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

In the Matter of the First Amended Accusation Against:	)	
Mark Anthony A. Wilmbley, M.D.	)	**Case No. 800-2014-005198**
Physician's and Surgeon's Certificate No. G 75382	)	
Respondent	)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on January 30, 2020.

IT IS SO ORDERED: December 31, 2019.

MEDICAL BOARD OF CALIFORNIA

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

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
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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 First Amended Accusation Against: MARK ANTHONY WIMBLEY, M.D. 12 Freedom Place Irvine, California 92602 Physician's and Surgeon's Certificate No. G 75382, Respondent.	Case No. 800-2014-005198 OAH No. 2017010131 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical Board of California ("Board"). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Rebecca L. Smith, Deputy Attorney General.

2. Respondent Mark Anthony Wimbley, M.D. ("Respondent") is represented in this proceeding by attorney Raymond J. McMahon, whose address is 5440 Trabuco Road Irvine, California 92620.

3. On or about October 13, 1992, the Board issued Physician's and Surgeon's Certificate No. G 75382 to Mark Anthony Wimbley, M.D. ("Respondent"). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2014-005198, and will expire on September 30, 20208, unless renewed.

JURISDICTION

First Amended Accusation No. 800-2014-005198 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on September 25, 2019. Respondent timely filed his Notice of Defense contesting the First Amended Accusation.

4. A copy of First Amended Accusation No. 800-2014-005198 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2014-005198. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

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CULPABILITY

8. Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations contained in First Amended Accusation No. 800-2014-005198 and that he has thereby subjected his license to disciplinary action.

9. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in First Amended Accusation No. 800-2014-005198 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

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

CONTINGENCY

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

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 75382 issued to Respondent Mark Anthony Wimbley, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for seven (7) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES - TOTAL RESTRICTION. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined in the California Uniform Controlled Substances Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5.

If Respondent forms the medical opinion, after an appropriate prior examination and a medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and a medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

2. CONTROLLED SUBSTANCES - SURRENDER OF DEA PERMIT. Respondent is prohibited from practicing medicine until Respondent provides documentary proof to the Board or its designee that Respondent's DEA permit has been surrendered to the Drug Enforcement Administration for cancellation, together with any state prescription forms and all controlled substances order forms. Thereafter, Respondent shall not reapply for a new DEA permit without the prior written consent of the Board or its designee.

3. COMMUNITY SERVICE - FREE SERVICES. Within sixty (60) calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval a community service plan in which Respondent shall, within the first two (2) years of probation, provide forty (40) hours of free services (e.g., medical or nonmedical) to a community or non-profit organization. If the term of probation is designated for two (2) years or less, the community service hours must be completed not later than six (6) months prior to the completion of probation.

Prior to engaging in any community service, Respondent shall provide a true copy of the Decision(s) to the chief of staff, director, office manager, program manager, officer, or the chief executive officer at every community or non-profit organization where Respondent provides community service and shall submit proof of compliance to the Board or its designee within fifteen (15) calendar days. This condition shall also apply to any change(s) in community service.

Community service performed prior to the effective date of the Decision shall not be accepted in fulfillment of this condition.

4. EDUCATION COURSE. Within sixty (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 forty (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 sixty-five (65) hours of CME of which forty (40) hours were in satisfaction of this condition.

5. PRESCRIBING PRACTICES COURSE – Condition Satisfied. Within sixty (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 First Amended 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 fifteen (15) calendar days after successfully completing the course, or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

6. MEDICAL RECORD KEEPING COURSE – Condition Satisfied. Within sixty (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 First Amended 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 fifteen (15) calendar days after successfully completing the course, or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

7. PROFESSIONALISM PROGRAM (ETHICS COURSE) – Condition Satisfied. Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations ("CCR") section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education ("CME") requirements for renewal of licensure.

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

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

8. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within sixty (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 one (1) year 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, First Amended Accusation, 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 three (3) and no more than five (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 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. 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 Respondent did not successfully complete the clinical competence assessment program, 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.

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

The Board or its designee shall provide the approved monitor with copies of the Decision and First Amended Accusation, and a proposed monitoring plan. Within fifteen (15) calendar days of receipt of the Decision, First Amended Accusation and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and First Amended Accusation, 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 sixty (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.

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If Respondent fails to obtain approval of a monitor within sixty (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 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, billing appropriately or both. 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 ten (10) calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within five (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 fifteen (15) calendar days. If Respondent fails to obtain approval of a replacement monitor within sixty (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.

10. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and First Amended 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 fifteen (15) calendar days.

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

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

12. 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.

13. 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 ten (10) calendar days after the end of the preceding quarter.

14. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

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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 thirty (30) calendar days prior to the dates of departure and return.

15. 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.

16. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within fifteen (15) calendar days of any periods of non-practice lasting more than thirty (30) calendar days and within fifteen (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 forty (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 eighteen (18) calendar months, Respondent shall successfully complete the Federation of State Medical Boards' 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.

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

18. 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.

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19. 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 fifteen (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.

20. 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.

ACCEPTANCE

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

DATED: 10/20/19

Mark Anthony Wimbley M.D.
MARK ANTHONY WIMBLEY, M.D.
Respondent

I have read and fully discussed with Respondent Mark Anthony Wimbley, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: October 21, 2019

RAYMOND McMAHON
Attorney for Respondent

ENDORSEMENT

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

DATED: 10/21/19

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2014-005198

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

In the Matter of the First Amended Accusation Against: Mark Anthony Wimbley, M.D. 12 Freedom Place Irvine, CA 92602 Physician's and Surgeon's Certificate No. G 75382, Respondent.	Case No. 800-2014-005198 OAH No. 2017010131 **FIRST AMENDED ACCUSATION**

PARTIES

1. Kimberly Kirchmeyer ("Complainant") brings this First 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 October 13, 1992, the Board issued Physician's and Surgeon's Certificate Number G 75382 to Mark Anthony Wimbley, M.D. ("Respondent"). That license was automatically placed on inactive status by operation of law, effective July 12, 2019, pursuant to Business and Professions Code section 2236.2, subdivision (a), and will expire on September 30, 2020, unless renewed.

3. In a disciplinary action entitled *Ex Parte Petition for Interim Suspension Order Against Mark Anthony Wimbley, M.D.*, the Board issued an order, effective October 31, 2016, in which Respondent was ordered not to prescribe any Schedule II, III, or IV controlled substances. The noticed hearing on the *Petition for an Interim Suspension Order* was held on November 17, 2016. The prohibition on prescribing any Schedule II, III, or IV controlled substances was reaffirmed following the noticed hearing. A copy of that order is attached as Exhibit A and is incorporated herein by this reference.

JURISDICTION

4. This First Amended Accusation 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.

5. Pursuant to Code section 2001.1, the Board's highest priority is public protection.

6. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

". . ."

7. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default

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has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

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

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

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

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

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

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

8. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

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

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

9. Section 2236 of the Code states:

"(a) The conviction of any offense substantially related to the qualifications, functions, or duties of a physician and surgeon constitutes unprofessional conduct within the meaning of this chapter [Chapter 5, the Medical Practice Act]. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred.

"(b) The district attorney, city attorney, or other prosecuting agency shall notify the Medical Board of the pendency of an action against a licensee charging a felony or misdemeanor immediately upon obtaining information that the defendant is a licensee. The notice shall identify the licensee and describe the crimes charged and the facts alleged. The prosecuting agency shall also notify the clerk of the court in which the action is pending that the defendant is a licensee,

and the clerk shall record prominently in the file that the defendant holds a license as a physician and surgeon.

"(c) The clerk of the court in which a licensee is convicted of a crime shall, within 48 hours after the conviction, transmit a certified copy of the record of conviction to the board. The division may inquire into the circumstances surrounding the commission of a crime in order to fix the degree of discipline or to determine if the conviction is of an offense substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(d) A plea or verdict of guilty or a conviction after a plea of nolo contendere is deemed to be a conviction within the meaning of this section and Section 2236.1. The record of conviction shall be conclusive evidence of the fact that the conviction occurred."

10. Section 2237 of the Code states:

"(a) The conviction of a charge of violating any federal statutes or regulations or any statute or regulation of this state, regulating dangerous drugs or controlled substances, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of such unprofessional conduct. A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section.

"(b) Discipline may be ordered in accordance with Section 2227 or the Medical Board may order the denial of the license when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing such person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, complaint, information, or indictment."

11. 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."

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12. Section 2242 of the Code states:

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

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

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

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

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

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

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

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

13. 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."

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14. California Code of Regulations, title 16, section 1360, states:

"For the purposes of denial, suspension or revocation of a license, certificate or permit pursuant to Division 1.5 (commencing with Section 475) of the code, a crime or act shall be considered to be substantially related to the qualifications, functions or duties of a person holding a license, certificate or permit under the Medical Practice Act if to a substantial degree it evidences present or potential unfitness of a person holding a license, certificate or permit to perform the functions authorized by the license, certificate or permit in a manner consistent with the public health, safety or welfare. Such crimes or acts shall include but not be limited to the following: Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision of the Medical Practice Act."

HEALTH AND SAFETY CODE SECTIONS

15. Health and Safety Code section 11153 states:

"(a) A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. Except as authorized by this division, the following are not legal prescriptions: (1) an order purporting to be a prescription which is issued not in the usual course of professional treatment or in legitimate and authorized research; or (2) an order for an addict or habitual user of controlled substances, which is issued not in the course of professional treatment or as part of an authorized narcotic treatment program, for the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use.

"(b) Any person who knowingly violates this section shall be punished by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, or in a county jail not exceeding one year, or by a fine not exceeding twenty thousand dollars ($20,000), or by both that fine and imprisonment.

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16. Health and Safety Code section 11154 states:

"(a) Except in the regular practice of his or her profession, no person shall knowingly prescribe, administer, dispense, or furnish a controlled substance to or for any person or animal which is not under his or her treatment for a pathology or condition other than addiction to a controlled substance, except as provided in this division."

FACTUAL SUMMARY

17. On July 15, 2019, in proceedings entitled *The People of the State of California v. Mark Anthony Andrew Wimbley*, case number 15CF2740, in the Orange County Superior Court, Respondent, upon his guilty plea, was convicted of guilty of nine counts of violating Health & Safety Code section 11153, subdivision (a), unlawful prescribing of controlled substance without legitimate medical purpose, misdemeanor offenses within the meaning of Business and Professions Code section 2236.2.

18. Respondent offered the following facts as the basis for his guilty plea:

"In Orange County, California, on July 3, 2013, July 10, 2013, August 8, 2013, August 28, 2013, August 28, 2013, September 11, 2013, September 11, 2013, September 25, 2013 and September 25, 2013, [Respondent] did unlawfully prescribe a controlled substance without a legitimate medical purpose and not in the usual course of my professional practice."

19. Respondent was sentenced to Orange County jail for one-hundred eighty (180) days and probation for three years, including the following terms and conditions:

A. pay various court related fines and fees;

B. pay restitution in the amount to be determined;

C. provide DNA sample and prints for the State DNA database pursuant to Penal Code sections 296 and 296.1;

D. submit person and property, any residence, premises, container or vehicle under his control, not including electronic devices, to search and seizure at any time of the day or night by any law enforcement officer, probation officer, or mandatory supervision officer, with or without a warrant, probable cause, or reasonable suspicion;

E. violate no law;

F. obey all orders, rules, regulations and directives of the Medical Board;

G. obey all orders, rules, regulations, and directives of the Court, Probation Department, and jail; and

H. disclose probation status and terms upon the request of any peace officer.

20. The Felony Complaint Warrant filed on December 10, 2015, alleged nine counts of Respondent unlawfully prescribing a controlled substance without a legitimate medical purpose and not in the usual course of his professional practice, in violation of Health and Safety Code section 11153(a) on the following days: July 3, 2013, July 10, 2013, August 8, 2013, August 28, 2013, August 28, 2013, September 11, 2013, September 11, 2013, September 25, 2013, and September 25, 2013.

21. During the period from March 26, 2013, up to and including September 25, 2013, four (4) undercover operatives ("UC's") visited Respondent's office. These visits were digitally recorded using both audio and video recording devices.

Undercover Operative Number 1:

22. Respondent first saw Undercover Operative Number 1 (UC1) on March 26, 2013, at approximately 5:15 p.m., in Respondent's office. UC1 met with Respondent until approximately 5:43 p.m. During that time Respondent and UC1 discussed UC1's relationships, meeting women, and UC1's sexual encounters.

23. At approximately 5:31 p.m., Respondent asked UC1 if he was taking Roxicodone.[1] UC1 responded that he was taking Roxicodone, but also needed Norco[2] and Soma.[3] UC1 told Respondent that he had neck pain, but had left the imaging disks (MRI and Cat Scan from Hoag

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[1] Roxicodone is a powerful opioid used as a painkiller.

[2] Norco is an analgesic formulation of acetaminophen (related to aspirin) and hydrocodone (a semisynthetic opioid analgesic similar to but more active than codeine) resulting in an opiate drug used as a painkiller.

[3] Soma is a skeletal muscle relaxant.

Hospital) in his car. In exchange for $160.00 Respondent prescribed Roxicodone #55 30 mg, Norco #40 10/325 mg and Soma #30 35 mg.[4]

24. Respondent did not perform any examination of UC1, did not ask UC1 about his pain and did not touch UC1 at any time during their meeting.

25. Respondent next saw UC1 on April 4, 2013, at approximately 1:43 p.m. In exchange for $160.00 Respondent again prescribed Roxicodone #55 30 mg, Norco #40 10/325 mg and Soma #30 35 mg. Respondent did not perform any examination of UC1, did not ask UC1 about his pain and did not touch UC1 at any time during their second meeting.

26. Respondent next saw UC1 on May 8, 2013, at 3:37 p.m. At this meeting Respondent told UC1 that he had heard "things" about him and asked several questions about UC1's job and other questions indicating that he was suspicions of UC1. UC1 reported after this meeting that Respondent kept glancing at UC1's bag, which held the digital video recording device.

27. At the May 8, 2013, visit, Respondent asked UC1 about his pain and performed a cursory examination of UC1, using a small reflex hammer and briefly tapping on both of UC1's arms. Respondent also used another unidentified tool asking UC1 if he could feel the tool when rolled over UC1's hands. Respondent also told UC1 that he wanted the MRI and Cat Scan reports.

28. Prior to leaving Respondent's office UC1 paid $160.00 and received a prescription for Roxicodone #55 30 mg, Norco #40 10/325 mg and Soma #30 35 mg and Naproxen[5] #60 500 mg.

Undercover Operative Number 2:

29. Respondent first saw Undercover Operative Number 2 (UC2) on July 3, 2013, at approximately 3:11 p.m. Respondent wrote a prescription for UC2 for Roxicodone #55 30 mg,

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[4] All prescription notations follow the form of drug prescribed (Roxicodone), number of tablets prescribed (#55) and dosage (30 mg).

[5] Naproxen is a nonsteroidal anti-inflammatory drug used to treat fever and pain.

OxyContin[6] #20 80 mg and Xanax[7] #20 2 mg. Respondent told UC2 that the charge was $200.00, but UC2 told Respondent he had only $80.00 in cash and would pay the rest later. Respondent took the $80.00 in exchange for the prescription.

30. Respondent did not perform any examination of UC2, did not ask UC2 about his pain and did not touch UC2 at any time during their meeting.

Undercover Operatives Numbers 2 and 3:

31. On July 10, 2013, at approximately 10:50 a.m., UC2 contacted Respondent and told him UC2 had a new patient for Respondent. Respondent advised UC2 to come to his office at 4:30 p.m. with the new patient.

32. On July 10, 2013, at approximately 4:30 p.m., UC2 and Undercover Operative Number 3 (UC3) arrived at Respondent's office. Respondent met with UC3 and after discussing her prior prescriptions with her, had her walk to the door on her heels and then walk back on her toes. Respondent then asked UC3 if anything was happening when she walked that way. UC3 said that it was not painful. Respondent then asked UC3 to lay on her back, at which time UC3 complained of a sharp pain in her lower back. Respondent had her lift her legs and also tapped on her knees with a reflex hammer. Respondent advised UC3 that she probably had a herniated disc. After telling UC3 to sit up, Respondent left the room. No other physical examination of any nature was conducted by Respondent at that visit.

33. Respondent did not ask UC3 about any past treatment if she had any diagnostic tests performed and did not refer her to a specialist.

34. Respondent returned and advised UC3 on the proper usage of the medications he was going to prescribe, advising her to take low dosages as much as possible. After discussing the dosages with her, Respondent told UC3 that the first visit was usually $250.00. UC3 told Respondent that she only had $200.00, which Respondent accepted in exchange for the prescription for Norco #55 10/325 mg, Ambien[8] #15 10 mg and Xanax #10 1 mg. At the same

[6] OxyContin is a powerful opioid narcotic analgesic.

[7] Xanax is an antianxiety medication.

[8] Ambien is a sedative for treatment of insomnia.

time, and with no examination, Respondent provided UC2 a prescription for Roxicodone #55 30 mg and OxyContin #50 40 mg in exchange for $200.00.

35. UC2 and UC3 also stated that Respondent had provided paperwork in the waiting room to fill out. The paperwork consisted of an Authorization for Treatment, Medication Agreement, Patient History Form and Pain Assessment Form. UC3 indicated a pain level of 6 on a scale of 10. UC2 did not recall what he had indicated, if anything.

36. Respondent next saw UC3 on August 8, 2013, at approximately 4:50 p.m. With no examination whatsoever Respondent asked, "What do you need today?" UC3 told Respondent that she needed something stronger than the Vicodin that he had previously prescribed. At the same time, UC3 handed cash to Respondent, which he placed in his front pants pocket. Respondent then asked UC3 to fill out a pain questionnaire form, on which she indicated pain at "5 out of 10."

37. Respondent discussed the medications that were being prescribed with UC3 and also advised her not to take Valium,[9] but to change to Ambien because it was not "as suspicious" to pharmacists. Respondent also advised UC3 on other methods to avoid having a pharmacy question the medications being prescribed.

38. In exchange for $250.00 Respondent gave UC3 a prescription for OxyContin #20 20 mg, Ambien #20 5 mg and Xanax #20 1 mg. No physical examination of any nature was performed at this visit.

Undercover Operatives Numbers 3 and 4:

39. On August 27, 2013, at approximately 12:18 p.m., UC3 contacted Respondent and told him UC3 had a new patient for Respondent. Respondent advised UC3 to come to his office at 4:30 p.m., with the new patient.

40. On August 28, 2013, at approximately 4:30 p.m., UC3 and Undercover Operative Number 4 (UC4)[10] arrived at Respondent's office.

41. After arrival at Respondent's office UC3 and UC4 were asked to fill out several pages

[9] Valium is a tranquilizer used to relieve anxiety and relax muscles.

[10] Undercover Operative Number 4 is a Drug Enforcement Administration Special Agent.

of paperwork, including a pain questionnaire, disclosure forms, a release of liability form, patient agreement, and a front sheet for personal patient information, which UC4 left mostly blank. UC4 indicated 8 out of 10 on the pain scale.

42. At the August 28, 2013, visit UC3 told Respondent that she was experiencing pain in her lower back. Respondent asked several questions about the pain, including if it was present when she walked and if it affected the soles of her feet. Respondent asked UC3 to walk on her heels and her toes. UC3 told Respondent that it was not comfortable when she did that. Respondent then had UC3 lie on her back, and he raised one of her legs, dropping it abruptly. UC3 told Respondent that the abrupt dropping of her leg caused pain in her lower back. Respondent repeated the procedure with the other leg, with a similar result and then advised UC3 that she had a herniated disk. Respondent asked if an MRI was done for UC3. After UC3 responded in the affirmative, Respondent asked her to bring it with her next time she came.

43. Respondent then discussed various medication options, in addition to the requested OxyContin, with UC3 including a discussion of proper dosages. Respondent then placed UC3 on what he called a "pain relief machine" which appeared to be an electrical stimulation apparatus, and applied electrical stimulation to UC3 for several minutes.

44. While UC3 was on the electrical stimulus machine, Respondent turned to UC4, who had been in the room the entire time, and asked her what her issues were.

45. UC4 told Respondent that she had been in an automobile accident several years prior and still suffered lower back pain. After discussing the accident and immediately following events, including the taking of an MRI, Respondent asked UC4 to bring him a copy of the MRI. Initially UC4 denied knowing what the MRI showed, but when Respondent asked if it showed a herniated disk UC4 stated that it did.

46. Respondent then discussed pain relief medication options with UC4 for several minutes. This discussion included the need to be careful so that people reviewing these prescriptions did not have any reason to scrutinize either the patient or him more carefully than usual. Respondent specifically stated that he could not write a prescription for Roxicodone because it might create a scrutiny issue with a pharmacy when the prescription was filled.

Respondent then told UC4 he would examine her now, while UC3 was still on the electrical stimulus machine, and asked her to stand up and walk on her heels and then her toes. UC4 told Respondent that it was not painful. Respondent and UC4 then went into another room to complete the examination.

47. Respondent asked UC4 to provide medical records from her prior doctors because he was unable to give her strong pain medications without that documentary support.

48. Less than 60 seconds later Respondent and UC4 returned to the room where UC3 was still connected to the electrical stimulus machine. Respondent removed the stimuli pads from UC3 and UC4 was then attached to the electrical stimulus machine. After ten minutes UC4 was removed from the machine.

49. Respondent, UC3 and UC4 then all went to Respondent's office where he discussed medication options with them for approximately five minutes. UC3 then paid Respondent $250.00 in cash and received a prescription for OxyContin #20 20 mg, Ambien #20 10 mg, Xanax #20 2 mg and Soma #20 350 mg. UC4 then paid Respondent $250.00 in cash and received a prescription for Norco #45 10/325 mg, Motrin[11] #50 and Soma #30 350 mg.

50. Respondent next saw both UC3 and UC4 together on September 11, 2013, at approximately 5:20 p.m. For that visit UC3 was provided an MRI image from a healthy female subject and UC4 was provided a blank disk, which she was to tell Respondent contained an MRI and medical records.

51. UC3 and UC4 went to Respondent's office together and Respondent viewed the MRI image from UC3. UC3 then told Respondent that she was continuing to experience pain in her lower back. UC3 asked Respondent for a higher pill count or a higher dosage for the prescription. Respondent then began discussing various medications, eventually inquiring if UC3 had tried morphine.[12] UC3 stated that she had tried morphine and that it worked very well.

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[11] Motrin is an ibuprofen painkiller sold over the counter in lesser dosages.

[12] Morphine is a potent opiate analgesic drug that is used to relieve severe pain.

52. UC3 discussed what medications she was taking with Respondent while he wrote out the prescriptions. UC3 then paid Respondent $200.00 and received a prescription for OxyContin #21 20 mg, Ambien #20 10 mg, Xanax #20 2 mg, Morphine #30 30 mg and Motrin #100 400 mg.

53. UC4 sat in the room with Respondent and UC3 while the above discussion and transaction took place, after which Respondent asked UC4 how her medications were working. UC4 told Respondent that it was not as effective as she needed and asked for OxyContin instead of the Norco. Respondent discussed the medication options with UC4 for approximately 2 minutes and also advised them to keep coming back every two weeks because if he prescribed lower amounts of medications it was less likely to cause "red flags" at a pharmacy. Respondent also advised UC3 and UC4 not to go into the same pharmacy together to have the prescriptions filled.

54. UC4 then paid Respondent $200.00 and received a prescription for OxyContin #21 20 mg, Norco #21 10/325 mg and Motrin #100 400 mg.

55. Respondent next saw UC3 on September 25, 2013, at approximately 4:35 p.m. On this occasion UC4 did not accompany UC3, but UC3 was able to procure a prescription from Respondent for UC4.

56. UC3 told Respondent that UC4 was unable to come to the office because she had to work, but needed the medications refilled. UC3 then requested a prescription for Adderall[13] be added to her prior medications. Respondent discussed the Adderall prescription at some length focusing on his perception that it might be a "red flag" for pharmacies and that he was very reluctant to prescribe that medication.

57. Following the discussion about Adderall, UC3 paid Respondent $200.00 and was given a prescription for OxyContin #21 20 mg, Morphine #30 30 mg, and Adderall #10 20 mg.

58. After she received her prescriptions, UC3 asked Respondent if she could get a prescription for UC4. Respondent agreed and UC3 paid Respondent an additional $200.00

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[13] Adderall is a central nervous system stimulant commonly used for patients with attention-deficit hyperactivity disorder who do not respond well to Ritalin.

ostensibly from UC4 and was given a prescription in the name of UC4 for OxyContin #21 20 mg and Morphine #30 30 mg.

59. For UC1, UC2, UC3 and UC4 at no time did Respondent: (a) obtain an adequate history or any history whatsoever; (b) confirm the current use of controlled substance medications with CURES (Physician Drug Monitoring Program in California) and Urine Drug Testing, and that they were not using any other controlled substance medication; (c) obtain a current/past history of alcohol/drug abuse; (d) obtain an adequate mental health history; (e) perform an adequate (or any) physical exam; (f) determine the functional ability or inability due to the patient's pain; (g) document an informed consent of specific risks/benefits of the treatment; (h) document specific treatment goals and management plans; (i) utilize additional treatment for the pain, including non-pharmacological treatments; (j) determine and document a medically legitimate diagnosis; and (k) appropriately document the visit with a progress note that conforms to even the minimum standards required.

Patient M.A.:[14]

60. Respondent first saw M.A. on or about October 24, 2010, for complaints of low back pain. The last documented visit was on May 18, 2015. Respondent prescribed Oxycodone[15] 30 mg + Hydrocodone[16] 10/325 mg to M.A.

61. Respondent's progress notes indicate no X-ray or vital signs were taken. No additional history, PMH[17] Assessment, or treatment plan was discussed. No informed consent specific to opioids or controlled substance medications was signed. Neither was a physical examination performed.

62. At no time did Respondent: (a) obtain an adequate history or any history whatsoever; (b) confirm the current use of controlled substance medications with CURES and Urine Drug

[14] The patients herein are identified by initials to protect their privacy.

[15] Oxycodone is an opioid analgesic derived from morphine.

[16] Hydrocodone is a semisynthetic opioid analgesic similar to but more active than codeine used to relieve pain and is six times more potent than codeine. Hydrocodone –Acetaminophen has an aspirin related compound added to reduce fever.

[17] Past Medical History.

Testing, and that he was not using any other controlled substance medication; (c) obtain a current/past history of alcohol/drug abuse; (d) obtain an adequate mental health history; (e) perform an adequate (or any) physical exam; (f) determine the functional ability or inability due to the patient's pain; (g) document an informed consent of specific risks/benefits of the treatment; (h) document specific treatment goals and management plans; (i) utilize additional treatment for the pain, including non-pharmacological treatments; (j) determine and document a medically legitimate diagnosis; and (k) appropriately document the visit with a progress note that conforms to even the minimum standards required.

Patient D.B.:

63. Respondent first saw D.B. on January 23, 2013, for complaints of a herniated disc and muscle spasms. The last documented visit was on February 17, 2015. Respondent saw D.B. on June 11, 2013, July 25, 2013, October 17, 2013, March 24, 2014, May 9, 2014, and on fifteen (15) additional occasions after March 2014 according to the CURES reports. Respondent prescribed Oxycodone 30 mg, Hydrocodone 10/325 mg to D.B.

64. Respondent's progress notes indicate no X-ray or vital signs were taken. No additional history, PMH Assessment, or treatment plan was discussed. No informed consent specific to opioids or controlled substance medications was signed. Neither was a physical examination performed.

65. At no time did Respondent: (a) obtain an adequate history or any history whatsoever; (b) confirm the current use of controlled substance medications with CURES and Urine Drug Testing, and that he was not using any other controlled substance medication; (c) obtain a current/past history of alcohol/drug abuse; (d) obtain an adequate mental health history; (e) perform an adequate (or any) physical exam; (f) determine the functional ability or inability due to the patient's pain; (g) document an informed consent of specific risks/benefits of the treatment; (h) document specific treatment goals and management plans; (i) utilize additional treatment for the pain, including non-pharmacological treatments; (j) determine and document a medically legitimate diagnosis; and (k) appropriately document the visit with a progress note that conforms to even the minimum standards required.

Patient G.B.:

66. Respondent first saw G.B. on January 6, 2013, for complaints of right leg pain. The last documented visit was on May 27, 2015. Respondent saw G.B. on January 21, 2013, September 23, 2013, February 20, 2014, April 10, 2014, January 5, 2015, January 21, 2015, April 6, 2015, April 24, 2015, May 7, 2015, and May 27, 2015. Respondent prescribed Oxycodone 30 mg + Hydrocodone 10/325 mg to G.B.

67. Respondent's progress notes indicate no X-ray or vital signs were taken. No additional history, PMH Assessment, or treatment plan was discussed. No informed consent specific to opioids or controlled substance medications was signed. Neither was a physical examination performed.

68. At no time did Respondent: (a) obtain an adequate history or any history whatsoever; (b) confirm the current use of controlled substance medications with CURES and Urine Drug Testing, and that he was not using any other controlled substance medication; (c) obtain a current/past history of alcohol/drug abuse; (d) obtain an adequate mental health history; (e) perform an adequate (or any) physical exam; (f) determine the functional ability or inability due to the patient's pain; (g) document an informed consent of specific risks/benefits of the treatment; (h) document specific treatment goals and management plans; (i) utilize additional treatment for the pain, including non-pharmacological treatments; (j) determine and document a medically legitimate diagnosis; and (k) appropriately document the visit with a progress note that conforms to even the minimum standards required.

Patient R.C.:

69. Respondent's first documented prescription to R.C. was on October 1, 2013, (although the date of his first visit is unknown). The last documented visit was on June 4, 2015. Respondent prescribed Oxycodone 30 mg + Hydrocodone 10/325 mg to R.C. on more than forty occasions.

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70. Respondent's minimal progress notes indicate no X-ray or vital signs were taken. No additional history, PMH Assessment, or treatment plan was discussed. No informed consent specific to opioids or controlled substance medications was signed. Neither was a physical examination performed.

71. At no time did Respondent: (a) obtain an adequate history or any history whatsoever; (b) confirm the current use of controlled substance medications with CURES and Urine Drug Testing, and that he was not using any other controlled substance medication; (c) obtain a current/past history of alcohol/drug abuse; (d) obtain an adequate mental health history; (e) perform an adequate (or any) physical exam; (f) determine the functional ability or inability due to the patient's pain; (g) document an informed consent of specific risks/benefits of the treatment; (h) document specific treatment goals and management plans; (i) utilize additional treatment for the pain, including non-pharmacological treatments; (j) determine and document a medically legitimate diagnosis; and (k) appropriately document the visit with a progress note that conforms to even the minimum standards required.

Patient M.L.:

72. Respondent's first visit with M.L. was on February 26, 2009, with complaints of back pain and the first documented prescription was on September 24, 2013. The last documented visit was on June 22, 2009, and the last documented prescription was on June 13, 2015. On February 26, 2009, Respondent's notes indicate a complaint of lumbar spine and shoulder pain. Respondent prescribed Oxycodone 30 mg, Hydrocodone 10/325 mg, Carisoprodol #40 and a Benzodiazepine[18] to M.L. on ninety-four occasions.

73. Respondent's minimal progress notes indicate no vital signs were taken. No additional history, PMH Assessment, or treatment plan was discussed. No informed consent specific to opioids or controlled substance medications was signed. Neither was a physical examination performed.

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[18] Benzodiazepine is a class of drugs having similar effects including antianxiety, muscle relaxing, and sedative and hypnotic effects.

74. At no time did Respondent: (a) obtain an adequate history or any history whatsoever; (b) confirm the current use of controlled substance medications with CURES and Urine Drug Testing, and that he was not using any other controlled substance medication; (c) obtain a current/past history of alcohol/drug abuse; (d) obtain an adequate mental health history; (e) perform an adequate (or any) physical exam; (f) determine the functional ability or inability due to the patient's pain; (g) document an informed consent of specific risks/benefits of the treatment; (h) document specific treatment goals and management plans; (i) utilize additional treatment for the pain, including non-pharmacological treatments; (j) determine and document a medically legitimate diagnosis; and (k) appropriately document the visit with a progress note that conforms to even the minimum standards required.

Patient J.M.:

75. Respondent's first visit with J.M. was on November 9, 2012, with complaints of low back pain. The last documented visit was on May 21, 2015. Respondent prescribed Oxycodone 30 mg and OxyContin 80 mg to J.M. on over seventy (70) occasions from the time of the first to the last visit.

76. Respondent's minimal progress notes indicate no X-ray or vital signs were taken. No additional history, PMH Assessment, or treatment plan was discussed. No informed consent specific to opioids or controlled substance medications was signed. Neither was a physical examination performed.

77. At no time did Respondent: (a) obtain an adequate history or any history whatsoever; (b) confirm the current use of controlled substance medications with CURES and Urine Drug Testing, and that he was not using any other controlled substance medication; (c) obtain a current/past history of alcohol/drug abuse; (d) obtain an adequate mental health history; (e) perform an adequate (or any) physical exam; (f) determine the functional ability or inability due to the patient's pain; (g) document an informed consent of specific risks/benefits of the treatment; (h) document specific treatment goals and management plans; (i) utilize additional treatment for the pain, including non-pharmacological treatments; (j) determine and document a medically

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legitimate diagnosis; and (k) appropriately document the visit with a progress note that conforms to even the minimum standards required.

Patient H.M.:

78. Respondent's first visit with H.M. was in March of 2004, but there are no progress notes after 2007, despite prescriptions being written up until March 20, 2014. Respondent prescribed Hydrocodone – Acetaminophen 7.5/750 mg to H.M. in an amount equal to 6,000 mg per day over the course of two months in February and March 2014, which represents a potentially toxic dosage.

79. Respondent's original minimal progress notes indicate no X-ray or vital signs were taken. No additional history, PMH Assessment, or treatment plan was discussed. No informed consent specific to opioids or controlled substance medications was signed. Neither was a physical examination performed.

80. At no time did Respondent: (a) obtain an adequate history or any history whatsoever; (b) confirm the current use of controlled substance medications with CURES and Urine Drug Testing, and that she was not using any other controlled substance medication; (c) obtain a current/past history of alcohol/drug abuse; (d) obtain an adequate mental health history; (e) perform an adequate (or any) physical exam; (f) determine the functional ability or inability due to the patient's pain; (g) document an informed consent of specific risks/benefits of the treatment; (h) document specific treatment goals and management plans; (i) utilize additional treatment for the pain, including non-pharmacological treatments; (j) determine and document a medically legitimate diagnosis; and (k) appropriately document the visit with a progress note that conforms to even the minimum standards required.

Patient B.P.:

81. Respondent's first visit with B.P. was in October 2012, for complaints of Sciatica and shoulder pain. The last documented visit was on June 17, 2015. Respondent prescribed Oxycodone 30 mg + Hydrocodone 10/325 mg to B.P. on more than thirty-five occasions.

82. Respondent's minimal progress notes indicate no X-ray or vital signs were taken. No additional history, PMH Assessment, or treatment plan was discussed. No informed consent

specific to opioids or controlled substance medications was signed. Neither was a physical examination performed.

83. At no time did Respondent: (a) obtain an adequate history or any history whatsoever; (b) confirm the current use of controlled substance medications with CURES and Urine Drug Testing, and that he was not using any other controlled substance medication; (c) obtain a current/past history of alcohol/drug abuse; (d) obtain an adequate mental health history; (e) perform an adequate (or any) physical exam; (f) determine the functional ability or inability due to the patient's pain; (g) document an informed consent of specific risks/benefits of the treatment; (h) document specific treatment goals and management plans; (i) utilize additional treatment for the pain, including non-pharmacological treatments; (j) determine and document a medically legitimate diagnosis; and (k) appropriately document the visit with a progress note that conforms to even the minimum standards required.

Patient J.S.:

84. Respondent's first and last documented visit with J.S. was not dated, for complaints of neck and back pain. However, the CURES report shows that Respondent prescribed Hydrocodone-Acetaminophen and Benzodiazepine to J.S. on eight occasions.

85. Respondent's minimal progress note indicates no X-ray or vital signs were taken. No additional history, PMH Assessment, or treatment plan was discussed. No informed consent specific to opioids or controlled substance medications was signed. Neither was a physical examination performed.

86. At no time did Respondent: (a) obtain an adequate history or any history whatsoever; (b) confirm the current use of controlled substance medications with CURES and Urine Drug Testing, and that he was not using any other controlled substance medication; (c) obtain a current/past history of alcohol/drug abuse; (d) obtain an adequate mental health history; (e) perform an adequate (or any) physical exam; (f) determine the functional ability or inability due to the patient's pain; (g) document an informed consent of specific risks/benefits of the treatment; (h) document specific treatment goals and management plans; (i) utilize additional treatment for the pain, including non-pharmacological treatments; (j) determine and document a medically

legitimate diagnosis; and (k) appropriately document the visit with a progress note that conforms to even the minimum standards required.

Patient K.S.:

87. Respondent's first visit with K.S. was on September 23, 2013, for complaints of low back pain. The last documented visit was on June 16, 2015. Respondent prescribed Oxycodone, Hydrocodone- Acetaminophen and Carisoprodol to K.S. on more than one hundred and forty occasions.

88. Respondent's progress notes indicate no X-ray or vital signs were taken. No additional history, PMH Assessment, or treatment plan was discussed. No informed consent specific to opioids or controlled substance medications was signed. Neither was a physical examination performed.

89. At no time did Respondent: (a) obtain an adequate history or any history whatsoever; (b) confirm the current use of controlled substance medications with CURES and Urine Drug Testing, and that he was not using any other controlled substance medication; (c) obtain a current/past history of alcohol/drug abuse; (d) obtain an adequate mental health history; (e) perform an adequate (or any) physical exam; (f) determine the functional ability or inability due to the patient's pain; (g) document an informed consent of specific risks/benefits of the treatment; (h) document specific treatment goals and management plans; (i) utilize additional treatment for the pain, including non-pharmacological treatments; (j) determine and document a medically legitimate diagnosis; and (k) appropriately document the visit with a progress note that conforms to even the minimum standards required.

Patient R.S.:

90. Respondent's first visit with R.S. was on August 20, 2013, with complaints of low back and knee pain. The last documented visit was on June 5, 2015. Respondent prescribed Oxycodone, Hydrocodone-Acetaminophen and Carisoprodol to R.S. on thirty-six occasions.

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91. Respondent's original minimal progress notes indicate no X-ray or vital signs were taken. No additional history, PMH Assessment, or treatment plan was discussed. No informed consent specific to opioids or controlled substance medications was signed. Neither was a physical examination performed.

92. At no time did Respondent: (a) obtain an adequate history or any history whatsoever; (b) confirm the current use of controlled substance medications with CURES and Urine Drug Testing, and that he was not using any other controlled substance medication; (c) obtain a current/past history of alcohol/drug abuse; (d) obtain an adequate mental health history; (e) perform an adequate (or any) physical exam; (f) determine the functional ability or inability due to the patient's pain; (g) document an informed consent of specific risks/benefits of the treatment; (h) document specific treatment goals and management plans; (i) utilize additional treatment for the pain, including non-pharmacological treatments; (j) determine and document a medically legitimate diagnosis; and (k) appropriately document the visit with a progress note that conforms to even the minimum standards required.

Patient S.T.:

93. Respondent's first visit with S.T. was on September 4, 2014, for complaints of back and face pain. The last documented visit was on January 20, 2015. Respondent prescribed Oxycodone, Hydrocodone- Acetaminophen and/or Carisoprodol to S.T. on thirty-six occasions.

94. Respondent's original minimal progress notes indicate no X-ray or vital signs were taken. No additional history, PMH Assessment, or treatment plan was discussed. No informed consent specific to opioids or controlled substance medications was signed. Neither was a physical examination performed.

95. At no time did Respondent: (a) obtain an adequate history or any history whatsoever; (b) confirm the current use of controlled substance medications with CURES and Urine Drug Testing, and that she was not using any other controlled substance medication; (c) obtain a current/past history of alcohol/drug abuse; (d) obtain an adequate mental health history; (e) perform an adequate (or any) physical exam; (f) determine the functional ability or inability due to the patient's pain; (g) document an informed consent of specific risks/benefits of the treatment;

(h) document specific treatment goals and management plans; (i) utilize additional treatment for the pain, including non-pharmacological treatments; (j) determine and document a medically legitimate diagnosis; and (k) appropriately document the visit with a progress note that conforms to even the minimum standards required.

Patient B.T.:

96. Respondent's first visit with B.T. was on March 29, 2012 (because many pages in the medical records of B.T. were not dated, there may have been an earlier visit), for complaints of back pain. The last documented visit was on June 15, 2015. Respondent prescribed Oxycodone to B.T. on thirty-eight occasions.

97. Respondent's original minimal progress notes indicate no X-ray or vital signs were taken. No additional history, PMH Assessment, or treatment plan was discussed. No informed consent specific to opioids or controlled substance medications was signed. Neither was a physical examination performed.

98. At no time did Respondent: (a) obtain an adequate history or any history whatsoever; (b) confirm the current use of controlled substance medications with CURES and Urine Drug Testing, and that he was not using any other controlled substance medication; (c) obtain a current/past history of alcohol/drug abuse; (d) obtain an adequate mental health history; (e) perform an adequate (or any) physical exam; (f) determine the functional ability or inability due to the patient's pain; (g) document an informed consent of specific risks/benefits of the treatment; (h) document specific treatment goals and management plans; (i) utilize additional treatment for the pain, including non-pharmacological treatments; (j) determine and document a medically legitimate diagnosis; and (k) appropriately document the visit with a progress note that conforms to even the minimum standards required.

Patient J.W.:

99. Respondent's first visit with J.W. was on February 8, 2012, for complaints of back and leg pain. The last documented visit was on June 17, 2015. Respondent prescribed Oxycodone, Hydrocodone- Acetaminophen and Percocet[19] to J.W. on seventy-three occasions.

[19] Percocet is a trademark for a drug containing oxycodone and acetaminophen.

100. Respondent's original minimal progress notes indicate no X-ray or vital signs were taken. No additional history, PMH Assessment, or treatment plan was discussed. No informed consent specific to opioids or controlled substance medications was signed. Neither was a physical examination performed.

101. At no time did Respondent: (a) obtain an adequate history or any history whatsoever; (b) confirm the current use of controlled substance medications with CURES and Urine Drug Testing, and that she was not using any other controlled substance medication; (c) obtain a current/past history of alcohol/drug abuse; (d) obtain an adequate mental health history; (e) perform an adequate (or any) physical exam; (f) determine the functional ability or inability due to the patient's pain; (g) document an informed consent of specific risks/benefits of the treatment; (h) document specific treatment goals and management plans; (i) utilize additional treatment for the pain, including non-pharmacological treatments; (j) determine and document a medically legitimate diagnosis; and (k) appropriately document the visit with a progress note that conforms to even the minimum standards required.

Patient N.W.:

102. Respondent's first visit with N.W. was in late 2013, but the exact date is unknown because records were not fully dated, with complaints of knee pain. The last documented visit was on June 16, 2014. Respondent prescribed Hydrocodone- Acetaminophen to N.W. on seventy-three occasions.

103. Respondent's original minimal progress notes indicate no X-ray or vital signs were taken. No additional history, PMH Assessment, or treatment plan was discussed. No informed consent specific to opioids or controlled substance medications was signed. Neither was a physical examination performed.

104. At no time did Respondent: (a) obtain an adequate history or any history whatsoever; (b) confirm the current use of controlled substance medications with CURES and Urine Drug Testing, and that she was not using any other controlled substance medication; (c) obtain a current/past history of alcohol/drug abuse; (d) obtain an adequate mental health history; (e) perform an adequate (or any) physical exam; (f) determine the functional ability or inability due

to the patient's pain; (g) document an informed consent of specific risks/benefits of the treatment; (h) document specific treatment goals and management plans; (i) utilize additional treatment for the pain, including non-pharmacological treatments; (j) determine and document a medically legitimate diagnosis; and (k) appropriately document the visit with a progress note that conforms to even the minimum standards required.

FIRST CAUSE FOR DISCIPLINE

(Conviction of a Crime)

105. By reason of the facts set forth above in paragraphs 17 through 20, Respondent is subject to disciplinary action under section 2236, subdivision (a), of the Code and California Code of Regulations, Title 16, section 1360 in that he was convicted of nine misdemeanor counts of unlawfully prescribing a controlled substance without legitimate medical purpose, in violation of section 11153, subdivision (a), of the Health and Safety Code, a crime substantially related to the qualifications, functions, or duties of a physician and surgeon.

106. Respondent's acts and/or omissions as set forth in paragraphs 17 through 20 above, whether proven individually, jointly, or in any combination thereof, constitute a conviction of a crime substantially related to the qualifications, functions, or duties of a physician and surgeon in violation of section 2236, subdivision (a), of the Code and California Code of Regulations, Title 16, section 1360. Therefore, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Drug Related Conviction)

107. By reason of the facts set forth above in paragraphs 17 through 20, Respondent is subject to disciplinary action under section 2237, subdivision (a), of the Code and California Code of Regulations, Title 16, section 1360 in that he was convicted of nine misdemeanor counts of unlawfully prescribing a controlled substance without legitimate medical purpose, in violation of section 11153, subdivision (a), of the Health and Safety Code, a state statute regulating controlled substances.

108. Respondent's acts and/or omissions as set forth in paragraphs 17 through 20 above, whether proven individually, jointly, or in any combination thereof, constitute a conviction of

state statute regulating controlled substances pursuant to section 2237, subdivision (a), of the Code. Therefore, cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence)

109. By reason of the matters set forth above in paragraphs 18, and 21 through 59, incorporated herein by this reference, Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he engaged in unprofessional conduct constituting gross negligence. The circumstances are as follows:

110. Respondent's prescribing of multiple controlled substances without medical indication to UC1, UC2, UC3 and UC4 constitutes gross negligence.

FOURTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

111. By reason of the matters set forth above in paragraphs 60 through 104, incorporated herein by this reference, Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that he engaged in unprofessional conduct constituting repeated negligent acts. The circumstances are as follows:

112. Respondent's repeated and continuous failure to assess the effects of the prescriptions given to M.A., D.B., G.B., R.C., M.L., J.M., H.M., B.P., J.S., K.S., R.S., S.T., B.T., J.W. and N.W. constitutes repeated negligent acts.

FIFTH CAUSE FOR DISCIPLINE

(Prescribing Controlled Substances without Medical Indication)

113. By reason of the matters set forth above in paragraphs 18, and 21 through 104, incorporated herein by this reference, Respondent violated Health and Safety Code section 11154, in that he prescribed controlled substances without medical indication for UC1, UC2, UC3, UC4, M.A., D.B., G.B., R.C., M.L., J.M., H.M., B.P., J.S., K.S., R.S., S.T., B.T., J.W. and N.W.

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SIXTH CAUSE FOR DISCIPLINE

(Violating Statute Regulating Controlled Substances)

114. By reason of the matters set forth above in paragraphs 18, and 21 through 104, incorporated herein by this reference, Respondent is subject to disciplinary action under section 2238 of the Code, in that he violated Health and Safety Code section 11154. The circumstances are as follows:

115. Respondent prescribed controlled substances without medical indication to UC1, UC2, UC3, UC4, M.A., D.B., G.B., R.C., M.L., J.M., H.M., B.P., J.S., K.S., R.S., S.T., B.T., J.W. and N.W., which constitutes a violation of Health and Safety Code section 11154 and, thus, section 2238 of the Code, and constitutes unprofessional conduct.

SEVENTH CAUSE FOR DISCIPLINE

(Prescribing Dangerous Drugs without Prior Examination or Medical Indication)

116. By reason of the matters set forth above in paragraphs 18, and 21 through 104, incorporated herein by this reference, Respondent is subject to disciplinary action under section 2242, subdivision (a), of the Code, in that he prescribed dangerous drugs without an appropriate prior examination and/or a medical indication to UC1, UC2, UC3, UC4, M.A., D.B., G.B., R.C., M.L., J.M., H.M., B.P., J.S., K.S., R.S., S.T., B.T., J.W. and N.W. The circumstances are as follows:

117. Respondent prescribed dangerous drugs without performing an appropriate prior examination to UC1, UC2, UC3, UC4, M.A., D.B., G.B., R.C., M.L., J.M., H.M., B.P., J.S., K.S., R.S., S.T., B.T., J.W. and N.W. Respondent's failure to properly examine any of the foregoing patients while prescribing dangerous drugs to those patients constitutes a violation of section 2242, subdivision (a).

EIGHTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

118. By reason of the facts set forth above in paragraphs 17 through 20, Respondent is subject to disciplinary action under section 2234, subdivisions (a) and (e), and section 2238 of the Code and California Code of Regulations, Title 16, section 1360, in that he engaged in

unprofessional conduct by committing dishonest acts substantially related to the qualifications, functions, or duties of a physician and surgeon by pleading guilty to and being convicted of unlawfully (1) transporting a controlled substance between non-contiguous counties in violation of section 11352, subdivision (b), of the Health and Safety Code and (2) issuing a prescription for hydrocodone in violation of section 11153, subdivision (a) of the Health and Safety Code.

119. Respondent's acts and/or omissions as set forth in paragraphs 17 through 20 above, whether proven individually, jointly, or in any combination thereof, constitute unprofessional conduct in violation of section 2234, subdivisions (a) and (e), and section 2238 of the Code. Therefore, cause for discipline exists.

NINTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

120. By reason of the matters set forth above in paragraphs 18, and 21 through 104, incorporated herein by this reference, Respondent violated Code section 2266, in that he failed to keep adequate records for UC1, UC2, UC3, UC4, M.A., D.B., G.B., R.C., M.L., J.M., H.M., B.P., J.S., K.S., R.S., S.T., B.T., J.W. and N.W. The circumstances are as follows:

121. Respondent's notes for UC1, UC2, UC3, UC4, M.A., D.B., G.B., R.C., M.L., J.M., H.M., B.P., J.S., K.S., R.S., S.T., B.T., J.W. and N.W. are incomplete and wholly lacking in required information concerning the provision of services to respective patients.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 75382, issued to Mark Anthony Wimbley, M.D.;

2. Revoking, suspending or denying approval of Mark Anthony Wimbley, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Mark Anthony Wimbley, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: September 25, 2019

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

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EXHIBIT A

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

KIMBERLY KIRCHMEYER, Executive Director, Medical Board, State of California, Petitioner, v. MARK ANTHONY WIMBLEY, M.D., Physician's and Surgeon's Certificate No. G 75382, Respondent.	Case No. 800-2014-005198 OAH No. 2016100989

INTERIM SUSPENSION ORDER

On October 27, 2016, Kimberly Kirchmeyer (Petitioner), Executive Director, Medical Board of California (Board), filed an Ex Parte Petition for Interim Suspension Order (Petition) pursuant to Government Code section 11529, seeking to suspend, pending a full hearing on the merits, the physician's and surgeon's certificate issued to Mark Anthony Wimbley, M.D. (Respondent).

The matter regularly came for hearing before Samuel D. Reyes, Administrative Law Judge, Office of Administrative Hearings, at Los Angeles, California, on October 28, 2016. Randall R. Murphy, Deputy Attorney General, represented Petitioner. David Klehm, Attorney at Law, represented Respondent. The parties submitted documents and presented arguments, and the matter was submitted for decision. On October 31, 2016, an Order issued restricting Respondent's certificate pursuant to Government Code section 11529.

On November 17, 2016, the matter regularly came for hearing before the Administrative Law Judge pursuant to the notice required by Government Code section 11529, subdivision (b). Randall R. Murphy, Deputy Attorney General, represented Petitioner. Raymond J. McMahon, Attorney at Law, represented Respondent. Petitioner and Respondent submitted documents, consecutively marked as Exhibits I, II, III, V, VI, VII, and VIII. The parties also presented oral argument.

The documentary evidence presented by Petitioner contained a mix of affidavits and other documents. In addition to a Certificate of Licensure issued by the Board pursuant to Business and Professions Code section 162 and a copy of a Felony Complaint Warrant, Petitioner submitted the Declaration of Special Agent Keith Bridgford (Bridgford), which has several attachments, including two expert reports and transcripts of recorded undercover operations. Bridgford is the Drug Enforcement Administration (DEA) agent in charge of the investigation, and a person familiar with the documents attached to his declaration. Exhibit VII, discussed below, also contains a declaration from Bridgford and an attached expert report.

Respondent objects to reliance on documentary evidence not in the form of affidavits, and urges dismissal of the Petition because not all evidence submitted was in the form of affidavits. For the reasons set forth in the Legal Conclusions, Respondent's objections are overruled, and Exhibits I (evidentiary portions), III, VII, and VIII are received in evidence. The objections have nevertheless been considered in determining the weight, if any, to give the evidence.

Petitioner submitted a Request to Consider Supplemental Report by Dr. Munzing and a Declaration of Special Agent Keith Bridgford (Supplemental Report), which were marked collectively as Exhibit VII. The record was left open for Respondent to reply to Exhibit VII. On December 2, 2016, Respondent filed a document entitled "Objections to Complainant's Supplemental Report and Declaration of Special Agent Keith Bridgford," which document has been marked as Exhibit IX. As set forth above, the objections are overruled.

The matter was submitted for decision on December 2, 2016.

FACTUAL FINDINGS

1. Petitioner filed the Petition in her official capacity.

2. On October 13, 1992, the Board issued Physician's and Surgeon's Certificate G 75382 to Respondent, which certificate has been renewed through September 30, 2018.

3. The DEA conducted nine separate undercover operations in its investigation of Respondent's practice. Three confidential informants and one undercover DEA investigator posed as patients seeking medical services from Respondent. The "patient" visits occurred between March 26, 2013, and September 25, 2013, and the interactions with Respondent were recorded. The information obtained from these undercover operations was provided to Rich Chavez, M.D. (Chavez) and Timothy A. Munzing, M.D. (Munzing) for their expert review. Dr. Chavez is a pain and addiction specialist. Dr. Munzing is a board-certified family medicine physician with extensive experience in reviewing physician prescription practices. The experts reviewed evidence from the undercover operations, including the recordings and investigation reports, as well as other information, such as Controlled Substance Utilization Review and Utilization System (CURES) reports, pertaining to Respondent's prescribing practices.

4. a. Dr. Chavez reviewed the evidence, and prepared a report dated January 31, 2014. Based on his analysis of the undercover operations, Dr. Chavez opined that Respondent repeatedly prescribed controlled substances without adequate medical justification and that his treatment of the four patients involved several extreme departures from the standard of care. In his opinion, Respondent did not obtain a good faith history or perform adequate physical examinations of the undercover agents. The underlying reason(s) for the pain complaints were not appropriately assessed. Respondent rarely recommend pain relief with a non-narcotic analgesic. Respondent did not derive any differential diagnoses or a plan of action for any of the undercover agents. Rather, the audiotapes revealed largely non-medical or social conversation, including inappropriate comments about locating the right pharmacy to obtain the drugs. Patients paid in cash, on average $250 for the first visit and $200 for subsequent visits, an accounting method Dr. Chavez described as highly unusual and not seen in legitimate physicians' offices. Dr. Chavez characterized Respondent's behavior as reckless and dangerous. Dr. Chavez's opinions regarding deviations from the standard of care and about excessive prescribing are supported by transcripts of recorded interactions with Respondent and by information from CURES reports, are consistent with the opinions of Dr. Munzing, and are credited.

b. Dr. Chavez recommended further review of Respondent's care and treatment of patents identified through the CURES reports.

5. a. On December 1, 2015, Dr. Munzing issued a detailed, 315-page report. The report contains multiple charts and tables summarizing the data reviewed. In addition to the information obtained during the DEA undercover investigation, Dr. Munzing reviewed patient charts for the undercover agents and for 19 other patients obtained from Respondent pursuant to a warrant.

b. Consistent with Dr. Chavez's analysis of the interactions with the undercover patients, Dr. Munzing concluded, for each of the 13 patient-visits, that Respondent failed to: obtain an appropriate history, obtain an appropriate medical history, perform an appropriate exam, inquire about current or past use of alcohol or illegal drugs, record a pain level, record a functional level, obtain prior medical records or contact a prior treating physician to confirm information provided by the patient, order a urine drug screen, discuss the risks and benefits of using controlled substances, obtain imaging tests, obtain laboratory tests, or check CURES reports. With the exception of one visit, Respondent did not order imaging tests, and in the one case, Respondent did not review the test results. During each visit, Respondent wrote multiple controlled substance prescriptions. In Dr. Munzing's opinion, Respondent's failures to conduct appropriate examinations and his prescription of controlled substances to these individuals in the existing circumstances constituted deviations from the standard of care and excessive prescription of controlled substances. Dr. Munzing's opinions are supported by transcripts of recorded interactions with Respondent and by information from CURES reports, are consistent with the opinions of Dr. Chavez, and are credited.

6. With respect to the 19 non-undercover patients, Dr. Munzing identified areas of concern similar to those identified with respect to the undercover patients. However, unlike his opinions with respect to the undercover visits, which were supported by evidence of Respondent's contemporaneous interactions with the patients, Dr. Munzing had no evidence other than chart information. Moreover, the chart information relied upon by Dr. Munzing was not submitted in evidence and was only summarized by the reviewer. Dr. Munzing's opinions about these patients were thus not supported or corroborated by other record evidence. Given these limitations, and the fact that Dr. Munzing's opinions were not provided under penalty of perjury, it was not established that Respondent violated the standard of care or engaged in excessive prescribing of controlled substances with respect to the 19 non-undercover patients.

7. Respondent did not present any expert testimony, in the form of affidavits or otherwise, contesting the factual allegations made by Petitioner. In argument, Respondent refers to selected passages in the undercover operation transcripts to argue that he complied with the standard of care. These arguments are unpersuasive.

8. a. In his supplemental report, which is incorporated in Bridgford's October 28, 2016 declaration, Dr. Munzing reviewed Respondent's treatment of two additional patients and provided additional information with respect to three of the 19 patients whose charts he had previously examined. As before, Dr. Munzing concluded that Respondent deviated from the standard of care in several respects, including excessive prescribing of controlled substances.

b. Of note, Dr. Munzing writes, based on his review of documents not submitted into evidence, that Respondent prescribed controlled substances to N.C.[1] on March 7 and 25, 2016, on April 9, 2016, and on June 10 and 22, 2016; that Respondent prescribed controlled substances to M.L. on May 31, 2016, and on June 29, 2016; that Respondent prescribed controlled substances to J.M. on April 9 and 19, 2016; that Respondent prescribed controlled substances to R.D. on June 2, 11, 20, and 28, 2016, on July 6, 14, and 22, 2016; that Respondent prescribed controlled substances to C.B. on January 6 and 25, 2016, on February 11, 2016, and on March 3, 2016. With the exception of unclear references to a visit by C.B. on March 3, 2016, Dr. Munzing wrote that there were no chart notes for patient visits on any of the foregoing dates.

9. For the same reasons set forth in factual finding number 6, the evidence contained in Dr. Munzing's supplemental report is insufficient to establish that Respondent deviated from the standard of care or excessively prescribed controlled substances. Moreover, the absence of progress notes for the dates in question can reasonably establish either a deviation from the standard or support Respondent's argument that he did not see the patients.

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[1] Initials have been used to protect patient privacy.

10. On December 10, 2015, the Orange County District Attorney (DA) filed a Felony Complaint Warrant against Respondent, alleging 12 counts of violation of Health and Safety Code section 11153, subdivision (a), during the period of March 26 to September 25, 2013.

11. On August 30, 2016, Respondent and the DA entered into an agreement prohibiting Respondent's prescription of Schedule II, III, and IV controlled medications. In a declaration dated October 28, 2016, Respondent asserts that he is complying with the agreement and that he has not prescribed any Schedule II, III, and IV controlled substances. In a declaration dated November 16, 2016, Respondent asserts he is complying with the restrictions contained in the October 31, 2016 Interim Suspension Order.

LEGAL CONCLUSIONS

1. Petitioner seeks relief under Government Code section 11529, which authorizes licensure suspension and imposition of other conditions pending a resolution of underlying disciplinary allegations. Subdivision (a) of the statute provides that: "The administrative law judge . . . may issue an interim order suspending a license, or imposing drug testing, continuing education, supervision of procedures, or other license restrictions. Interim orders may be issued only if the affidavits in support of the petition show that the licensee has engaged in, or is about to engage in, acts or omissions constituting a violation of the Medical Practice Act . . . and that permitting the licensee to continue to engage in the profession for which the license was issued will endanger the public health, safety, or welfare." Subdivision (e) provides: "[t]he administrative law judge shall grant the interim order where, in the exercise of discretion, the administrative law judge concludes that: [¶] (1) There is a reasonable probability that the petitioner will prevail in the underlying action. [¶] (2) The likelihood of injury to the public in not issuing the order outweighs the likelihood of injury to the licensee in issuing the order."

2. Petitioner objects to reliance on any documentary evidence, including expert opinions, which is not in the form of affidavits. Dismissal of the Petition is urged because the evidence was not all in the form of affidavits. As set forth above, Government Code section 11529, subdivision (a), permits issuance of interim suspension orders if "the affidavits in support of the petition" support issuance of the order. However, the statute does not define the type of affidavit that may be considered or prohibit the introduction of documents that may supplement the affidavits.

In this case, Petitioner submitted a Certificate of Licensure, a Felony Complaint Warrant, and declarations under penalty of perjury from Bridgford, which incorporate attached reports and documents. Submission of the Certificate of Licensure and the Felony Complaint Warrant are not prohibited by Government Code section 11529, and the documents may be considered to supplement the necessary affidavits. The expert reports and other supporting documents are incorporated in the affidavits from Bridgford, and thus broadly comply with the affidavit requirement of Government Code section 11529.

Nevertheless, Respondent's objections have been considered in weighing the evidence presented in support of the Petition. On the one hand, Bridgford was in charge of the investigation and had oversight and coordination responsibility over the gathering of the evidence that was attached to his declarations. He was therefore familiar with the evidence submitted and can attest to its authenticity and reliability. On the other hand, Bridgford is not a medical expert and cannot attest, under penalty of perjury, to the opinions contained in the reports. Moreover, although the evidence from the experts was incorporated in Bridgford's affidavits, the reports themselves were not written under penalty of perjury. Absent such safeguard, the expert opinions contained in the reports have been evaluated in light of the evidence supporting or corroborating the opinions and any contrary expert opinion in affidavit form arrayed against it.

3. Business and Professions Code section 725, subdivision (a), provides, in part, that "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 . . . ." The expert opinions of Drs. Chavez and Munzing and the supporting documentation from the undercover operations show that Respondent excessively prescribed controlled substances to the undercover operatives. Petitioner has therefore established a reasonable probability of prevailing on the claim that Respondent violated Business and professions Code section 725, subdivision (a), by reason of factual finding numbers 3 through 5.

4. Business and Professions Code section 2234 provides that the Board may take action against a physician who engages in gross negligence (subd. (b)) or repeated negligent acts (subd. (c).) The expert opinions of Drs. Chavez and Munzing and the supporting documentation from the undercover operations establish deviations from the standard of care in the care provided by Respondent to the undercover operatives. Petitioner has therefore established a reasonable probability of prevailing on the claim that Respondent engaged in gross negligence or repeated negligent acts in violation Business and professions Code section 2234, subdivisions (b) or (c), by reason of factual finding numbers 3 through 5.

5. Permitting Respondent to continue to engage in the unrestricted practice of medicine will endanger the public health, safety, and welfare by reason of factual finding numbers 3 through 5 and legal conclusion numbers 1 through 4.

Restrictions will be imposed to address the specific public health, safety and welfare concerns identified in the credible evidence submitted by Petitioner while maintaining the status quo pending a full litigation of the allegations. In this regard, the established excessive prescription of controlled substances occurred during the period of March 26, 2013, to September 25, 2013, and, pursuant to his agreement with the DA and as ordered on October 31, 2016, Respondent is no longer prescribing Schedule II, III, and IV controlled substances. Continued limitation of Respondent's prescription practices is appropriate and warranted.

However, given the relative ease of verification through CURES reports of Respondent's compliance with the limitation on prescribing controlled substances, the low probability that someone requiring controlled substances will not be referred to another physician, and the relative hardship on Respondent in employing another physician to monitor compliance, the condition that Respondent employ a physician to monitor his patient files contained in the October 31, 2016 Interim Suspension Order will be removed.

6. The likelihood of injury to the public in not issuing the order set forth below outweighs the likelihood of injury to Respondent in issuing the order, by reason of factual finding numbers 3 through 5 and legal conclusion numbers 1 through 5.

7. Cause exists to issue an interim order restricting Respondent's license pursuant to Government Code section 11529, by reason of factual finding numbers 3 through 5 and legal conclusion numbers 1 through 6.

ORDER

1. The Petition is granted, and Respondent's physician's and surgeon's certificate is restricted in accordance with Government Code section 11529.

2. Pending a full determination of whether Respondent violated the Medical Practice Act, the following restrictions are imposed on Respondent's physician's and surgeon's certificate:

a. Respondent shall not prescribe any Schedule II, III, or IV controlled substances.

b. Respondent shall make appropriate referral of patients who require Schedule II, III, or IV controlled substances and for whom no equally effective alternatives are available within the standard of care.

c. On a monthly basis, commencing one month from issuance of this Order, Respondent shall submit to Petitioner or her designee a declaration attesting to compliance with the restrictions contained in this Interim Suspension Order.

DATED: 2/7/16

Samuel D. Reyes
Administrative Law Judge
Office of Administrative Hearings