 2013, Respondent prescribed medications containing acetaminophen for Patient A, containing approximately 4300 mg. per day of acetaminophen;

D. In and about 2011, and thereafter, Respondent continued to prescribe medications under Patient A's Pain Agreement, despite Patient A's violations of the Pain Agreement; and

E. Between 2010 and 2014, Patient A's urine tests were inconsistent with medications prescribed on 14 occasions, and/or on November 11, 2014, showed no controlled substances, but Respondent continued to prescribe medications under Patient A's Pain Agreement despite inconsistencies.

Patient B:

F. On or about February 27, 2013, and thereafter, Respondent failed to discuss and/or document a discussion of the risks and benefits of the use of controlled substances with Patient B and/or enter into a Pain Agreement with Patient B during the time that he provided her care and treatment;

G. In or about a ten-month period of time in 2013, Respondent frequently prescribed to Patient B more than 30-day doses of controlled substances;

H. In or about the time period from December 2013, through on or about September 2014, Respondent wrote prescriptions for medications containing acetaminophen for Patient B, with daily average acetaminophen doses of approximately 4.6 grams; and

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I. While under Respondent's care, Patient B displayed aberrant behaviors, including multiple requests for early refills, filling similar prescriptions at different pharmacies at less than 30-day intervals, during which time Respondent continued to prescribe for Patient B, with no discussion and/or no documentation of discussion regarding these behaviors.

Patient C:

J. On or about August 8, 2008, Patient C signed a Pain Agreement, and discussed the risks and benefits of the use of opioid medications. Patient C signed no additional agreements, and had no additional discussions of opioid medications' risks and benefits, although during that time, Patient C violated the Pain Agreement multiple times with frequent requests for early refills, or by reporting the medications were lost or stolen;

K. During the time periods in or about 2012 and 2013, Respondent frequently prescribed to Patient C extra controlled substances prescriptions and/or prescribed two short acting Oxycodone prescriptions the same months in or about March, April, May, June, September and October of 2013; and

L. During an approximate ten-month period that Respondent provided care and treatment to Patient C, he wrote prescriptions for more than a 30-day supply, including extra prescriptions and refills.

Patient D:

M. Between on or about March 22, 2011, through on or about October 25, 2011, Respondent continued to prescribe to Patient D, despite the fact that she had repeatedly displayed aberrant behaviors, possible addiction, and noncompliance with her Pain Agreement.

Patient E:

N. Between on or about February 12, 2009, through on or about January 31, 2012, Respondent continued to prescribe to Patient E, without taking a systematic and thorough history including vitals, without periodically reviewing and documenting efficacy of treatment, without regularly assessing for possible diversion, and without

periodically discussing the risks, benefits, and alternatives of pharmacological treatment.

O. Between on or about February 12, 2009, through on or about January 31, 2012, despite two hospitalizations, Respondent failed to refer Patient E for behavioral management, psychiatry, or addiction treatment, but continued to prescribe to the patient.

P. Between on or about February 12, 2009, through on or about January 31, 2012, Respondent regularly prescribed Methadone to a known alcoholic, in addition to multiple other contraindicated medications known for causing sudden death, and never ordered an EKG or took the patient's vital signs.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

55. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 43963 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients A, B, C, and D, as more particularly alleged hereinafter:

56. Paragraphs 13 through 54, above, are incorporated by reference and realleged, as if fully set forth herein.

57. Respondent committed the following repeated negligent acts:

(a) Paragraphs 54 A through 54 P, inclusive;

(b) **Patient B:** On or about February 27, 2013, Respondent performed an initial history and physical examination of Patient B, that lacked an appraisal of prior non-opioid treatments for chronic pain, and/or an assessment of psychological and/or addiction risk, and a baseline urine drug screen;

(c) **Patient C:** On or about August 8, 2008, Respondent performed an initial history and physical examination of Patient C, that lacked an appraisal of prior non-opioid treatments for chronic pain, and/or an assessment of psychological and/or addiction risk, and a baseline urine drug screen;

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(d) **Patient D:** Between on or about March 22, 2011, through on or about October 25, 2011, Respondent failed to consider a referral for a psychiatry consultation for addiction, despite the fact that Patient D displayed aberrant behaviors, possible addiction, and noncompliance with her Pain Agreement; and

(e) **Patient D:** Between on or about March 22, 2011, through on or about October 25, 2011, Respondent failed to obtain a urine drug screen on Patient D, and failed to conduct or document a pill count, despite the fact that Patient D displayed aberrant behaviors, possible addiction, and noncompliance with her Pain Agreement.

THIRD CAUSE FOR DISCIPLINE

(Repeated Acts of Excessive Prescribing of Drugs)

58. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 43963 to disciplinary action under Code sections 2227 and 725, as defined by section 725, subdivision (a), of the Code, in that he excessively prescribed drugs to Patients A, B, and C, as more particularly alleged in paragraphs 13 through 54, above, which are incorporated by reference and realleged, as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Prescribing Dangerous Drugs without an Appropriate Prior Examination)

59. Respondent has further subjected his Physician's and Surgeon's Certificate. No. A 43963 to disciplinary action under Code sections 2227 and 2242, as defined by sections 4021 and 4022 of the Health and Safety Code, in that he prescribed dangerous drugs to Patients B and C, without requiring the patients to present for an adequate and/or appropriate prior examinations, as more particularly alleged in paragraphs 13 through 54, above, which are incorporated by reference and realleged, as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Accurate and Adequate Medical Records)

60. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 43963 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain accurate and adequate medical records in his care and

treatment of Patients A, B, C, D, and E, as more particularly alleged in paragraphs 13 through 54 above, which are incorporated by reference and realleged, as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Violation of any Federal Statute or Federal Regulation or any State Statute or Regulation Regulating Dangerous Drugs or Controlled Substances)

61. Respondent has subjected his Physician's and Surgeon's Certificate No. A 43963 to disciplinary action under sections 2227 and 2238, as defined by sections 4021 and 4022 of the Health and Safety Code, in that he has violated Federal statute(s) or regulation(s) or State statute(s) or regulation(s) regulating dangerous drugs or controlled substances, as more particularly alleged in paragraphs 13 through 54 above, which are incorporated by reference and realleged, as if fully set forth herein.

SEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

62. Respondent has subjected his Physician's and Surgeon's Certificate No. A 43963 to disciplinary action under sections 2227 and 2234, as defined by section 2234, of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine, as more particularly alleged in paragraphs 13 through 54 above, which are incorporated by reference and realleged, as if fully set forth herein.

EIGHTH CAUSE FOR DISCIPLINE

(Violating or Attempting to Violate, Directly or Indirectly, Assisting in or Abetting the Violation of, or Conspiring to Violate any Provision of this Chapter)

63. Respondent has subjected his Physician's and Surgeon's Certificate No. A 43963 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (a), of the Code, in that he has engaged in conduct which violates or attempts to violate, directly or indirectly, assists in or abets the violation of, or conspires to violate any provision of this chapter, as more particularly alleged in paragraphs 13 through 54 above, which are incorporated by reference and realleged, as if fully set forth herein.

NINTH CAUSE FOR DISCIPLINE

(Incompetence)

64. Respondent has subjected his Physician's and Surgeon's Certificate No. A 43963 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that he has demonstrated incompetence in his care and treatment of Patient E, by prescribing Methadone to a known alcoholic, in addition to multiple other contraindicated medications known for causing sudden death, without ever ordering an EKG or taking the patient's vital signs, as more particularly alleged in paragraphs 13 through 54 above, which are 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 No. A 43963, issued to Respondent Bradley Howard Chesler. M.D.;

2. Revoking, suspending or denying approval of Respondent Bradley Howard Chesler M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Bradley Howard Chesler, 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: July 18, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
State of California
Complainant