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

In the Matter of the Accusation Against:	)	
Jamaal David El-Khal, M.D.	)	**Case No. 800-2015-018583**
Physician's and Surgeon's Certificate No. A 102035	)	
Respondent	)	

DECISION

The attached Stipulated Settlement 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 March 6, 2020.

IT IS SO ORDERED: February 7, 2020.

MEDICAL BOARD OF CALIFORNIA

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

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

In the Matter of the Accusation Against: **JAMAAL DAVID EL-KHAL, M.D.** **680 Cohasset Rd** **Chico, CA 95926-2213** **Physician's and Surgeon's Certificate No. A 102035** Respondent.	Case No. 800-2015-018583 OAH No. 2019031099 **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. Christine J. Lally (Complainant) is the Interim 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 Jannsen Tan, Deputy Attorney General.

2. Respondent Jamaal David El-Khal, M.D. (Respondent) is represented in this proceeding by attorney Jennifer A. Scott, whose address is: 400 Capitol Mall, 27th Floor Sacramento, CA 95814.

3. On or about November 9, 2007, the Board issued Physician's and Surgeon's Certificate No. A 102035 to Jamaal David El-Khal, 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 Accusation No. 800-2015-018583, and will expire on June 30, 2021, unless renewed.

JURISDICTION

Accusation No. 800-2015-018583 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on November 8, 2018. Respondent timely filed his Notice of Defense contesting the Accusation.

4. A copy of Accusation No. 800-2015-018583 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 Accusation No. 800-2015-018583. 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 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 understands and agrees that the charges and allegations in Accusation No. 800-2015-018583, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a prima facie case with respect to the charges and allegations contained in Accusation No. 800-2015-018583, and that Respondent hereby gives up his right to contest those charges.

10. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2015-018583 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving respondent in the State of California .

11. 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.

RESERVATION

12. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

13. 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.

14. 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.

15. 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. A 102035 issued to Respondent Jamaal David El-Khal, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for three (3) years on the following terms and conditions.

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

2. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent.

Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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

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

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

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

Respondent shall submit a certification of successful completion to the Board or its

designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

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

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of 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 the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

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

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a

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

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

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

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

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective

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

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

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

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

6. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief

Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

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

7. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses outside of his current employer.

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

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

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

10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

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

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

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

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

In the event Respondent's period of non-practice while on probation exceeds 18 calendar

months, Respondent shall successfully complete the Federation of State Medical Boards's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

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

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

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

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

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

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

shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

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

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Jennifer A. Scott. 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: 12/12/2019

Jamaal D. El-Khal, MD

JAMAAL DAVID EL-KHAL, M.D.
Respondent

I have read and fully discussed with Respondent Jamaal David El-Khal, 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: 12·12·2019

JENNIFER A. SCOTT
Attorney for Respondent

ENDORSEMENT

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

DATED: 12/12/2019

Respectfully submitted,

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

JANNSEN TAN
Deputy Attorney General
Attorneys for Complainant

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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 Accusation Against: **Jamaal David El-Khal, M.D.** **680 Cohasset Rd** **Chico, CA 95926-2213** **Physician's and Surgeon's Certificate No. A 102035,** Respondent.	Case No. 800-2015-018583 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this 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 November 9, 2007, the Medical Board issued Physician's and Surgeon's Certificate No. A 102035 to Jamaal David El-Khal, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2019, unless renewed.

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JURISDICTION

3. This 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.

4. Section 2227 of the Code states:

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

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

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

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

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

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

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

5. Section 2234 of the Code states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

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

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

6. 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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7. 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."

8. Section 725 of the Code states:

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

physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

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

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

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

DRUGS AT ISSUE

9. Zolpidem Tartrate, brand name Ambien, among others, is a sedative and hypnotic used for short term treatment of insomnia. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

10. Hydrocodone, brand name Norco, among others, is a semi-synthetic opioid derived from codeine. It is commonly used in combination with Acetaminophen. It is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

11. Lorazepam, is a benzodiazepine drug used to treat anxiety disorders. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

12. Diazepam, brand name Valium, among others, is a benzodiazepine drug used to treat a wide range of conditions, including anxiety, panic attacks, insomnia, seizures (including status epilepticus), muscle spasms (such as in tetanus cases), restless legs syndrome, alcohol withdrawal, benzodiazepine withdrawal, opiate withdrawal syndrome and Ménière's disease. It is

a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022

13. Trazodone, is an antidepressant of the serotonin antagonist used for anxiety disorders. It is a dangerous drug pursuant to Business and Professions Code section 4022.

14. Gabapentin, brand name Neurontin, is a medication used as an anticonvulsant and analgesic used to treat epilepsy. It is a dangerous drug pursuant to Business and Professions Code section 4022.

15. Methadone, is a synthetic opioid. It is used medically as an analgesic and a maintenance anti-addictive and reductive preparation for use by patients with opioid dependence. It is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

16. Fentanyl, brand name Duragesic, is a potent, synthetic opioid analgesic with a rapid onset and short duration of action used for pain. It is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

17. Oxycodone is a semisynthetic opioid. It is an analgesic generally indicated for relief of moderate to severe pain. It is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

18. Alprazolam, brand name Xanax, is a short-acting anxiolytic of the benzodiazepine class of psychoactive drugs used for treatment of panic disorder, and anxiety disorders. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

19. Carisoprodol, brand name Soma, is a centrally acting skeletal muscle relaxant. Effective January 11, 2012, it was reclassified from a non controlled substance to a Federal Schedule IV controlled substance pursuant to Controlled Substances Act. It is a dangerous drug pursuant to Business and Professions Code section 4022.

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20. Clonazepam, brand name Klonopin, is an anti-anxiety medication in the benzodiazepine family. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

21. Morphine, sold under different trade names, is an opioid analgesic drug. It is the main psychoactive chemical in opium. Like other opioids, such as oxycodone, hydromorphone, and heroin, morphine acts directly on the central nervous system (CNS) to relieve pain. It is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

22. Temazepam, brand name Restoril, among others, is an intermediate-acting 3-hydroxy hypnotic of the benzodiazepine class of psychoactive drugs. It is a Schedule IV controlled substance pursuant to Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

23. Hydromorphone, brand name Dilaudid, among others, is a centrally acting pain medication of the opioid class. It is made from morphine. It is a Schedule II controlled substance pursuant to Health and Safety Code 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

24. Nordiazepam, sold under different trade names, is a benzodiazepine derivative. It has amnesic, anticonvulsant, anxiolytic, muscle relaxant, and sedative properties. It is used primarily in the treatment of anxiety disorders. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

25. Phentermine, sold under different trade names, is a psychostimulant drug of the substituted amphetamine chemical class. It is used medically as an appetite suppressant for short term use, as an adjunct to exercise and reducing calorie intake. It is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence, Furnishing Dangerous Drugs Without Examination, and Excessive Prescribing – Patient 1)

26. Respondent is subject to disciplinary action under sections 2227, 2242, 725, and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patient 1[1], as more particularly alleged hereinafter.

27. Respondent is a physician and surgeon who practiced at the Ampla Health, Federally Qualified Health Center.

28. On or about September 13, 2011, Respondent saw Patient 1 for an office visit. Patient 1 was a 40-year-old female, with a history of depression, obesity, anxiety, restless leg syndrome, psoriasis, arthritis, insomnia, and ovarian cancer at age 23. She was allergic to penicillin and most antibiotics ("cillin" drugs), latex and a smoker for over 15 years. Patient 1 also had a number of social issues including homelessness, lack of insurance coverage at times, lack of transportation and unable to work. Patient 1 complained of having high blood pressure and shortness of breath after mild exercise. Patient 1's medication list included methadone, Vicodin (hydrocodone-acetaminophen), Soma (carisoprodol), Xanax (alprazolam) and Restoril (temazepam). Respondent prescribed methadone 10 mg, temazepam, alprazolam, and carisoprodol.

29. On or about September 13, 2011, Respondent entered into a pain agreement/controlled substance agreement with Patient 1. Respondent failed to check CURES[2] and document Respondent's discussion with Patient 1, regarding the risk of controlled substances. During this visit, Respondent documented his objective notes:

> "Heart: Regular rate and rhythm. S1 and S2. No murmurs, gallops or rubs were appreciated. Lungs: clear to auscultation bilaterally. No rales, rhonci, or wheezes were appreciated. Abdomen: bowel sounds present, nontender, nondistended. Extremities: No cyanosis, clubbing or edema. Neuromusculoskeletal: Cranial nerves II through XII are intact. Reflexes are

[1] Patient names have been redacted to protect patient confidentiality.

[2] Controlled Substance Utilization Review and Evaluation System stores Schedule II, III, and IV controlled substance prescription information as dispensed in California.

intact. Strength is 5/5 bilaterally. Negative SLR's. Patient has some back spasms."

30. On or about October 1, 2011, Respondent saw Patient 1 for an office visit. Respondent's objective notes remained the same without the neuromusculoskeletal portion. Respondent documented that Patient 1 presented with back pain. Respondent documented that Patient 1 had low back spasms and pain upon palpation. CT scan of Patient 1 lumbar spine taken on August 8, 2011 revealed multilevel neural foraminal narrowing with disk disease with moderate severe narrowing at L5-S1 level. Disk protrusion seen at multiple levels, including the lower three lumbar vertebrae. Respondent documented his assessment as lumbar disc disease and arthritis. He prescribed Dilaudid, ordered an MRI of the lumbosacral spine and advised patient to follow up at her regular appointment.

31. On or about October 12, 2011, Respondent saw Patient 1 for an office visit. Respondent documented that Patient 1's reason for visit was for medication refills and lab results. Respondent documented his assessment as routine physical, hypertension, hypercholesterolemia, and "bipolar." Respondent refilled Patient 1's carisoprodol. Respondent's objective notes remained the same.

32. On or about November 7, 2011, another provider in Ampla Health, drug screen tested Patient 1, who tested positive for Methadone and benzodiazepines, but negative for temazepam, alprazolam, carisoprodol, amphetamines, and fentanyl.

33. On or about November 22, 2011, Respondent saw Patient 1 for an office visit. Respondent documented that Patient 1 presented for medication refills and to get some medication to lose weight. Respondent documented his assessment as obesity, anxiety, depression, and insomnia. Respondent prescribed phentermine, and temazepam during this visit. Respondent's objective notes remained the same.

34. Respondent saw Patient 1 for office visits on or about November 28, 2011, December 6, 2011, and December 13, 2011. During these visits, Respondent documented his assessments as back pain, insomnia, obesity, chronic pain, lumbar disk disease, and refilled Patient 1's medications. Respondent's objective notes remained the same.

35. On or about February 31, 2012, Respondent prescribed Avelox for upper respiratory infections without indication.

36. Respondent saw Patient 1 for office visits on or about February 3, 2012, April 3, 2012, and May 3, 2012. During these visits, Respondent documented assessments as URI, Chronic pain, lumbago, arthritis, obesity, and eczema. Respondent also refilled Patient 1's methadone. Respondent's objective notes remained the same.

37. On or about May 31, 2012, Respondent saw Patient 1 for an office visit. Patient 1's chief complaint was medication refills. Respondent documented his assessment as fatigue, URI, chronic pain, back pain, anxiety, depression, hypercholesterolemia, obesity, and insomnia. Respondent documented that he was going to refill Dilaudid, alprazolam, temazepam, phentermine, and discontinue Soma. Respondent prescribed doxycyline for upper respiratory infections without indication.

38. Respondent saw Patient 1 for office visits on or about July 26, 2012, August 27, 2012, and November 21, 2012. During these visits, Respondent's objective notes remained the same as previous notes. Respondent periodically refilled methadone, Dilaudid, alprazolam, temazepam, and phentermine. Respondent documented his assessments intermittently as anxiety, depression, psoriaisis, arthritis, mood irritability psoriasis, chronic pain, fibromyalgia, and obesity.

39. On or about November 21, 2012, Respondent ordered a urine toxicology drug screen test which was positive for methadone, hydromorphone, alprazolam, temazepam, Soma, nordiazepam, and lorazepam. The test was negative for amphetamines.

40. On or about November 21, 2012, Respondent entered into a pain agreement/controlled substance agreement with Patient 1. Respondent failed to check CURES and document Respondent's discussion with Patient 1, regarding the risk of controlled substances.

41. Respondent saw Patient 1 for office visits on or about January 24, 2013, February 26, 2013, May 21, 2013, August 21, 2013, November 18, 2013, November 22, 2013, and December 6, 2013. During these visits, Respondent documented his assessments intermittently as Anxiety, Arthritis, Back pain, COPD, Chronic pain, depression, fatigue and malaise,

Hypercholesteromia, hypertension, insomnia, obesity, osteoarthritis, Psoriasis, Psoriatic arthropathy. During these visits, Respondent periodically refilled alprazolam, Dilaudid, and methadone.

42. On or about November 27, 2013, another provider in Ampla Health, drug screen tested Patient 1, who tested negative for alprazolam, methadone and hydromorphone. The other physician made a notation on the chart that "[t]he Ameritox showed no alprazolam, methadone or hydromorphone and I will leave further action up to her PCP." Respondent acknowledged the results on or about December 5, 2013.

43. On or about January 8, 2014, Respondent saw Patient 1 for an office visit. Respondent documented the chief complaint as "hospital follow up." Respondent documented the history of present illness as "patient seen in hospital for chest pain. Workup at ER was unremarkable... Patient would like referral to podiatrist and rheumatologist for care of her feet and psoriatic arthritis." Patient 1's relevant medication list as of 2014 was Abilify, alprazolam, dilaudid, methadone, Spiriva.

44. On or about January 23, 2014, Respondent saw Patient 1 for an office visit. Respondent documented the chief complaint as "burn on R foot. Pt requesting lab work before going to rheumatologist." Respondent documented his plan as "test ordered: a complete metabolic panel, arthritis panel, cbc with diff, complete urinalysis, ferritin, folate, vitamin B12, HGB A1c w/ EAG, H.Pylori IgG ab, magnesium, phosphorous, free t4, hypothyroid panel, vit d, 25 hydroxy, VAP cholesterol prof." Respondent continued to prescribe methadone and Dilaudid.

45. Respondent saw Patient 1 for office visits on or about February 4, 2014, April 5, 2014, May 7, 2014, May 27, 2014, June 24, 2014, July 21, 2014, August 20, 2014, September 23, 2014, and November 13, 2014. During these visits, Respondent periodically prescribed and refilled alprazolam, Dilaudid, fentanyl, gabapentin, zolpidem, Spiriva, methadone, and methotrexate. During these visits, Patient 1 presented with psoriatic pain.

46. On or about June 24, 2014, Respondent prescribed azithromycin for an upper respiratory infection without medical indication.

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47. On or about May 13, 2015, Respondent saw Patient 1 for an office visit. Respondent documented the reason for the visit as medication refill. Respondent documented his plan to continue Patient 1 on fentanyl, gabapentin, alprazolam, hydromorphone, and Abilify. Respondent discontinued zolpidem. Respondent ordered labs, including a complete metabolic panel, arthritis panel, cbc with diff, complete urinalysis, ferritin, folate, vitamin B12, HGB A1c w/ EAG, H.Pylori IgG ab, magnesium, phosphorous, free t4, hypothyroid panel, vitamin d, 25 hydroxy, VAP cholesterol prof.

48. Respondent saw Patient 1 for office visits on or about June 30, 2015, September 1, 2015, September 29, 2015, October 13, 2015, October 29, 2015, November 5, 2015, November 10, 2015, November 12, 2015, and November 25, 2015. During these visits, Respondent periodically prescribed and refilled alprazolam, Abilify, fentanyl, gabapentin, hydromorphone, and oxycodone.

49. On or about September 1, 2015, Patient 1 reported her pain medication was stolen.

50. On or about May 9, 2016, Respondent saw Patient 1 for an office visit. Respondent documented the chief complaint as follow up for chronic pain and refill. Patient 1 reported that her home was broken into and her pain medication was stolen.

51. Respondent saw Patient 1 for office visits on or about June 2, 2016, October 3, 2016, and November 10, 2016. During these visits, Respondent periodically prescribed and refilled alprazolam, Abilify, fentanyl, gabapentin, hydromorphone, and oxycodone.

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

A. During the period of 2011 to 2016, Respondent failed to determine a definitive diagnosis for Patient 1's chronic pain.

B. During the period of 2011 to 2016, Respondent failed to appropriately monitor Patient 1's use of opiates.

C. During the period of 2011 to 2016, Respondent failed to consider CURES, toxicology results, "stolen prescriptions" and other red flags of opioid abuse or diversion.

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D. During the period of 2011 to 2016, Respondent used "trial and error" to determine dosages of controlled medication and failed to consider equivalent strengths or Morphine equivalents when prescribing opioids.

SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts – Patient 1)

53. Respondent is subject to disciplinary action under sections 2227, 2242, 725 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient 1, as more particularly alleged hereinafter. Paragraphs 26 through 51, above, are hereby incorporated by reference and realleged as if fully set forth herein.

54. Respondent committed repeated negligent acts in his care and treatment of Patient 1 which included, but were not limited to the following:

A. During the period of 2011 to 2016, Respondent prescribed multiple benzodiazepines together with opioids, muscle relaxants and sleep aids without warnings or precautions to Patient 1.

B. During the period of 2011 to 2016, Respondent prescribed multiple benzodiazepines together with opioids, muscle relaxants and sleep aids despite inconsistent drug screenings.

C. Respondent ordered unnecessary tests such as Urinalyses, H. pylori screenings, and thyroid screenings without medical justification.

D. During the period of 2011 to 2016, Respondent failed to prescribe and order pneumonia vaccinations.

E. Respondent prescribed three courses of antibiotics for "Upper Respiratory Infections" without medical indication.

F. Respondent failed to maintain adequate records. Respondent's records contain verbatim entries from visit to visit. Respondent's diagnosed Patient 1 with a number of mental health conditions, but failed to document affect from 2011 to 2013. Respondent diagnosed arthritis, but never examined Patient 1's joints. Respondent ordered urine toxicology

screenings, but never reviewed or commented on results. Respondent failed to take into account results from other providers.

THIRD CAUSE FOR DISCIPLINE
(Gross Negligence, Furnishing Dangerous Drugs Without Examination, and Excessive Prescribing – Patient 2)

55. Respondent is subject to disciplinary action under sections 2227, 2242, 725 and 2234, as defined by section 2234, subdivision (b), of the code, in that he committed gross negligence in his care and treatment of Patient 2, as more particularly alleged hereinafter.

56. On or about December 8, 2011, Respondent saw Patient 2 for an office visit. Patient 2 was a 41-year-old male, with a history of chronic shoulder and back pain related to prior fractures and presumed disc disease, anxiety, and vitamin D deficiency. Patient 2 also smoked daily. Patient 2 worked as a tire mechanic and had no medication allergies. Respondent failed to document whether Patient 2 used alcohol or illicit substances. Patient 2's medication list included methadone, Norco, diazepam, alprazolam, oxycodone, temazepam, and Soma. Respondent documented he entered into a pain contract with Patient 2. Respondent documented that Patient 2 had presented with medication withdrawal. Respondent documented that he ordered labs, "arthritis panel, CMP, lipid panel, CBC, UA, microalbumin, ferritin, folate, B12, hemoglobin A1c, H.pylori, iron studies, magnesium, phosphorus, thyroid panel, Vit. D level and PSA."

57. On or about December 30, 2011, Patient 2 went to another provider for an office visit. Patient 2 stated he had run out of medication early.

58. On or about January 5, 2012, another provider at Ampla Health ordered a urine toxicology drug screen. Patient 2 was positive for opiates, methadone, lorazepam, temazepam, diazepam, and negative for alprazolam, oxycodone and Soma.

59. On or about January 19, 2012, Respondent saw Patient 2 for an office visit. Respondent documented Patient 2's chief complaint as medication refills. Respondent documented that Patient 2 reported "no nausea, vomiting, chest pain, headache or fever." Respondent refilled Patient 2's methadone, oxycodone, Soma, alprazolam, and diazepam.

60. Respondent saw Patient 2 for office visits on or about February 16, 2012, February 29, 2012, April 2, 2012, June 7, 2012, August 30, 2012, and November 30, 2012. During these

visits, Respondent documented that Patient 2 reported "no nausea, vomiting, chest pain, headache or fever." Respondent prescribed and refilled Patient 2's methadone, oxycodone, Soma, alprazolam, and diazepam.

61. On or about November 30, 2012, Respondent ordered a urine toxicology drug screen. Patient 2 was positive for methadone, diazepam, alprazolam, and negative for Soma and oxycodone. Respondent entered into a pain management contract with Patient 2.

62. On or about February 22, 2013, Respondent saw Patient 2 for an office visit. Respondent documented that Patient 2 reported "no nausea, vomiting, chest pain, headache or fever." Respondent noted Patient 2's negative results for Soma and oxycodone. Respondent discontinued Soma. Respondent increased Patient 2's Valium and refilled methadone, alprazolam, diazepam, and oxycodone. Respondent documented that he ordered labs,"CMP, lipid panel, CBC, UA, hemoglobin A1c, H.pylori, thyroid panel, Vit. D level, PSA, and total and free testosterone."

63. Respondent saw Patient 2 for office visits on or about May 16, 2013, and August 16, 2013. During these visits, Respondent prescribed and refilled Patient 2's methadone, oxycodone, alprazolam, and diazepam.

64. On or about September 20, 2013, Patient 2's urine drug screen revealed he was positive for benzodiazepines, opiates, methamphetamines, methadone and oxycodone.

65. On or about January 13, 2014, Respondent saw Patient 2 for an office visit. Respondent documented Patient 2's chief complaint as medication refills and rapid weight loss. Respondent documented Patient 2's problem lists as anxiety, arthritis, chronic pain, degenerative disc disease, fatigue and malaise, and vitamin deficiency. Respondent prescribed and refilled diazepam, methadone, and discontinued oxycodone. Respondent documented that Patient 2 said he was without methadone for 1.5 months and was stretching what he had left. Respondent ordered labs, "complete metabolic panel, arthritis panel, CBC with diff, complete urinalysis, ferritin, folate, vitamin b12, HGB a1c w EAG, H.Pylori IgG Ab, magnesium, phosphorous, free t4, hypothyroid panel, vit d, 25-hydroxy, VAP cholesterol prof, HIV Ag Ab Combo, Iron studies,

PSA (Hyrbitech), testosterone, total, testosterone, free, direct, C-spine MRI w/o dye, T-Spine MRI w/o dye, lumbar spine MRI w/o dye, MRI shoulder."

66. On or about February 20, 2014, Respondent saw Patient 2 for an office visit. Respondent documented the chief complaint as "WI MEDS." Respondent documented that Patient 2 had lost his prescription and accidentally tore it up in the trash. Respondent documented that a CURES report was run and that Patient 2 did not turn it in anywhere else. Respondent prescribed and refilled, diazepam, methadone, and oxycodone.

67. On or about June 23, 2014, Respondent saw Patient 2 for an office visit. Respondent documented "sinus congestion for the past week." Respondent documented that patient was afebrile with normal heart, lung, ear examination; and no sign of lymph node enlargement. Respondent failed to examine Patient 2's throat, nose, and sinuses. Respondent diagnosed sinusitis and prescribed azithromycin.

68. Respondent saw Patient 2 for office visits on or about March 24, 2014, June 23, 2014, and September 22, 2014. During these visits, Respondent prescribed and refilled, diazepam, methadone, and oxycodone.

69. On or about March 23, 2015, Respondent saw Patient 2 for an office visit. Respondent documented Patient 2's chief complaint as "follow up lab results." Respondent prescribed Levaquin 750 mg without medical indication. Respondent failed to document any infectious symptoms and the review of systems was negative for any ENT or pulmonary symptoms. Respondent refilled and prescribed methadone, oxycodone, and diazepam.

70. On or about June 22, 2015, Respondent ordered labs, complete metabolic panel, arthritis panel, CBC with diff, complete urinalysis, ferritin, folate, vitamin b12, HGB a1c w EAG, H.Pylori IgG Ab, magnesium, phosphorous, free t4, hypothyroid panel, vitamin D, 25-hydroxy, VAP cholesterol prof, HIV Ag Ab Combo, Iron studies, PSA.

71. Respondent saw Patient 2 on or about June 23, 2015, and November 18, 2015. During these visits, Respondent prescribed and refilled, diazepam, methadone, and oxycodone.

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72. On or about March 16, 2016, Respondent saw Patient 2 for an office visit. Respondent documented Patient 2's chief complaint as "pt f/u lab, rx refill." Respondent refilled and prescribed diazepam, methadone, and oxycodone.

73. On or about June 21, 2016, Respondent saw Patient 2 for an office visit. Respondent documented that Patient 2 had "run out of methadone for the past seven days. He was in the hospital ER 2 days ago and was given Norco and Valium for a few days. He is shaking and having cold and warm chills. He feels like a vacuum cleaner is in his a— because everything is flowing through him."

74. On or about July 19, 2016, Patient 2's urine drug screen revealed he was negative for benzodiazepines, opiates, methadone, and positive for amphetamines.

75. Respondent saw Patient 2 on or about March 16, 2016, June 21, 2016, July 19, 2016, July 21, 2016, and November 22, 2016.

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

A. During the period of 2011 to 2016, Respondent failed to determine a definitive diagnosis for Patient 2's chronic pain.

B. During the period of 2011 to 2016, Respondent failed to appropriately monitor Patient 2's use of opiates.

C. During the period of 2011 to 2016, Respondent failed to consider CURES, toxicology results, "stolen prescriptions" and other red flags of opioid abuse or diversion.

D. During the period of 2011 to 2016, Respondent used "trial and error" to determine dosages of controlled medication and failed to consider equivalent strengths or Morphine equivalents when prescribing opioids.

E. During the period of 2011 to 2016, Respondent prescribed high doses of methadone without informed consent, and/or without monitoring for QT prolongation while prescribing other medications that are known to prolong QT interval.

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FOURTH CAUSE FOR DISCIPLINE
(Repeated Negligent Acts – Patient 2)

77. Respondent is subject to disciplinary action under sections 2227, 2242, 725, and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient 2, as more particularly alleged hereinafter. Paragraphs 56 through 75, above, are hereby incorporated by reference and realleged as if fully set forth herein.

78. Respondent committed repeated negligent acts in his care and treatment of Patient 2 which included, but were not limited to the following:

A. During the period of 2011 to 2016, Respondent prescribed multiple benzodiazepines together with opioids, muscle relaxants and sleep aids without warnings or precautions to Patient 2; and despite inconsistent drug screenings.

B. Respondent ordered unnecessary tests such as Urinalysis, H. pylori screening, and thyroid screenings without medical justification.

C. Respondent prescribed antibiotics for one episode of sinusitis and another without a diagnosis. In both instances, Respondent failed to examine and/or document medical necessity.

D. Respondent failed to maintain adequate records. Respondent's records contain verbatim entries from visit to visit. Respondent ordered urine toxicology screenings but never reviewed or commented on results. Respondent failed to take into account results from other providers.

FIFTH CAUSE FOR DISCIPLINE
(Gross Negligence, Furnishing Dangerous Drugs Without Examination, and Excessive Prescribing – Patient 3)

79. Respondent is subject to disciplinary action under sections 2227, 2242, 725 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patient 3, as more particularly alleged hereinafter.

80. On or about September 10, 2011, Respondent saw Patient 3 for an office visit. Patient 3 was a 47-year-old female, with a history of left knee arthritis, chronic pain, insomnia,

and anxiety. Respondent documented Patient 3's chief complaint as "... medication refills. Patient reports no nausea, vomiting, chest pain, headache or fever. She states she is in a lot of pain secondary to her arthritis." Respondent prescribed and refilled Patient 3's Norco, clonazepam, Oxycontin, Soma, and trazodone. Respondent also referred Patient 3 to an orthopedic specialist. Patient 3 had a pain agreement dated April 13, 2011.

81. On or about October 10, 2011, Respondent saw Patient 3 for an office visit. Patient 3 presented with cough, sore throat, and ear pain. Respondent's examination reveals normal temperature and vital signs, red throat, swollen lymph nodes in the neck, and "congested lung sounds." Respondent diagnosed Bronchitis, and prescribed Levaquin and Phenergan with Codeine.

82. Respondent saw Patient 3 for office visits on or about November 10, 2011, and December 9, 2011. During these visits, Respondent periodically prescribed and refilled Norco, clonazepam, Oxycontin, Soma, and trazodone. On the last visit, Respondent ordered labs, "arthritis panel, CMP, lipid panel, CBC, UA, ferritin, folate, B12, hemoglobin A1c, H.pylori, iron studies, magnesium, phosphorus, thyroid panel, vit. D level and stool for blood."

83. On or about February 8, 2012, Respondent saw Patient 3 for an office visit. Respondent documented Patient 3's chief complaint as "lab results and medication refills. Patient reports no nausea, vomiting, chest pain, headache or fever. She underwent an arthroscopy on the left knee last week and has had a little pain..." Respondent found that the UA test was "4+ positive for bacteria and was positive for nitrites." Respondent also noted that Patient 3 had hypertension and vitamin D deficiency. Respondent prescribed and refilled trazodone, Soma, clonazepam, Oxycontin, and Norco. He also prescribed Bactrim and vitamin D.

84. On or about May 22, 2012, Patient 3 saw another provider in Ampla Health, who noted that Patient 3 signed a new pain contract because he could not find an existing one. Patient 3 ran out of medications early. There were no x-rays available. His objective notes also indicated that Patient 3 had diffuse tenderness on palpation of her entire spine, left hip and left knee. He noted spondylosis of the cervical spine, chronic degenerative changes of her thoracic and lumbar spine and left hip.

85. On or about November 13, 2012, Respondent saw Patient 3 for an office visit. Patient 3 presented with a cold and cough. Respondent's examination shows normal vital signs, lack of fever, and Patient 3's lungs were clear. Respondent diagnosed Patient 3 with "URI" and prescribed Z-Pak (azithromycin) and Phenergan DM. Respondent ordered labs, "arthritis panel, CMP, lipid panel, CBC, UA, ferritin, folate, B12, hemoglobin A1c, H.pylori, iron studies, magnesium, phosphorus, thyroid panel, vit. D level and stool for blood, a urine culture and sensitivity, amylase and lipase." Patient 3's November 2012, urine toxicology drug screen was negative for Norco, positive for Oxycontin and clonazepam. Respondent failed to realize the significance of this test. Respondent ordered another urine screen.

86. Respondent saw Patient 3 for office visits on or about March 8, 2012, April 12, 2012, June 7, 2012, July 9, 2012, August 7, 2012, September 18, 2012, November, 13, 2012, and December 13, 2012. Respondent prescribed and refilled refilled trazodone, clonazepam, Oxycontin, and Norco. Respondent also prescribed diazepam.

87. On or about January 24, 2013, Respondent saw Patient 3 for an office visit. Respondent documented results of labwork performed on January 12, 2013. Respondent's objective notes remained substantially unchanged from previous notes. Respondent documented that "Repeat Ameritox 12/13/2012: Results were consistent with her prescribed medications." Respondent prescribed and refilled Oxycontin, Norco, trazodone, Cymbalta, and diazepam. Respondent also prescribed Bactrim.

88. Respondent saw Patient 3 for office visits on or about March 7, 2013, July 2, 2013, and November 15, 2013. Respondent prescribed and refilled trazodone, clonazepam, Oxycontin, diazepam, and Norco. Respondent also prescribed Cymbalta. Respondent ordered labs, "arthritis panel, CMP, lipid panel, CBC, UA, ferritin, folate, B12, hemoglobin A1c, H.pylori, iron studies, magnesium, phosphorus, thyroid panel, vit. D level and stool for blood."

89. On or about January 15, 2014, Respondent saw Patient 3 for an office visit. Respondent documented the chief complaint as medication refills. Respondent documented the results of labs performed on January 4, 2014. Patient 3 had positive occult blood, but it was not

addressed by Respondent. Respondent prescribed and refilled Norco, Oxycontin, Latuda, trazodone, Oxycontin, and Cymbalta. Respondent discontinued diazepam.

90. Respondent saw Patient 3 for office visits on or about April 15, 2014, October 13, 2014, and December 4, 2014. Respondent prescribed and refilled Latuda, Norco, Oxycontin, and trazodone.

91. On or about January 3, 2015, Patient 3 saw a pain specialist, where she reported that she was a daily smoker and smoked marijuana twice a day.

92. On or about January 13, 2015, Respondent saw Patient 3 for an office visit. Respondent documented the chief complaint as follow up lab results. Respondent refilled and prescribed Norco, Latuda, trazodone, oxycontin, and Cymbalta. Patient 3 had positive occult blood results on January 13, 2015 and April 25, 2015, but they were not addressed by Respondent.

93. Respondent saw Patient 3 for office visits on or about April 3, 2015, April 24, 2015, May 27, 2015, and November 10, 2015. Respondent refilled and prescribed Norco, Latuda, trazodone, oxycontin, and Cymbalta. Respondent ordered labs taken on or about April 6, 2015.

94. On or about January 9, 2016 and March 31, 2016, Respondent saw Patient 3 for an office visit. Patient 3 reported "a lot of congestion." Respondent's examination was normal, except for "rhonchi" in the lungs. Respondent diagnosed Patient 3 with an Upper Respiratory Infection and prescribed Levaquin. Respondent reviewed labs taken on January 7, 2016. Respondent refilled and prescribed Oxycontin, Norco, Latuda, and trazodone.

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

A. During the period of 2011 to 2016, Respondent failed to consider safer alternatives for treatment of Patient 3's arthritis.

B. During the period of 2011 to 2016, Respondent failed to appropriately monitor Patient 3's use of opiates.

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C. During the period of 2011 to 2016, Respondent failed to consider CURES, toxicology results, marijuana use, and other red flags of opioid abuse or diversion such as Patient 3's falls, being tired, and losing balance.

D. During the period of 2011 to 2016, Respondent used "trial and error" to determine dosages of controlled medication and failed to consider equivalent strengths or Morphine equivalents when prescribing opioids.

E. During the period of 2011 to 2016, Respondent prescribed benzodiazepines to Patient 3 concurrently with opiates and marijuana, without specific warnings or precautions.

SIXTH CAUSE FOR DISCIPLINE
(Repeated Negligent Acts – Patient 3)

96. Respondent is subject to disciplinary action under sections 2227, 2242, 725 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient 3, as more particularly alleged hereinafter. Paragraphs 80 through 94, above, are hereby incorporated by reference and realleged as if fully set forth herein.

97. Respondent committed repeated negligent acts in his care and treatment of Patient 3 which included, but were not limited to the following:

A. Respondent failed to recommend smoking cessation, to recommend Pneumococcal vaccinations, and to follow up on abnormal fecal occult blood testing.

B. Respondent prescribed three courses of antibiotics without medical indication.

C. Respondent failed to maintain adequate records. Respondent's records contain verbatim entries from visit to visit. Respondent diagnosed Patient 3 with a number of mental health conditions, but did not comment or asses Patient 3's affect or noted it as "normal." He also diagnosed Patient 3 with knee arthritis and disc disease, yet never fully examined Patient 3's knees or back. Respondent's review of systems was often inconsistent with notations in the history of present illness.

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SEVENTH CAUSE FOR DISCIPLINE

(Gross Negligence, Furnishing Dangerous Drugs Without Examination, and Excessive Prescribing – Patient 4)

98. Respondent is subject to disciplinary action under sections 2227, 2242, 725 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patient 4, as more particularly alleged hereinafter.

99. On or about September 10, 2011, Respondent saw Patient 4 for an office visit. Patient 4 was a 50-year-old male, who presented to the clinic for a medication refill. Patient 4 had an MRI of his lumbar spine ordered by his prior physician, on or about January 18, 2011, which showed no significant disc disease. Respondent documented "no nausea, vomiting, chest pain, headache or fever." Respondent documented his assessment as chronic pain and anxiety. Respondent refilled and prescribed Oxycontin, Soma, and Norco. Respondent documented his examination as follows:

"... HEENT: PERRLA. EOMI. Moist mucus membranes. No pharyngeal erythema. HEART: Regular rate and rhythm. S1 and S2. No murmurs, gallops, or rubs were appreciated. LUNGS: clear to auscultation bilaterally. No rales, rhonci or wheezes were appreciated. ABDOMEN: Bowel sounds present, nontender, nondistended. EXTREMITIES: No cyanosis, clubbing or edema."

100. Respondent saw Patient 4 for office visits on or about October 10, 2011, November 10, 2011, and December 9, 2011. Respondent's examination remained unchanged. Respondent prescribed and refilled Oxycontin, alprazolam, and Norco. During the last 2011 visit, Respondent ordered labs, "arthritis panel, CMP, lipid panel, CBC, UA, ferritin, folate, B12, hemoglobin A1c, H.Pylori, iron studies, PSA, thyroid panel, Vi. D level and stool for blood."

101. On or about February 8, 2012, Respondent saw Patient 4 for an office visit. Respondent's examination remained unchanged. Respondent documented the chief complaint as medication refills and lab results. Respondent prescribed and refilled, Norco, Soma, Xanax, Oxycodone.

102. On or about September 18, 2012, Respondent saw Patient 4 for an office visit. Patient 4 reported that he woke up at night due to pain for the last four nights. Respondent

prescribed Ambien to Patient 4. Respondent failed to question Patient 4 regarding sleep habits, sleep hygiene, caffeine or alcohol use, smoking or any other sleep aids. Respondent failed to document Patient 4's affect and general impression regarding his appearance. Respondent failed to discuss any warnings and precautions related to Ambien.

103. Respondent saw Patient 4 for office visits on or about, March 8, 2012, April 12, 2012, April 26, 2012, June 7, 2012, July 9, 2012, August 7, 2012, September 18, 2012, November 13, 2012, and December 13, 2012. Respondent's examination remained unchanged. Respondent prescribed and refilled Oxycontin, Norco, Xanax, and Ambien.

104. On or about November 13, 2012, Respondent saw Patient 4 for an office visit. Patient 4 presented with cough and congestion for an unknown amount of time. Respondent's examination was normal with no fever except for "congested lung sounds on expiration." Respondent diagnosed bronchitis, and prescribed a "z- pak" (azithromycin.) Respondent also ordered labs, "arthritis panel, CMP, lipid panel, CBC, UA, ferritin, folate, B12, hemoglobin A1c, H.pylori, iron studies, magnesium, phosphorus, thyroid panel, Vit. D level, stool for blood and a PSA." Respondent also ordered a urine drug toxicology screen. Respondent entered into a pain management agreement with Patient 4. Respondent failed to discuss the risks of long term opiates with Patient 4. The urine drug screen was negative for alprazolam.

105. On or about December 13, 2012, Respondent saw Patient 4 for an office visit. Patient 4's urine drug screen was positive for Xanax. Respondent documented: "consistent with taking both Oxycontin and Norco. However, the Xanax was in his system at very minimal levels." Respondent failed to document questioning Patient 4 regarding Xanax.

106. On or about January 24, 2013, Respondent saw Patient 4 for an office visit. Respondent's examination remained unchanged. Respondent documented the chief complaint as medication refills and lab results. Respondent prescribed and refilled Oxycontin, Norco, and alprazolam.

107. Respondent saw Patient 4 for office visits on or about March 7, 2013, and September 3, 2013. Respondent prescribed and refilled Norco, OxyContin, and alprazolam.

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108. On or about January 15, 2014, Respondent saw Patient 4 for an office visit. Respondent documented the chief complaint as "Pt c/o flu Sx for 1 day. Pt. requests Rx refills." Respondent documented lab results collected on January 7, 2014, which were positive for opiates. Respondent failed to document and discuss Patient 4's positive fecal occult blood result and document or offer a colonoscopy. Respondent prescribed and refilled Norco, Oxycontin, and alprazolam. Respondent's review of systems was normal except for fever, chills and fatigue. Patient 4's temperature was 100.2 and the remainder of the examination was completely normal. Respondent prescribed Levaquin without medical indication.

109. On or about July 14, 2014, Patient 4 had an MRI which revealed no significant disc disease. Respondent continued to diagnose Patient 4 with disc disease and did not change Patient 4's pain medications.

110. On or about October 13, 2014, Respondent saw Patient 4 for an office visit. Respondent documented that Patient 4 presented for "refills on his medications. He would also like to get a flu shot." Respondent's review of system was normal and "no systemic symptoms. No pulmonary symptoms. No musculoskeletal symptoms." Respondent ordered labs, "arthritis panel, CMP, lipid panel, CBC, UA, ferritin, folate, B12, hemoglobin A1c, H.pylori, iron studies, magnesium, phosphorus, thyroid panel, Vit. D level, stool for blood and a PSA."

111. Respondent saw Patient 4 for office visits on or about April 15, 2014, July 14, 2014, October 13, 2014, and December 10, 2014.

112. On or about January 13, 2015, Respondent saw Patient 4 for an office visit. Respondent documented the chief complaint as "fu lab results med refill." Respondent prescribed and refilled Norco, Oxycontin, trazodone, and clonazepam. Respondent documented the lab results collected on January 3, 2015.

113. Respondent saw Patient 4 for office visits on or about February 25, 2015, April 3, 2015, April 22, 2015, and September 9, 2015. Respondent prescribed and refilled Norco, Oxycontin, and trazodone. Respondent discontinued alprazolam.

114. On or about May 19, 2016, Respondent saw Patient 4 for an office visit. Respondent documented the chief complaint as "follow up cholesterol and refill." Respondent

ordered labs, "urinalysis, CBC, CMP, Hemoglobin A1c, lipid panel, Vit. B12, Vit. D, TSH, and T4." Respondent prescribed and refilled Clonazepam and Oxycodone.

115. On or about August 8, 2016, Respondent saw Patient 4 for an office visit. Respondent diagnosed Patient 4 with "UTI." Respondent failed to document symptoms of a UTI and failed to perform an adequate review of systems. Respondent prescribed Metronidazole without medical indication.

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

A. During the period of 2011 to 2016, Respondent failed to consider safer alternatives for treatment of Patient 4's facet syndrome.

B. During the period of 2011 to 2016, Respondent failed to appropriately monitor Patient 4's use of opiates.

C. During the period of 2011 to 2016, Respondent failed to consider CURES, toxicology results, marijuana use, and other red flags of opioid abuse or dependence.

D. During the period of 2011 to 2016, Respondent used "trial and error" to determine dosages of controlled medication and failed to consider equivalent strengths or Morphine equivalents when prescribing opioids.

E. During the period of 2011 to 2016, Respondent prescribed benzodiazepines to Patient 4 concurrently with other respiratory depressants, opiates and marijuana, without specific warnings or precautions.

EIGHT CAUSE FOR DISCIPLINE
(Repeated Negligent Acts – Patient 4)

117. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient 4, as more particularly alleged hereinafter. Paragraphs 99 through 115, above, are hereby incorporated by reference and realleged as if fully set forth herein.

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

A. Respondent diagnosed insomnia without taking adequate history, and failed to recommend standardized therapies such as counseling, relaxation techniques, or safer medications for Patient 4, who was taking multiple controlled medications.

B. Respondent failed to provide a Pneumococcal vaccination, and failed to follow up on Patient 4's abnormal fecal occult blood and glyco-hemoglobin testing. Respondent also ordered unnecessary tests.

C. Respondent failed to identify and appropriately treat influenza. Respondent ordered a urinalysis without medical indication, and failed to recognize Lactobacillus is a contaminant. Respondent also treated Patient 4's UTI without symptoms, and prescribed antibiotics for bronchitis.

D. Respondent failed to maintain adequate records. Respondent's records contain verbatim entries from visit to visit. Respondent's review of systems was often inconsistent with the notations in the history of present illness and often contradictory.

NINTH CAUSE FOR DISCIPLINE
(Gross Negligence – Patient 5)

119. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the code, in that he committed gross negligence in his care and treatment of Patient 4, as more particularly alleged hereinafter.

120. On or about February 21, 2011, Respondent saw Patient 5 for an office visit. Patient 5 was a 52-year-old male who presented with increasing right shoulder pain and left hand pain. He had a history of shoulder pain due to arthritis and an injury. Patient 5 also has a Dupuytren's contracture of the left hand. His right shoulder x-ray dated January 2011 revealed some osteoarthritis. Patient 5 was scheduled for a surgery consult. Respondent prescribed and refilled Valium, Percocet, and advised Patient 5 to follow up in March for a methadone refill. Respondent failed to discuss the long term effects of opioids with Patient 5. Respondent also failed to enter into a legible pain contract with Patient 5.

121. On or about May 31, 2011, Patient 5 took more pain medications than prescribed. Respondent explained that this was due to a recent clavicular fracture.

122. During the period of February 16, 2011 to December 19, 2011, Respondent prescribed and refilled diazepam, methadone, and hydrocodone.

123. On or about June 15, 2012, a CT scan of the lumbar spine was performed which revealed spondylolisthesis, foraminal bilateral stenosis, and degenerative disc changes of T2-11.

124. On or about July 19, 2012, Patient 5 took more Norco than prescribed because of increased back pain after falling off his horse. Respondent failed to address this increased intake in his assessment and plan.

125. On or about November 14, 2012, Respondent ordered a urine drug toxicology screen which was positive for Norco, methadone, Diazepam, and Oxycodone. Oxycodone was not being prescribed at the time. Respondent failed to address this discrepancy and continued to prescribe the same medications.

126. During the period of January 3, 2012 to December 23, 2012, Respondent prescribed and refilled diazepam, methadone, and hydrocodone.

127. On or about May 13, 2013, Patient 5 reported taking more oxycodone than prescribed because his back was "acting up."

128. On or about September 11, 2013, Patient 5 had a pain consultation with a pain management specialist, who noted that oxycodone was found in Patient 5's recent drug screen and Patient 5 admitted to using his mother's oxycodone.

129. During the period of January 3, 2013 to December 31, 2013, Respondent prescribed and refilled Vicodin, fentanyl, diazepam, methadone, oxycodone, and hydrocodone.

130. On or about January 30, 2014, Patient 5 mistakenly put on two fentanyl patches and ran out early. Respondent's musculoskeletal examination and review of systems was normal.

131. On or about April 15, 2014, Patient 5 had a positive H.pylori test. Respondent failed to address this test, or treat Patient 5. Respondent ordered "routine health maintenance labs" including H pylori antibodies, urinalysis, full arthritis panel, thyroid panel and iron studies yearly.

132. On or about August 5, 2014, Respondent ordered a urine drug toxicology screen which was negative for all benzodiazepines, and positive for oxycodone and fentanyl.

133. During the period of January 3, 2014 to December 19, 2014, Respondent prescribed and refilled Vicodin, fentanyl, oxycodone, and diazepam.

134. During the period of January 23, 2015 to December 5, 2015, Respondent prescribed and refilled hydrocodone, fentanyl, oxycodone, and diazepam.

135. During the period of January 6, 2016 to November 6, 2016, Respondent prescribed and refilled: fentanyl, oxycodone, and diazepam.

136. Respondent committed gross negligence in his care and treatment of Patient 5 which included, but not limited to the following:

A. During the period of 2011 to 2016, Respondent prescribed benzodiazepines without specific indication and in combination with opiates without specific warnings, precautions or offering safer alternatives.

TENTH CAUSE FOR DISCIPLINE
(Repeated Negligent Acts – Patient 5)

137. Respondent is subject to disciplinary action under sections 2227, 2242, 725 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient 5, as more particularly alleged hereinafter. Paragraphs 120 through 135, above, are hereby incorporated by reference and realleged as if fully set forth herein.

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

A. Respondent failed to address aberrant urine toxicology screenings, did not review CURES reports, prescribed high doses of narcotics, and did not consider all safer alternatives.

B. Respondent failed to maintain adequate records. Respondent's records contain verbatim entries from visit to visit. Respondent's examination contained verbatim entries that are contradictory as most of his musculoskeletal review of systems were normal,

although Patient 5 had significant shoulder and back issues. Respondent also diagnosed Patient 5 with benign prostate hypertrophy, but never examined Patient 5's prostate. Respondent ordered urine toxicology screenings, but never reviewed or commented on the results. Respondent failed to address Patient 5's positive H. pylori test.

ELEVENTH CAUSE FOR DISCIPLINE
(Gross Negligence – Patient 6)

139. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the code, in that he committed gross negligence in his care and treatment of Patient 6, as more particularly alleged hereinafter.

140. On or about July 3, 2012, Respondent saw Patient 6 for an office visit. Patient 6 was a 54-year-old male who presented at the clinic for "medication refills and labwork." Respondent documented his assessments as bipolar, anxiety, opioid dependence, history of encephalitis, restrictive lung disease, and health maintenance. Respondent prescribed and refilled clonazepam, Seroquel and methadone. Respondent prescribed methadone to treat "opioid dependence." Respondent's physical examination for Patient 6 was normal.

141. During the period of June 2012 to March 2016, Respondent saw Patient 6 and prescribed and refilled methadone, clonazepam, and Seroquel.

142. On or about July 14, 2012, and November 27, 2012, Respondent entered into a pain management agreement with Patient 6. On or about November 26, 2012, another provider at Ampla Health, documented that Patient 6 had been asking for a medication refill, and the provider documented that he was "not comfortable with filling such high doses of narcotics for pain syndrome [he] was not sure of." Patient 6 used foul language at the provider.

143. On or about January 25, 2013, Respondent had a urine drug toxicology screen which was positive for methadone and benzodiazepines, and negative for illicit substances.

144. On or about October 24, 2016, Respondent saw Patient 6 for an office visit. Respondent documented that Patient 6 "was discharged from pain management because he was not following their protocol and it was found that he was using other people's medication." In addition, Patient 6 was "belligerent and using foul language." Respondent documented that

"Today, the patient had come in a few hours early to his appointment and while he was waiting in the room, he was found to be passed out on the floor."

145. Respondent committed gross negligence in his care and treatment of Patient 6 which included, but was not limited to the following:

A. During the period of 2012 to 2016, Respondent prescribed high doses of methadone to Patient 6, without informing and/or documenting the cardiac risks of methadone without EKG monitoring or questioning regarding personal or family history of heart rhythm abnormalities. Respondent also prescribed other medications that can prolong the QT interval (including Seroquel) and therefore increased the risk of sudden death from methadone. Respondent failed these interactions and did not monitor the patient's EKG.

B. Respondent prescribed high dose methadone without medical indication, and failed to appropriately monitor Patient 6's use of opiates and counseling regarding risks of overdose.

TWELFTH CAUSE FOR DISCIPLINE
(Failure to Maintain Adequate and Accurate Medical Records)

146. Respondent is further subject to discipline under sections 2227 and 2334, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate medical records in the care and treatment of Patients 1, 2, 3, 4, 5, and 6, as more particularly alleged hereinafter: Paragraphs 26 through 145, above, are hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 102035, issued to Jamaal David El-Khal, M.D.;

2. Revoking, suspending or denying approval of Jamaal David El-Khal, M.D.'s authority to supervise physician assistants and advanced practice nurses;

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3. Ordering Jamaal David El-Khal, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: November 8, 2018

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

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